2027 EVIDENCE OF COVERAGE

[AmeriHealth Caritas VIP Next, Inc.]

Individual Member Health Maintenance Organization (HMO) Policy

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

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

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

This document is your contract with us. Sometimes we refer to it as a "**policy.**" It outlines what **health care services** and prescription drugs your insurance covers and the amount you will need to pay toward their costs during the period of your **policy**. It explains how to get coverage for the **health care services** and prescription drugs you need. **Please read this document carefully and keep it in a safe place.** This document is also available in alternate formats such as Braille, large print, or audio. You have 10 days from the date of receipt of this **policy** to examine its provisions and surrender the **policy**, for any reason, to AmeriHealth Caritas Next.

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

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

Renewal

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

If you have any questions about this document, how to obtain alternate formats of this document, or how to use your health plan, please feel free to contact our Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.]

[AmeriHealth Caritas VIP Next, Inc.]

[ **]**

[Loretta Lenko, President – Exchange]

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Definitions of Important Words Used in This Document

- **Adverse Benefit Determination —** A coverage determination by **the health benefit plan** that:
    - An admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the **health benefit plan's** requirements for **medical necessity**, appropriateness, health care setting, level of care or effectiveness, or the prudent layperson standard for coverage of **emergency services** due to an **emergency medical condition** per Delaware law, and coverage for the requested service is therefore denied, reduced, or ended; or
    - The **health benefit plan** will not provide or make payment based on a determination of the member's eligibility to participate in a plan; or
    - Coverage has been rescinded (whether or not the rescission has an adverse effect on any particular benefit at that time).
- **Allowed amount** – The amount we pay a **provider** for a **covered health service** provided to a **member.** It is the lesser of the **provider's** charge or our maximum payment amount. If you need to pay a **coinsurance,** it is a percentage of the **allowed amount.**
- **AmeriHealth Caritas Next Virtual Care 24/7 —** The preferred vendor with whom we have contracted to provide **virtual care services** to our **members**. Our preferred vendor contracts with **providers** to render **virtual care services** to our **members**.
- **Annual enrollment period —** A set time each Fall when **members** can change their health plan. Generally, the **annual enrollment period** begins the November prior to the health **plan year**.
- **Appeal —** A disagreement with our **Adverse Benefit Determination** to deny a request for coverage of **health care services** or prescription drugs, or payment for services or drugs you already received. You may also make an **appeal** if you disagree with our determination to stop services that you are receiving. For example, you may ask for an **appeal** if we do not pay for a drug, item, or service you think you should be able to receive.
- **Applied behavior analysis —** The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. These include, but are not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
- **Autism spectrum disorder (ASD) —** As defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems.
- **Behavioral health —** The diagnosis and treatment of a mental or behavioral disease,

disorder, or condition listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as revised, or any other diagnostic coding system. This applies whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin.

- **Benefit period —** One calendar year or one **plan year**, applied per the terms of the **member's** plan. However, when a member is initially enrolled, the **benefit period** will be the date of enrollment through the end of the then-current calendar year.
- **Benefits —** Your right to payment for **covered health services** available under this **policy**.
- **Brand name drug —** A prescription drug that is made and sold by the pharmaceutical company that originally researched and developed the drug. **Brand name drugs** have the same active-ingredient formula as the generic version of the drug. However, **generic drugs** are made and sold by other drug manufacturers. These drugs are generally not available until after the patent on the **brand name drug** has expired.
- **Center of Excellence —** A **Center of Excellence** is a team, shared facility, or entity, that provides leadership, best practices, research, and support, and/or training for a focus area. AmeriHealth Caritas Next evaluates transplant programs throughout the U.S. AmeriHealth Caritas Next only includes transplant programs that meet our strict Centers of Excellence criteria in our Network. We annually re-evaluate programs to ensure the network maintains its standards of care.
- **Chronic care management services —** Services provided to **members** who have 2 or more medical conditions expected to last at least 12 months or until the death of the **member**, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Services must be provided in accordance with the Chronic Care Management Services Program, as administered by the Centers for Medicare and Medicaid Services.
- **Clinical peer —** A health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the **health care services** subject to **utilization review.**
- **Clinical review criteria —** The written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an **insurer** to determine the necessity and appropriateness of **health care services** and supplies. They are based on sound clinical evidence that is periodically evaluated to ensure ongoing efficacy.
- **Clinical trials —** Includes **clinical trials** that are approved or funded by use of the following entities:
  - One of the National Institutes of Health (NIH);
  - An NIH cooperative group or center which is a formal **network** of facilities that collaborate on research projects and have an established NIH-approval peer review

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

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

- **Coinsurance —** A percentage of the **allowed amount** you need to pay for **covered health services** and prescription drugs. A **copayment** is not a **coinsurance**. **Copayment** is defined elsewhere in this document.
- **Complaint —** The formal name for making a **complaint** is "filing a **grievance**". The **complaint** process is only used for certain types of problems. These include problems related to quality of care, waiting times, and the customer service you receive (see "**Grievance**," in this list of definitions). **Complaints** do not involve coverage or payment disputes. Those types of disputes are addressed through the **appeals** process (see "**Appeal**" in this list of definitions.)
- **Complication of pregnancy —** Medical conditions whose diagnoses are separate from pregnancy. They may be caused or made more serious by pregnancy. They may also put the mother's life or health in jeopardy or make a live birth less viable. Examples include:
  - Abruption of placenta.
  - Acute nephritis.
  - **Emergency** caesarean section, if provided in the course of treatment for a **complication of pregnancy**.
  - Kidney infection.
  - Placenta previa.
  - Poor fetal growth.
  - Preeclampsia or eclampsia.
- **Copayment (or copay) —** A specific dollar amount you may need to pay as your share of the **allowed amount** for **covered health services** or prescription drugs you receive. A **copayment** is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug. A **copayment** is not a **coinsurance**. **Coinsurance** is defined elsewhere in this document.
- **Cost-sharing —** Amounts that a **covered person** must pay when services or drugs are received. **Cost-sharing** includes any combination of these types of payments:

  - Any **coinsurance** amount, a percentage of the total amount paid for a service or drug that a health plan requires when a specific service or drug is received.
  - Any **deductible** amount a health plan may impose before services or drugs are covered.
  - Any fixed **copayment** amount that a health plan requires when a specific service or drug is received.

- **Covered health service — Health care services** that are payable under this **Evidence of Coverage.** They must be **medically necessary** and ordered or performed by a **provider** who is legally authorized or licensed and appropriately credentialed to order or perform the service. **Covered health services** include things such as a medical service or supply, doctor's visit, **hospital** visit, or prescription drug. For prescription drugs, **covered health services** mean drugs or supplies to treat medical conditions, such as disposable needles and syringes when dispensed with insulin.
- **Covered person, member or you —** A policyholder, **subscriber**, enrollee, or other individual covered by this **health benefit plan**.
- **Deductible —** The amount you must pay for **covered health services** or prescription drugs each year before your **health benefit plan** begins to pay.
- **Department —** The Delaware Department of Insurance.
- **Dependent —** The **subscriber's** spouse, domestic partner, or child by blood or by law who is less than 26 years of age who resides within the United States. "Child" includes a biological child, an adopted child, or a child placed for adoption or foster care who is younger than 18 years of age on the date of the adoption or placement for adoption or foster care.
- **Diabetes equipment and supplies —** blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies.
- **Disenroll** or **disenrollment —** The process of ending your membership in our health plan. **Disenrollment** may be voluntary (your own choice) or involuntary (not your own choice).
- **Durable medical equipment (DME) —** Certain medical equipment and supplies ordered by your **provider** for medical reasons. Examples include:
  - Crutches
  - Diabetes supplies
  - Hospital beds ordered by a **provider** for use in the home.
  - IV infusion pumps
  - Nebulizers
  - Oxygen equipment

- Power mattress systems
- Speech-generating devices
- Walkers
- Wheelchairs

- **Effective date —** The date a **member** becomes covered under this **policy for covered health services**.

- **Emergency** or **emergency medical condition —** An **emergency medical condition** is when you, or any other prudent layperson with an average knowledge of health and medicine, reasonably believe that you have acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could mean:
  - Placing your health (or, for a pregnant person, the health of the person or their unborn child) in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

  For a pregnant person having contractions, this includes if there is inadequate time to safely transfer the person to another **hospital** before delivery, or if that transfer may pose a threat to the health or safety of the person or unborn child.

- **Emergency Services —** If you have an emergency medical condition, you can go to the emergency room right away, including a freestanding emergency room that is not part of a hospital. You do not need to ask your Plan first. It does not matter if the emergency room is in your Plan's network or not - you are covered either way. This includes the care you get right after you arrive, and it also includes extra care you may need to become stable. That extra care is still treated as emergency care and covered the same way, unless you are in a condition to safely be moved to an in-network hospital. The emergency room cannot charge you extra for going out of network. Any money you pay for an emergency medical condition at an emergency room counts toward your deductible, if applicable, and your yearly limit on out of pocket costs, just like it would at an in-network emergency room.

- **Enrollment Date —** The date of enrollment, or if earlier, the first day of the waiting period for the enrollment

- **Evidence of Coverage (EOC)** and **coverage information —** This document, your enrollment form, and any other attachments, **Schedule of Benefits, riders**, or other optional coverage selected, that explains your coverage. It explains your rights, what we must do, and what you must do as a **member** of our health plan.

- **Experimental** or **Investigational —** Services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply that meets one or more of the following criteria

as determined by AmeriHealth Caritas Next:

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

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

- **Final internal adverse benefit determination (Final Determination)** – An **Adverse Benefit Determination** that has been upheld by us and completes our internal **appeal** process.
- **Formulary/formulary drugs —** A list of medications that we cover. Products are on the **formulary** generally cost less than products that are not on the **formulary**.
- **Foster Child —** A minor over whom a guardian has been appointed by the clerk of superior court of any county in Delaware. This can also be a minor for whom a court of competent jurisdiction has ordered a guardian the primary or sole custody.
- **Generic drug —** A recognized drug approved by the Food and Drug Administration (FDA) as having the same active ingredients as a **brand name drug**. Generally, a **generic drug** works the same as a **brand name drug** and costs less.
- **Grievance —** A **complaint** submitted by a **covered person** about:
  - An **insurer's** decisions, policies, or actions related to availability, delivery, or quality of **health care services**. A **complaint** submitted by a **covered person** about a decision rendered only because that the **health benefit plan** has a **benefits** exclusion for the **health care services** in question is not a **grievance** if the exclusion of the service requested is clearly stated in the **Evidence of Coverage**.
  - Claims payment and handling or reimbursement for services
  - The contractual relationship between a **covered person** and an **insurer**
- **Habilitative services — Health care services** that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech and language therapy, and other services for people with disabilities in inpatient or

outpatient settings.

- **Health benefit plan —** Any of the following if offered by an **insurer**:
  - Accident and health insurance policy or certificate
  - Nonprofit hospital or medical service corporation contract
  - Health maintenance organization **subscriber** contract
  - Plan provided by a multiple employer welfare arrangement

  "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. Sometimes it is called a "health plan."

  Health benefit plan also does not mean any of the following kinds of insurance:
  - Accident
  - Adult and **dependent** dental coverage
  - Adult vision coverage
  - Coverage issued as a supplement to liability insurance
  - Credit
  - Disability income
  - **Hospital** income or indemnity
  - Insurance implemented or administered by the State Health Plan for Teachers and State Employees
  - Insurance under which **benefits** are payable with or without regard to fault and that is statutorily required to be contained in any liability **policy** or equivalent self-insurance
  - Long-term or nursing home care
  - Medical payments under automobile or homeowners
  - Medicare supplement
  - Specified disease
  - Workers' compensation
- **Health care provider** or **provider—** Any person who is licensed, registered, or certified under state laws or the laws of a state to provide **health care services** in the ordinary care of business, practice, or profession or in an approved education or training program. This can also mean a pharmacy or a health care facility as defined in the laws of Delaware, to

operate as a health care facility.

- **Health care services —** Services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- **Hearing aid —** Any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices such as FM systems.
- **Home health aide —** A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or prescribed exercising). **Home health aides** do not have a nursing license or provide therapy.
- **Home health care — Health care services** provided to the **member** in the home for treatment of an illness or injury by an organization licensed and approved by the state to provide these services.
- **Hospice —** A program for **members,** who have six months or less to live, that addresses the physical, psychological, social, and spiritual needs of the **member** and their immediate family.
- **Hospital —** A facility for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses. **Hospital** does not mean health resorts, spas, or infirmaries at schools or camps.
- **Iatrogenic infertility —** An impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment.
- **Infertility —** A disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth, including the following:
    - Absent or incompetent uterus.
    - Damaged, blocked, or absent fallopian tubes.
    - Damaged, blocked, or absent male reproductive tract.
    - Damaged, diminished, or absent sperm.
    - Damaged, diminished, or absent oocytes.
    - Damaged, diminished, or absent ovarian function.
    - Endometriosis.
    - Hereditary genetic disease or condition that would be passed to offspring.
    - Adhesions.

  - Uterine fibroids.
  - **Sexual dysfunction** impeding intercourse.
  - Teratogens or idiopathic causes.
  - Polycystic ovarian syndrome.
  - Inability to become pregnant or cause pregnancy of unknown etiology.
  - Two or more pregnancy losses, including ectopic pregnancies.
  - Uterine congenital anomalies, including those caused by diethylstilbestrol (DES).
- **Inherited metabolic diseases —** Diseases caused by an inherited abnormality of biochemistry. This includes any diseases for which the state screens newborn babies.
- **Inpatient rehabilitation facility —** A facility that provides inpatient rehabilitation health **services**, as authorized by law.
- **Insulin pump —** A small, portable medical device that is approved by the FDA to provide continuous subcutaneous insulin infusion.
- **Insurer —** An entity that writes a **health benefit plan** and that is any of the following:
  - An insurance company
  - A service corporation
  - A health maintenance organization
  - A multiple employer welfare arrangement.
- **Low protein modified formula or food product —** A formula or food product that is specially formulated to have less than 1 gram of protein per service, and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. This does not include a natural food that is naturally low in protein.
- **Managed care plan —** A **health benefit plan** in which an **insurer** either requires a **covered person** to use or creates incentives, including financial incentives, for a **covered person** to use **providers** that are under contract with or managed, owned, or employed by the **insurer**.
- **Medical formula or food —** Intended for the dietary treatment of an inherited metabolic disease for which nutritional requirements and restrictions have been established by medical research and formulated to be consumed or administrated enterally under the direction of a physician.
- **Medically necessary or medical necessity —** The **covered health services** or supplies that are:
  - Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease. They are not for **experimental**, **investigational**, or for cosmetic purposes,

except as allowed under Delaware law.

- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not only for the convenience of the insured, the insured's family, or the **provider.**

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

- **Member** (**member** of our health plan, or "**health plan member"**) **—** A person who is eligible to receive **covered health services**, after their enrollment has been confirmed and any necessary **premiums** have been paid. A **member** includes the **subscriber** and any **dependents**.
- **National Coverage Determination Services —** A service, item, test, or treatment which has been determined to be covered nationally by the Secretary of the U.S. Department of Health and Human Services.
- **Network or in-network —** Health care professionals, medical groups, **hospitals**, health care facilities, and **providers** who have agreed to provide **covered health services** to our **members**. They also have agreed to accept our payment and any **cost-share** the member pays as a full payment.
- **Network or in-network pharmacy —** A pharmacy that has an agreement with our **health benefit plan** to provide prescription drugs and other items to our members. They agree to accept our payment and any **member** cost-share as a full payment. In most cases, your prescriptions are covered only if they are filled at one of our **network pharmacies**.
- **Network or in-network provider** or **network/in-network facility — Providers** who have an agreement with our health plan to provide **covered health services** to our **members** and to accept our payment and any **member** cost-share as a full payment. Our health plan pays **network providers** based on the agreements we have with them. **Network providers** may also be referred to as "**health plan providers**."
- **Out-of-network pharmacy —** A pharmacy that does not have an agreement with our health plan to provide covered prescriptions or other items to our **members**. Under this **Evidence of Coverage**, most drugs you get from **out-of-network pharmacies** are not covered by our health plan unless certain conditions apply.
- **Out-of-network provider** or **out-of-network facility —** A **provider** or facility that does not have an agreement with us to coordinate or provide **covered health services** to **members** of our health plan. They have also not agreed to accept our payment and any **member** cost-share as a full payment. **Out-of-network providers** are not employed, owned, or operated

by our health plan.

- **Out-of-pocket costs —** See the definition for **cost-sharing** above. A **member's cost-sharing** requirement to pay for a portion of services or drugs received or any **deductible** amount is also called the **member's out-of-pocket cost** requirement.
- **Out-of-pocket maximum** amount **—** The most that you pay out-of-pocket during the calendar year for **in-network covered health services**, including **deductibles** and any **cost-sharing** amounts you have paid. Amounts you pay for your **premiums** do not count toward the **out-of-pocket maximum** amount.
- **Partial hospitalization —** Services received from a free-standing or hospital-based program that provides services at least 20 hours per week and continuous treatment for at least three hours but no more than 12 hours per 24-hour period.
- **Participating provider —** A **provider** who has an agreement with an **insurer** or an **insurer's** contractor or subcontractor, to provide **health care services** to **covered persons**. In return, the **provider** receives direct or indirect payment from the **insurer**. This payment does not include **coinsurances**, **copayments**, or **deductibles**. This **provider** also agrees to accept the payment and any **member cost-sharing** as a full payment.
- **Physician —** A person duly licensed (other than an intern, resident, or house physician) as a medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, optometrist, ophthalmologist, physician assistant or licensed doctoral psychologist legally entitled to practice within the scope of his or her license and who normally bills for his or her services.
- **Placement for adoption** or **being placed for adoption —** The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child's placement with a person terminates upon the termination of such legal obligations.
- **Plan year —** This is typically a calendar year. However, if your initial **effective date** is other than January 1, your initial **plan year** will be less than 12 months. It will then start on the **effective date** and run through December 31 of the same year.
- **Policy —** The document that describes the agreements between the **health benefit plan** and the **member**. Your **policy** includes this document, the **Schedule of Benefits**, your application, and any amendments or **riders**. Sometimes your **policy** is called a contract.
- **Premium —** The periodic payment to AmeriHealth Caritas Next or a health care plan for health and/or prescription drug coverage.
- **Prescription insulin drugs —** A drug containing insulin that is dispensed under federal and state law for the treatment of diabetes.
- **Primary care provider (PCP) —** The doctor or other **provider** you see first for most health problems. This provider can be a physician in family medicine, general medicine, internal

medicine, or pediatric medicine; advanced practice nurse; certified nurse practitioner; or physician's assistant. They make sure you get the care you need for your best health. They may also talk with other **health care providers** about your care and refer you to them.

- **Prior authorization —** Approval in advance to get services or certain drugs that may or may not be on our **formulary**. Some in-network medical services are covered only if your **in-network provider** gets **prior authorization** from your **health benefit plan**.
- **Prosthetics and orthotics —** Medical devices ordered by your doctor or other **health care provider**. Covered items include, but are not limited to:
  - Arm, back, and neck braces
  - Artificial eyes
  - Artificial limbs;
  - Devices to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.
  - Prostheses following mastectomy
- **Provider —** A general term we use for doctors, other health care professionals, **hospitals**, and health care facilities licensed or certified under state law or the laws of another state to provide **health care services**.
- **Quantity limits —** A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Drugs may be limited by the amount we cover per prescription or for a defined time frame.
- **Rehabilitation services —** These services include physical therapy, speech and language therapy, and occupational therapy. Services may be provided on an inpatient or outpatient basis and subject to limitations as described in the **Schedule of Benefits**.
- **Rider —** An amendment to this **Evidence of Coverage** that may modify the covered **benefits**.
- **Routine patient care costs for clinical trials —** All items or **covered health services** that are otherwise generally available to a **covered person** that are provided in a **clinical trials** except the following:
  - The **investigational** items or service itself.
  - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patients.
  - Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.
- **Schedule of Benefits —** A document that identifies the **member,** applicable **copayments**,

coinsurance, **deductibles**, **out-of-pocket maximum**, and benefit limits for **covered health services**. If we issue a new **Schedule of Benefits**, it will replace any prior **Schedule of Benefits** on the **effective date** of the new **Schedule of Benefits**. A **Schedule of Benefits**, together with the **Evidence of Coverage**, riders, and other documents that amend the **Evidence of Coverage** make up your benefit plan **policy**.

- **Serious and complex condition or illness** — an acute condition or chronic illness that requires specialized treatment over a period of time to avoid injury, or impairment that results in, or is likely to result in, any of the following:
  - Death or permanent harm;
  - Significant decline in physical, mental, or psychosocial functioning that is not solely due to the normal progression of a disease or aging process;
  - Loss of limb, or disfigurement;
  - Avoidable pain that is excruciating, and more than transient; or
  - Other serious harm that creates life-threatening complications/conditions.
- **Service area — Service area** means the geographic area in Delaware as described by the HMO where an HMO enrolls persons who either work in the **service area**, reside in the **service area**, or work and reside in the **service area**, as approved by the Commissioner. Visit our website to see our coverage map of counties in our **service area**: [https://www.amerihealthcaritasnext.com/de/view-plans/coverage-area.aspx]. You may also contact our Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays], for additional information.
- **Sexual dysfunction —** Any of a group of sexual disorders that cause inhibition either of sexual desire or the psychophysiological changes that are usually part of sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.
- **Skilled nursing facility (SNF) care —** Skilled nursing care and **rehabilitation services** provided continuously and daily in a **skilled nursing facility**. Examples of **SNF** care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.
- **Special enrollment period —** An opportunity to enroll in a health plan outside of the annual open enrollment period based on specific qualifying events such as birth, adoption, divorce, or marriage.
- **Stabilize —** To provide medical care appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, per the Health Care Financing Administration (HCFA) interpretative guidelines, policies, and regulations for responsibilities of **hospitals** in **emergency** cases. These are as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42

U.S.C.S. § 1395dd. They include **medically necessary** services and supplies to maintain stabilization until the person is transferred.

- **Standard fertility preservation services —** Procedures consistent with established medical practices and professional guidelines published by professional medical organizations, including the American Society for Clinical Oncology and the American Society for Reproductive Medicine.
- **Step therapy —** A pharmacy management tool that requires you to first try another drug to treat your medical condition before we will cover the drug your **provider** may have initially prescribed.
- **Subscriber —** The **covered person** who is properly enrolled under this **policy**, and on whose behalf this **policy** is issued. It does not include **dependents.**
- **Therapeutic equivalents —** A contraceptive drug, device, or product that is all of the following:
  - Approved as safe and effective.
  - Pharmaceutically equivalent to another contraceptive drug, device, or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendia or other applicable standards of strength, quality, purity, and identity.
  - Assigned, by the FDA, the same therapeutic equivalence code as another contraceptive drug, device, or product.
- **Urgent care services —** Services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. **Urgent care services** may be furnished by **network providers** or **out-of-network providers** when **in-network providers** are temporarily unavailable or inaccessible.
- **Utilization Review —** A set of formal techniques to monitor the use or evaluate the clinical necessity, appropriateness, efficacy or efficiency of **health care services**, procedures, **providers**, or facilities. These techniques may include:
  - Ambulatory review — **Utilization review** of outpatient services.
  - Case management — A coordinated set of activities for individual patient management of serious, complicated, protracted, or other health conditions.
  - Certification — A determination by an **insurer** or its designated **Utilization Review Organization (URO)** that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the **insurer's** requirements for **medically necessary** services and supplies, appropriateness, health care setting, level of care, and effectiveness.

- Concurrent review — **Utilization review** during a patient's **hospital** stay or course of treatment.
- Discharge planning — The formal process for determining, before discharge from a **provider** facility, the coordination and management of the care that a patient receives after discharge from a **provider** facility.
- Prospective review — **Utilization review** before an admission or a course of treatment including any required preauthorization or precertification.
- Retrospective review — **Utilization review** of **medically necessary** services and supplies after services have been provided to a patient. It includes the review of claims for **emergency services** to determine whether the prudent layperson standard has been met per Delaware law.
  - Retrospective review does not include a review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment
- Second opinion — A clinical evaluation by a **provider** other than the **provider** originally recommending a service. This is to assess the clinical necessity and appropriateness of the proposed service.

- **Utilization Review Organization (URO) —** An entity that conducts **utilization review** under a **managed care plan** but not an **insurer** performing **utilization review** for its own **health benefit plan**.
- **Virtual care services —** Includes evaluation, management, and consultation services with a professional **provider** for **behavioral health** and nonemergency medical issues via an interactive audio or video telecommunications system.

Eligibility and Termination

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

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

Eligible dependents

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

- Your spouse or domestic partner, as recognized under the applicable marriage or civil union laws of Delaware, who resides within the **service area**.
- Your natural child or a legally adopted child who is less than 26 years of age.
- Stepchildren.
- Children awarded coverage pursuant to an administrative or court order.
- **Foster children.**

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

- The child is and remains incapable of self-sustaining employment by reason of intellectual disability or physical handicap.
- The condition started before the child reached age 26.
- The child was covered under this or any other health plan before the child reached age 26 and stayed continuously covered after reaching age 26.
- The child depends on you for most or all of their support.

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

Per all applicable requirements of Public Law 110-381, known as Michelle's Law, we will extend coverage for a child enrolled in a postsecondary educational institution during a **medically necessary** leave of absence.

When coverage begins

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

If you were previously a **member** of AmeriHealth Caritas Next **health plan** you will need to make your first month's **premium** payment for the new coverage period to begin on new or renewing **policies**. If you were previously terminated by AmeriHealth Caritas Next due to non-payment of **premiums**, we will still allow you to enroll in a new **policy**. **Premium** payments paid toward the new **policy** will not be applied to any outstanding balance from a previously terminated health plan.

Enrollment periods

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

If you have a change in circumstances, you may be eligible for a **special enrollment period** within 60 days of that event per Delaware and federal law and regulation. Events that may qualify for a **special enrollment period** include:

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

Enrolling dependents

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

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

effective date of coverage for the **dependent**. You will need to provide any **premium** that may be due or any documentation to show the **effective date** of the qualifying event with the application.

A newborn **dependent** child of the **subscriber** is automatically covered for the first 30 days of life. Coverage includes services due to injury or sickness, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, and routine care furnished any infant from the moment of birth. If you want to continue enrollment of the newborn beyond the 31st day, you will need to enroll the newborn within 31 days of the date of birth.

If the **dependent** is a newly adopted child or **foster child**, the **effective date** of coverage is the date of the adoption or placement for adoption, or the placement for foster care. An eligible adopted child must be enrolled within 30 days from the legal date of the adoption. We will provide **benefits** to your adopted child under the same terms and conditions that apply to naturally born **dependent** children, irrespective of whether the adoption has become final when your adopted child's coverage becomes effective. A **foster child** must be enrolled within 30 days from the date of placement in the foster home.

If the **premium** changes because of adding the newborn, **foster child** or adopted child to your coverage, then you will need to pay the full **premium** amount for the newborn within 31 days of the date of birth or 30 days of the legal adoption date or placement of the **foster child**.

Changes in eligibility

You will need to notify us of any changes that might affect your eligibility or the eligibility of any **dependents** for coverage under this **policy**. Any notification must happen within 60 days of the change. These changes include but are not limited to the following:

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

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

End of coverage — termination of enrollment

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

Reasons for ending coverage may include any of the following:

- You give us written notice asking us to cancel this **policy** for you and/or your **dependents**. If you have already paid any **premiums** in advance for any months after the date of termination, we will refund or credit that amount within 30 days of the request for termination. For retroactive terminations, we will not refund or credit any **premium** when claims have been submitted for dates of service after the requested date of termination.
- Loss of eligibility, if you are no longer living in the **service area** served by our plan.
- For an enrolled **dependent**, the end of the calendar year in which they turn 26.
- For non-dependents covered under a child only **policy**, the end of the calendar year in which they turn 21.
- The death of the **subscriber**, although **dependents** may continue coverage under a new **policy**.
- Loss of eligibility of an enrolled spouse **dependent** due to legal separation or termination of marriage by divorce or annulment or similar actions.
    - Loss of eligibility begins on the date a final decree of divorce, annulment or dissolution of marriage is entered between the **dependent** spouse and **subscriber** or the date a termination of domestic partnership between the **subscriber** and domestic partner is entered.
- If **premiums** are not paid when they are due. In this case we will give you 15 days' advance written notice of pending termination before ending coverage.
- Discontinuation of this plan, in which case we will give you 90 days' advance written notice before ending coverage.
- Discontinuation of all of our plans in the Delaware Exchange, in which case we will give you 180 days advance written notice before ending coverage.
- Fraud, including improper use of your member ID card.

Payment of premiums

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

Premium payments are due in advance for each calendar month. Monthly payments are due on or before the first day of each month for coverage for that month. A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which

grace period the policy shall continue in force. If you are receiving a federal **premium** subsidy (Advance Premium Tax Credit) your grace period will be 3 months, and your coverage will remain in force during the grace period. If we do not receive full payment of your **premium** within the grace period, your coverage will end as of the last day of the last month for which a **premium** has been paid. We will notify the **subscriber** of the nonpayment of **premium** and pending termination. We will also notify the **subscriber** of the termination if the **premium** hasn't been received within the grace period.

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

Reinstatement of coverage

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

Certificate of creditable coverage

We will provide you with a **certificate of creditable coverage** when you or your **dependents'** coverage ends under this **policy** or you exhaust continuation of coverage. Please keep this **certificate of creditable coverage** in a safe place. You can also request a **certificate of creditable coverage** while you are still covered under this **policy** and for up to 24 months after the end of your coverage. To do so, call Member Services at the number listed on your member ID card.

How To Use Your Health Plan

Our plan uses **network providers** to provide **covered health services** to you. This means that we will not pay for services you might receive from **out-of-network providers** unless you have an **emergency medical condition** or we authorize services from an **out-of-network provider** because the **medically necessary** services you need are not available from a **network provider**. If we authorize **out-of-network** services your cost share responsibility will be at your **in-network** cost share unless otherwise stated in your **Schedule of Benefits**. You can find a **network provider** online through our on-line **provider** directory at [https://amerihealthcaritasnext.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACNEXT_I&brandCode=ACNEXT&alphaPrefix=&bcbsaProductId=&productCode=DEEX]. You can also call our Member Services number on your member ID card or provided at the end of this document in **How To Contact Us**. **Network providers** are not employees of our plan.

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

You can see any network specialist, including a network provider who specializes in obstetrical and gynecological care, without a referral. We will not require prior authorization to see a specialist in obstetrical and gynecological care. If you use a network provider, the provider will bill us for any covered health services they provide. You will be responsible for paying any deductibles, copayments, and coinsurance as outlined in your Schedule of Benefits. You will also be required to pay for any non-covered health services. This means that we will not pay for services you might receive from **out-of-network providers** unless you have an **emergency medical condition** or we authorize services from an **out- of-network provider** because the **medically necessary** services you need are not available from an **in-network provider**. If we authorize out-of-network services your cost share responsibility will be at your **in-network** cost share.

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

AmeriHealth Caritas Next plans comply with the provisions of the No Surprises Act of the 2021 Consolidated Appropriations Act and any associated rules or regulations that the Centers for Medicare and Medicaid Services (CMS) or other regulatory authorities may issue. The **member** will not be penalized and will not incur out of network benefit levels unless participating providers

able to meet the **member's** health needs are reasonably available without unreasonable delay or the **member** agrees to sign over their rights. The **member** will not be charged for balance bills for out-of-network care (emergency services or care by a non-participating **provider** at an **in-network facility**) without the informed consent of the **member** or **prior authorization**. If the **member** receives incorrect information from AmeriHealth Caritas Next about a provider's network status, they will only be responsible for the in-network cost share. If a **provider** or health care facility leaves our **network** and you are in active treatment or terminally ill, AmeriHealth Caritas Next will continue to cover **covered health services** at the **member's** in-network cost share for up to 90 days. Please refer to the "Continuity/transition of care" section of this **policy** for additional information.

Choosing a primary care provider (PCP)

Once you enroll, you and any covered **dependents** in this plan must choose a **PCP**. If you do not select one, we will pick one for you. You can also change your **PCP** if the **PCP** is no longer a **network provider**. Your **PCP** will oversee your care and coordinate services from other **network providers** when needed. In certain instances, if you have been diagnosed with a serious or chronic degenerative, disabling, or life-threatening condition or disease, you may select a specialist to serve as your **PCP** subject to our health plan's approval. Female members can select an obstetrics and gynecology doctor as their PCP. The specialist must have expertise in treating your disease or condition and be responsible for and capable of providing and coordinating your primary and specialty care. If we determine that your care would not be appropriately coordinated by that specialist, we may deny access to that specialist being chosen as a **PCP**. You will be allowed to choose an **in-network** pediatrician as the **PCP** for any covered **dependents** younger than age 18.

Continuity/transition of care

Continuity of care means making sure your current health care does not get disrupted. It helps ensure that you keep getting the right care to help keep your treatment on track and prevent confusion or gaps in care. Subject to prior authorization and medically necessary criteria review, if you are in an active course of treatment, for up to 90 days (or until treatment is completed, if less than 90 days), we may cover out-of- network covered health services with your out of network treating provider for any medical or behavioral health condition currently being treated at the time of the member's enrollment in our plan.

If a member is in the first trimester of pregnancy when they become eligible, they will need to select a network provider for pregnancy related services. If the member is at least 13 weeks along, the member may continue with their existing provider if they choose. Pregnancy-related services will be covered through 60 calendar days postpartum.

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

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

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

If you are terminally ill, services that are for the treatment of your illness or its medical symptoms will be covered via out of network care through the period of your current treatment or up to 90 days, whichever is shorter.

If you are in any inpatient hospital setting on the date of enrollment, AmeriHealth Caritas Next may be responsible for all care from the date of enrollment. If your request to continue your care is denied, you will receive an adverse benefit determination explaining your right to an internal appeal and external review. This letter will explain your right to an internal appeal and external review. Please see the Grievance and Appeals section of this policy for additional information regarding how to appeal an adverse benefit determination.

Continuity of care timeframe does not apply to providers whose participation as network providers has been terminated for cause by the plan. In situations where the provider termination is related to quality of care or program integrity, AmeriHealth Caritas Next's Care Management department staff will assist you in identifying and transitioning to a new provider that can meet your needs.

Additionally, AmeriHealth Caritas Next provides timely information for members transitioning out of an AmeriHealth Caritas Next plan to another health plan or newly enrolling from another Health Plan to help ensure continuity of care for each member and minimize the burden on providers during the transition.

Medical necessity

Covered benefits and services under our plan must be medically necessary. We use clinical criteria, scientific evidence, professional practice standards, and expert opinion in making decisions about medical necessity. The clinical criteria for making determinations related to medical necessity is objective, measurable, based on sound clinical evidence and consistent with current standards of care. The cost of services and supplies that are not medically necessary will not be eligible for coverage. They will not be applied to deductibles or out-of-pocket amounts.

Utilization Management

We use our Utilization Management program to help ensure you receive the most clinically

appropriate services in the most efficient manner possible while maintaining consistency in decision making. We will provide services that are sufficient in the amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

Some services may require a clinical review before you can get the service, which is called a prior authorization. This may include review for scheduled inpatient services, continued stay review, discharge planning, outpatient services, and retrospective reviews. For services that require prior authorization, we will objectively determine if a requested service is medically necessary based on your benefit plan, state and federal guidelines, and evidence based clinical guidelines before you get the service. Your provider is responsible for requesting and obtaining a prior authorization for any services that require prior authorization.

If you have any questions regarding your benefits or services, please contact Member Services Monday – Friday from 8 a.m. to 6 p.m. ET at 1-833-590-3300 (TTY 711).

This list of physical or **behavioral health** services needing **prior authorization** is subject to change. For the most up-to-date information, please visit or have your **provider** visit **the prior authorization** section of the plan website at Prior Authorization Lookup Tool.

Physical health services requiring prior authorization

- All out-of-network services excluding **emergency services**
- All services that may be considered **experimental** and/or **investigational**
- All miscellaneous services
- Bariatric surgery
- Biomarker testing
- Chemotherapy
- Cochlear implantation
- Congenital cleft lip and palate oral and facial surgery or orthodontic services
- Dental anesthesia
- Doula services
- **Durable Medical Equipment (DME)**:
  - All unlisted or miscellaneous items, regardless of cost
  - **DME** leases or rentals and custom equipment
  - Items with billed charges equal to or greater than $750, including prosthetics and custom orthotics
  - Negative pressure wound therapy
- 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
- Genetic testing
- **Hearing aids**:
  - Any newly fit monaural **hearing aid** (**prior authorization** required over $750)
  - Any replacement **hearing aid** (**prior authorization** required over $750)
  - All newly fit binaural **hearing aids** (**prior authorization** required over $750)
- Hearing services:
  - Cochlear and auditory brainstem implant external parts replacement and repair
  - Soft band and implantable bone conduction **hearing aid** external parts replacement and repair
  - Cochlear and auditory brainstem implants
  - Implantable bone conduction **hearing aids** (bone-anchored **hearing aid** [BAHA])
- Home-based services
- **Home health aide** services
- **Home health care services** - Including, but not limited to, physical therapy, occupational therapy, speech and language therapy, and skilled nursing services. **Prior authorization** is required after any combination of six **home health care** service visits are received to allow coverage for any additional home health care services
- Home infusion services and injections
- Home sleep studies
- **Hospice** inpatient services
- Hyperbaric oxygen
- Hysterectomy (Hysterectomy Consent Form required)
- **Infertility** testing or treatment
- Inpatient **hospital** services:
  - All inpatient **hospital** admissions, including medical, surgical, long-term acute, skilled nursing, and rehabilitation

  - Elective transfers for inpatient and/or outpatient services between acute care facilities
  - Medical detoxification
  - Obstetrical admissions and newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section
- **Medically necessary** contact lenses
- Pain management including, but not limited to:
  - Epidural steroid injections
  - External infusion pumps
  - Implantable infusion pumps
  - Nerve blocks
  - Radiofrequency ablation
  - Spinal cord neurostimulators
- Personal care services, or help with activities of daily living including bathing, eating, dressing, toileting, and walking
- Post mastectomy inpatient care
- Private duty nursing (extended nursing services)
- Reconstructive breast surgery (following a mastectomy)
- **Rehabilitation services** and **habilitative services** (speech and language, occupational, and physical therapy):
  - Speech and language, occupational, and physical therapy require **prior authorization** after initial assessment or reassessment. This applies to private and outpatient facility-based services
- Removal of lesions
- Skilled nursing care
- Surgical services that may be considered cosmetic, including:
  - Blepharoplasty
  - Breast reconstruction not associated with a diagnosis of breast cancer
  - Mastectomy for gynecomastia
  - Mastopexy
  - Maxillofacial surgery
  - Panniculectomy
  - Penile prosthesis
  - Plastic surgery/cosmetic dermatology
  - Reduction mammoplasty

  - Septoplasty
- The following radiology services, when performed as outpatient services, may require **prior authorization**
  - Computed tomography (CT) scan
  - Magnetic resonance imaging (MRI)
  - Magnetic resonance angiography (MRA)
  - Nuclear cardiac imaging
  - Positron emission tomography (PET) scan
- Transplants, including transplant evaluations
- Treatments provided as a part of **clinical trials**

Physical health services that do not require prior authorization

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

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

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

Behavioral health services requiring prior authorization

- All out-of-network services except **emergency** care
- Ambulatory detoxification
- Crisis intervention services
- Electroconvulsive therapy (ECT)
- Intensive outpatient treatment

- Mobile crisis management
- Nonhospital medical detoxification
- **Partial hospitalization**
- Psychiatric inpatient hospitalization
- Psychological testing

Behavioral health services that do not require prior authorization

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

AmeriHealth Caritas Next complies with the federal Mental Health Parity and Addiction Equity Act. We provide coverage for mental health and substance use services in parity with medical or surgical **benefits** within the same classification or subclassification.

AmeriHealth Caritas Next's utilization management staff are available to **providers** and **members** from [8:00 a.m. to 5:00 p.m. ET], Monday through Friday, with the exception of company observed holidays by calling our toll free number at [833-301-3377]. Utilization Management clinical staff are available on call after normal business hours, weekend and holidays by calling [833-533-8686]. A toll free fax line is available to receive inbound communications from **providers** 24 hours a day 7 days a week at [844-332-9329]. TTD/TTY and language assistance is also available at [711].

Prior Authorization Review types:

- Non-Urgent Preservice: utilization review that is conducted prior to an admission or a course of treatment.
- Concurrent: A review conducted during a course of treatment to determine whether the prescribed services should continue in amount, duration, and scope or whether modification is necessary.
- Urgent Preservice: 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.

- Retrospective: A review of care or services that have already been received.

We will not require more than 1 prior authorization for an episode of care. When your provider submits a prior authorization request, we will work with your provider to obtain the clinical information needed to make a decision. If the request does not have enough clinical information to make a decision, we may need to ask your provider to send us the needed information and extend the timeframe to make the correct decision. You and your provider will be notified if the timeframe is extended. If we fail to receive the requested information in the required timeframe, we may deny certification of the requested service.

We will review service requests within the timeframes below and notify you of our determination, adverse or not, to you and your provider as directed by Delaware regulations and our policies.

Review Type	Decision Timeframe	Extension
Non-Urgent Preservice Review	Decided and communicated within 3 Business Days following receipt date of electronic request. 5 calendar days following receipt date of a non-electronic request.	15 Calendar Days
Concurrent	Decided and communicated within 24 hours from receipt date of the request.	N/A
Urgent Preservice	Decided and communicated as soon as possible taking into account the medical needs but will not exceed 24 hours from receipt of the request.	48 Hours
Retrospective Review	Decided and communicated within 30 calendar days from receipt date of the request.	15 Calendar Days

If we deny a concurrent review, we will be responsible for covered health care services until you have been notified of the adverse benefit determination (i.e., a denial does not become effective until notice is provided to the covered member).

If we do not make a determination and send notification within the time frames above, the request shall be deemed to be approved.

In making a decision, we will take any urgent medical needs into account. As long as we receive

the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, we will notify the **member** and the **member's provider** of the benefit determination, whether adverse or not, within 24 hours for urgent concurrent requests and within 24 hours for urgent prospective requests after the plan's receipt of the request. Notification of any **adverse benefit determination** concerning a request to extend the course of treatment shall be made in accordance with this plan.

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

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

To obtain **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 our Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.]

Cost-sharing requirements

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

- A **copayment** or **copay** is your share of the cost for **covered health services** or prescription drugs that you pay as a set dollar amount.
- **Coinsurance** is your share of the cost for **covered health services** or prescription drugs that you pay, usually shown as a percentage of the **allowed amount** for a **covered health service**.

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

Covered Health Services

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

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

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

The **Schedule of Benefits** and other **policy** documents are available on request by contacting our Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.] You may also access **policy** documents online at [https://www.amerihealthcaritasnext.com/de/members/forms-and-documents.aspx].

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 cover abortion services related to the termination of pregnancy at no cost to you up to a maximum of $750 per covered individual, per year. Once this benefit is used and the maximum is met, 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.

Allergenic protein dietary supplements

We will cover early egg allergen introduction and early peanut allergen introduction dietary supplements at no cost to you. Early egg allergen introduction and early peanut allergen

introduction dietary supplements are dietary supplements that are prescribed to an infant by a health-care practitioner and contain sufficient infant-safe, well-cooked egg and peanut protein to reduce the risk of food allergies. An infant is a child who has not attained the age of 1 year.

Allergy testing and treatment

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

Ambulance services

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

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

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

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

Autism spectrum disorders (ASDs)

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

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

services.

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

Bariatric surgery

Covered health services under this benefit include bariatric surgery that modifies the gastrointestinal tract with the purpose of decreasing weight. Before pursuing bariatric surgery, a complete nutritional, behavioral, and medical evaluation must be completed, and requirements must be met. Bariatric surgery must be **medically necessary** to be eligible for coverage. Bariatric surgery is limited to one procedure per lifetime. For information on skin removal related to weight loss, please see the Panniculectomy section of this document.

Baseline lead poisoning screening or testing

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

Biofeedback

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

Biomarker testing

We cover biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a **covered person's** disease or condition to guide treatment decisions if medical and scientific evidence indicates that the biomarker testing provides clinical utility to the **covered person**. Biomarker testing for the purposes of screening are not covered.

Blood products

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

Bone mass measurement services

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

Breast examinations

We will cover diagnostic breast examinations and supplemental screening examinations. **Benefits**

are provided at the same coverage and cost applicable to a screening mammography for breast cancer.

Chemotherapy services

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

Chiropractic Care

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

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

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

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

Clinical Trials

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

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

- The subject or purpose of the trial must be the evaluation of an item or service that falls

within the covered benefits of the policy and is not specifically excluded from coverage.

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

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

Complications of pregnancy

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

Congenital cleft lip and palate care and treatment

We will cover, 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 and speech and language therapy assessment and treatment.

If a **member** with a cleft lip and palate is covered by a dental **policy**, teeth capping, prosthodontics and orthodontics shall be covered by the dental **policy** to the limit of coverage

given. Any excess thereafter shall be provided by this plan.

Dental services for children with severe disabilities

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

Developmental delay screening for infants and toddlers

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

Developmentally delayed speech coverage

We cover **medically necessary** therapy or services required to treat a child, from birth to age 18, diagnosed with any of the following speech-language disorders classified by the International Classification of Diseases (ICD-10):

- Childhood onset fluency disorder.
- Developmental disorder of speech and language unspecified.
- Expressive language disorder.
- Mixed receptive-expressive language disorder.
- Phonological disorder.
- Receptive language disorder.
- Social pragmatic communication disorder.

Please refer to the **Schedule of Benefits** for additional information and any limitations on Rehabilitative Speech Therapy or Habilitation services.

Diabetes services and supplies

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

- Monitoring equipment, blood glucose meters and strips, urine testing strips, insulin, syringes and pharmacological agents for controlling blood sugar, and certain supplies that may be covered under your pharmacy benefit. **Diabetes equipment and supplies** including blood glucose meters and strips, urine testing, syringes, continuous glucose monitors and supplies, and **insulin pump** supplies must be purchased from a **network**

pharmacy. Please see the prescription drugs section of this **policy** for additional information.

- Diabetes education including diabetes self-management training when determined medically necessary by a network provider.
- Exams, including diabetic eye examinations and foot examinations.
- **Insulin pumps** and supplies needed for the **insulin pumps. Insulin pumps** are covered at no charge.
- Outpatient medical nutrition therapy services ordered by a physician and provided by appropriately licensed or registered health care professionals.
- Podiatric appliances for the prevention of complications associated with diabetes.
- Routine foot care.

Diagnostic services — outpatient

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

Dialysis services — outpatient

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

Durable medical equipment (DME) and Devices

We cover **medically necessary DME** ordered or provided by a physician. **DME** may require a **prior authorization**, and we reserve the right to approve rental instead of purchase of the **DME**. Examples of **DME** include, but are not limited to, crutches, orthotics (including for positional plagiocephaly), prosthetics, and wheelchairs. Prosthetic and orthotic devices are only covered if they are **provided** by a network vendor, and orthotic or prosthetic services are rendered by a network **provider**, who is licensed by the State to provide **prosthetics and orthotics**. **Prosthetics and orthotics** device coverage is limited to the most appropriate model that adequately meets the medical needs of the **covered person**. The repair and replacement of prosthetic and orthotic devices is covered unless necessitated by misuse or loss. **Medical formula or food** and **low protein modified food products** are covered for you and any family **members** covered under this **policy** if prescribed as **medically necessary** for the therapeutic treatment of **inherited metabolic diseases** and are administered under the direction of a **network** physician.

Emergency services

We will cover services needed to start treatment and **stabilize** your **emergency medical condition**. These services may include a **hospital** or facility charge, supplies, and associated professional services. If you are admitted to the **hospital** from the emergency room, any

applicable **copay** for emergency room services will not apply. If you are admitted to an **out-of-network hospital** from the emergency room, you must notify us within 24 hours. When you are **stabilized**, we will transfer you by ambulance to the closest appropriate **in-network hospital** or facility. Coverage will only apply if the condition meets the definition of an **emergency medical condition**, but you do not need to notify us in advance before seeking treatment for an **emergency**. **Emergency services** and some post-stabilization services received from an **out-of-network provider** will be covered at the **in-network** benefit level. The **out-of-network provider** is prohibited from billing you more than your **in-network** cost-share.

Family planning services

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

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

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

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

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

- Male condoms are covered with a prescription only.

- A prescription for contraceptives intended to last for no more than a 12-month period which may be dispensed all at once or over the course of the 12-month period.

- Voluntary female sterilization procedures.

- Education and counseling on contraception.

- Follow-up services related to covered contraceptive drugs, devices, products, including management of side effects, counseling for continued adherence, and device insertion and removal.

- Immediate postpartum insertion of long-acting reversible contraception

Certain contraceptive medications may be covered under your pharmacy benefit.

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

- Fetal reduction surgery

- Reversal of sterilization or vasectomies

- Services related to surrogate parenting

Fertility care and infertility services

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

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

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

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

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

Habilitative services

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

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

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

- Charges for care not provided in an office setting
- Chelation therapy
- Maintenance or preventive treatment consisting of routine, long-term, or not **medically**

necessary care provided to prevent reoccurrences or to maintain the patient's current status

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

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

Hearing aids and hearing services

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

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

Prior authorization may be required for hearing services.

Home health care

We will cover certain services received in the home from a certified/licensed home health agency when ordered by a physician. Examples of these services include skilled care, physical/ occupational/speech and language/respiratory therapy, social work services, and home infusion. Services must only be provided on a part-time, intermittent basis and cannot be solely for assisting with activities of daily living. Home health services are limited to one visit per day, per specialty. A nurse and a **home health aide** count as one specialty for this benefit. Please refer to your **Schedule of Benefits** for more information and any limitations that may apply.

Hospice care

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

Hospital services

This plan covers inpatient **hospital** services and physician and surgical services for the treatment of an illness or injury and associated services and supplies for this care, including anesthesia,

subject to **prior authorization**. Treatment may require inpatient services when they cannot be adequately provided on an outpatient basis.

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

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

Lymphedema services

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

Mastectomy and breast cancer reconstruction

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

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

Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas. Inpatient discharge decisions following mastectomy procedures will be made by the attending physician in consultation with the patient. Length of post-mastectomy inpatient stays are based on the unique characteristics of each patient, taking into consideration their health and medical history.

Breast reconstruction is covered regardless of the time elapsed between the mastectomy and the reconstruction. These **benefits** will be provided subject to the same **deductible** and **coinsurance** applicable to other medical and surgical **benefits** provided under this plan. If you would like more information, please call the number on the back of your AmeriHealth Caritas Next member ID card.

Mental /behavioral health and substance use services

We cover mental/behavioral health and substance use services to diagnose and treat biologically based mental illnesses, alcoholism and substance use disorders. 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.

AmeriHealth Caritas Next complies with the federal Mental Health Parity and Addiction Equity Act. We provide coverage for mental health and substance use services in parity with medical or surgical **benefits** within the same classification or subclassification.

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

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

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

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

Other practitioners/provider office visits

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

Outpatient facility services (*e.g.,* ambulatory surgery center)

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

Outpatient surgery physician/surgical services

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

Ovarian cancer monitoring and screening tests

We will cover monitoring tests for ovarian cancer subsequent to treatment and annual screening tests for women at risk for ovarian cancer. **Benefits** are provided at the same

coverage and cost applicable to a screening mammography for breast cancer.

Monitoring and screening tests mean tests and examinations for ovarian cancer using any of the following methods when ordered by an **in-network provider**:

- Tumor marker tests supported by national clinical guidelines, national standards of care, or peer-reviewed medical literature.
- Transvaginal ultrasound.
- Pelvic examination.
- Other screening tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

Panniculectomy

We cover medically necessary removal of excess skin and subcutaneous tissue, including a panniculectomy. Panniculectomy means an operative procedure used to contour the abdominal wall by removing significant excess skin and subcutaneous adipose tissue.

Pediatric autoimmune neuropsychiatric disorders

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

Pediatric Vision services

We cover pediatric **vision services** through the last day of the month in which a child turns age 19. **Covered health services** include: one comprehensive low vision exam every five years and low vision aids; one routine eye exam per calendar year and one pair of eyeglasses or contact lenses per calendar year. Frames and lenses are covered up to the **provider's** allowed amount. If the item is requested exceeds the approved allowed amount, then the approved amount for the basic item may be applied toward the price of the item at the member's option. You are responsible for any costs over the approved amount designated by AmeriHealth Caritas Next for an item that may be prescribed.

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

Physician services for sickness and injury

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

Pregnancy services

Covered health services include prenatal care, delivery, postnatal care, and services for any related complications of pregnancy. We will cover services including those that may be provided by a certified nurse midwife or a stand-alone birthing center. The minimum duration of a

covered inpatient stay for a delivery is 48 hours for the mother and the newborn after a vaginal delivery or 96 hours for the mother and newborn after a cesarean section delivery, not including the day of delivery or surgery. You are not required to obtain **prior authorization** during this time frame, however, **prior authorization** is required after the minimum duration inpatient stay expires. The mother could be discharged earlier. If so, timely post-delivery follow-up care will be provided to the mother no later than 72 hours immediately following discharge. Complications of pregnancy are treated the same as any other illness. An **emergency** (non-elective) cesarean section is considered a **complication of pregnancy**.

Coverage also includes well-baby care and hearing loss screening tests of newborns and infants in the **hospital** or birthing center. Complications of pregnancy are treated the same as any other illness. An **emergency** (non-elective) cesarean section is considered a **complication of pregnancy**.

Doula services

Doula services are provided by a trained doula and designed to provide physical, emotional, and educational support to pregnant and birthing persons, before, during, and after childbirth. Doula services include the following:

- Support and assistance during labor and childbirth
- Prenatal and postpartum support and education
- Breastfeeding assistance and lactation support
- Parenting education
- Support for a birthing person following loss of pregnancy

We will cover doula services, when provided by a doula who is certified by the Delaware Certification Board, that includes all of the following:

- Three prenatal visits of up to 90 minutes
- Three postpartum visits of up to 90 minutes
- Attendance through labor and birth

Additional postpartum doula visits are provided if you receive a recommendation from a practitioner or clinician licensed under state law within their scope of practice.

Preventive health care services

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

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

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

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

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

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

of medical practice and all applicable patient safety laws and regulations.

- Mammograms/OBGYN — in accordance with the most recent guidelines of the American Cancer Society, we cover one baseline mammogram for any female **member** ages 35 – 39, and one mammogram per female **member,** 40 years of age or older, every year.
- Newborn hearing screening
- Nutritional counseling
- Ovarian cancer screening — for female **members** age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered
- Preventive care and screenings for infants, children, and adolescents according to guidelines supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screenings for women according to guidelines supported by HRSA
- Prostate screenings that are medically necessary and a clinically-appropriate method for the detection and diagnosis of prostate cancer, including a digital rectal exam and prostate specific antigen test, and associated laboratory work. In accordance with the most recent published guidelines of the American Cancer Society, coverage shall begin at:
  - Age 50 for men at average risk of developing prostate cancer
  - Age 45 for men at high risk for developing prostate cancer, including African American men and men who have a first-degree relative diagnosed with prostate cancer
  - Age 40 for men at even higher risk for prostate cancer, including men who have more than 1 first-degree relative diagnosed with prostate cancer
- 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 or diagnose illness, disease, or injury. **Chronic care management services** are covered at no charge to the **member** and is not subject

to any **deductibles**.

Private duty nursing

Covered health services under this section include **medically necessary** nursing care provided to a patient one on one by licensed nurses in an inpatient or home setting. Private duty nursing care is covered when you are an inpatient in an acute hospital. Services are limited to 240 hours per benefit year.

Radiation therapy — outpatient

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

Rehabilitation services

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

Outpatient **rehabilitation services** are only covered when the service can help your condition improve in a reasonable and predictable amount of time, or is needed to establish an effective home exercise program. In order for speech therapy services to be covered the service must be determined **medically necessary** to improve speech problems caused by disease, trauma, congenital defect, or recent surgery. .

Some **rehabilitation services** have benefit limitations:

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

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

Routine foot care

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

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

Skilled nursing facility services

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

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

Specialist visits

Office visits for specialty care services are covered.

Temporomandibular joint (TMJ) disorder

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

Transplant services

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

Urgent care services

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

Virtual care services

Virtual care services are covered at no cost when received through an **AmeriHealth Caritas Next Virtual Care 24/7 in-network provider**. Certain specialty services including pediatrics are not eligible for **AmeriHealth Caritas Next Virtual Care 24/7. Virtual care services** from any other professional **provider** are covered, subject to the same **cost-sharing** and **out-of-network** limitations as the same **health care services** when delivered to a **member** in-person. You can check with your **provider** to see if **virtual care services** are available.

Prescription Drug Benefits

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

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

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

Formulary
The list of prescription drugs covered under this plan is called a formulary. The formulary applies only to drugs you get at retail, mail-order, and specialty pharmacies. Along with the covered drugs, the formulary also allows you to review any limitations or restrictions such as prior authorization, step therapy, quantity limits, and age limits. The formulary does not apply to drugs you get if you are in the hospital. For our latest pharmacy benefit and formulary information, please visit [https://www.amerihealthcaritasnext.com/de/members/find-a-provider-or-pharmacy.aspx] or call us at [**1-833-590-3300]**.

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

The formulary covers both Preferred Generic and Brand drugs, and Non-Preferred Generic and Brand drugs and will determine what your out-of-pocket costs will be under our plan based on the drug tier. Please refer to your Summary of Benefits and Coverage for more information on copays and deductibles.

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

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

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

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

Your cost-share responsibility for **diabetes equipment and supplies** such as blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies will be no more than $35 per month for each enrolled individual, regardless of the amount or types of **diabetes equipment and supplies** needed to fill the covered individual's prescription. This $35 per month capitation includes **deductible** and **cost-sharing** amounts once **deductible** is met. **Diabetes equipment and supplies** are only covered under your pharmacy benefit and must be purchased from a **network** pharmacy. These products are not covered as **DME** (Durable Medical Equipment) under the medical benefit. Refer to the plan **formulary** for a list of covered brands of **diabetes equipment and supplies.** In order for non-formulary **diabetes equipment and supplies** to be covered**,** a non-formulary exception request must be submitted and AmeriHealth Caritas Next's PBM will review the request based on **medical necessity**.

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

- Oral and injectable drug therapies used in the treatment of covered infertility services only when you have been approved for covered infertility treatment.
- Compounded medications: If at least one active ingredient requires a prescription by law and is approved by the U.S. Food and Drug Administration (FDA). Compounding kits that are not FDA approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call the Member Services team. Some compounded medications may be subject to prior authorization.
- Off-label drugs: We will also cover certain off-label uses of FDA-approved drugs in accordance with state law. To qualify for off-label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following compendia: (1) National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium; (2) The Thompson Micromedex DrugDex; (3) American Hospital Formulary Service; (4) Lexi-Drugs; (5) United States Pharmacopoeia-Drug Information (6) the American Medical Association Drug Evaluations; or (7) any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

    - AmeriHealth Caritas Next does not limit or exclude coverage for a drug used for the treatment of cancer that is approved by the United States Food and Drug Administration by mandating that you first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of a different drug or drugs; provided, however that the use of such drug or

drugs is consistent with best practices for the treatment of stage 4 advanced, metastatic cancer or, in the case of other cancers, the use of the drug is supported by national clinical guidelines, national standards of care, or peer reviewed medical literature for the treatment of the cancer, or in the case of targeted therapy, the target at issue.

- AmeriHealth Caritas Next does not limit or exclude coverage for drugs used for the treatment of associated conditions of metastatic cancer that are approved by the United States Food and Drug Administration by mandating that you first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of a different drug or drugs; provided, however that the use of such drug is consistent with best practices for the treatment of the associated conditions of metastatic cancer and is supported by national clinical guidelines, national standards of care, or peer reviewed medical literature. Associated conditions are the symptoms or side effects associated with metastatic cancer or its treatment and which, in the judgment of the health-care practitioner, further jeopardizes the health of a patient if left untreated.

Included in the formulary are:

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

Narrow therapeutic index (NTI) drugs

AmeriHealth Caritas Next will cover certain narrow therapeutic index (NTI) brand medications. The medication may require prior authorization to be covered.

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

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

Preventive medications

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

These include certain medications in the following categories:

- Bowel preparations — for members from ages 45 to 75

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

Note:
(1) **Contraceptive products:** A prescription is no longer required for FDA-approved emergency and non-emergency contraception available over-the-counter (OTC) with the exception of male condoms. All prescription contraceptives and OTC male condoms require a prescription.
(2) **Non-contraceptive products:** A prescription is required for all listed medications, including over-the-counter (OTC) medications.

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

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

Prescription drug benefit exclusions

What is not covered:

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

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

For our latest pharmacy benefit and formulary information, please visit [https://www.amerihealthcaritasnext.com/de/members/find-a-provider-or-pharmacy.aspx] or call us at [**1-833-590-3300]**.

Formulary changes

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

Formulary Tier Explanation (Signature Plans)

Tier 1 – Preferred Generic Drugs

Tier 2 – Preferred Brand Drugs

Tier 3 – Non-Preferred Brand and Non-Preferred Generic Drugs

Tier 4 – Specialty Drugs

Formulary Tier Explanation (All Other Plans)

Tier 1a — Preferred Generic Drugs

Tier 1b — Non-Preferred Generic Drugs

Tier 2 — Preferred Brand Drugs

Tier 3 — Non-Preferred Brand and Non-Preferred (High Cost) Generic Drugs

Tier 4a — Specialty Drugs

Tier 4b —Non-Preferred Specialty Drugs

Please see your specific "metal level" coverage for copay and coinsurance amounts.

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

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

Prior authorizations (PA)

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

Step therapy (ST)

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

Quantity limits (QL)

To make sure the drugs you take are safe and that you are getting the right amount, we may limit how much you can get at one time. Your provider can ask us for approval if

you need more than we cover.

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

Age limits (AL)

Age limits are designed to prevent potential harm to members and promote appropriate use. The approval criteria are based on information from the FDA, medical literature, actively practicing consultant physicians and pharmacists, and appropriate external organizations.

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

Generic drugs

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

New-to-market drugs

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

Nonformulary drugs

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

Noncovered drugs with over-the-counter alternatives

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

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

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

you.

Prior authorization and exception requests

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

For non-formulary drugs, non-formulary exception requests can be made. Non-formulary exception requests are reviewed on a case-by-case basis. Your provider will be asked to provide medical reasons and any other important information about why you need an exception. AmeriHealth Caritas Next's PBM will review the requests and will determine if a request is consistent with our medical necessity guidelines.

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

and

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

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

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

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

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

Providers:

- Electronically: directly to AmeriHealth Caritas Next's PBM, through Electronic Prior Authorization (ePA) in your Electronic Health Record (EHR) tool software, or your healthcare provider can submit through either of the following online portals:
    - [CoverMyMeds https://www.covermymeds.com/main/]
    - [Surescripts https://providerportal.surescripts.net/ProviderPortal/]

- By fax: [1-844-470-2506] for standard (nonurgent) requests [1-844-470-2509] for expedited (fast)* requests

- By mail:
  [200 Stevens Drive
  Philadelphia, PA 19113 CC: 236]

- By phone: [1-833-733-7977]
  Hours of Operation [Monday through Friday 8 a.m. to 6 p.m. ET, excluding holidays]

Members:

- By phone: [1-833-733-7977]
  Hours of Operation [Monday through Friday 8 a.m. to 6 p.m. ET, excluding holidays]

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

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

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

- Standard (nonurgent): no later than **72 hours** after we receive the request and any additional required information
- Expedited (fast)*: no later than **24 hours** after we receive the request and any additional required information

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

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

You can ask for an appeal yourself. You may also ask a friend, a family member, your provider, or a lawyer to help you. You can call AmeriHealth Caritas Next at [**1-833-590-3300 (TTY 711**)] if you need help with your appeal request. It's easy to ask us for an appeal by using one of the

options below:

- Mail: Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 180 days after the date on this notice.
- Fax: Fill out, sign, and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax number listed on the form.
- By phone: Call [**1-833-590-3300 (TTY 711**)] and ask for an appeal.

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

Non-formulary exception request denial rights
For non-formulary exception request denials, you also have the right to pursue either a standard or, if warranted and appropriate, an expedited external review by an impartial, third-party reviewer known as an Independent Utilization Review Organization (IURO).

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

- Mail: [Member Appeals AmeriHealth Caritas Next P.O. Box 7135 London, KY 40742-7135]
- Phone: [**1-833-590-3300** (TTY 711)]
- Fax: [**1-833-356-7329**]

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

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

In addition to contacting us, you may contact the Consumer Services Division at:

Delaware Department of Insurance
[Insurance Commissioner and Department of Insurance Consumer Services Division
1351 West North Street Suite 101
Dover, DE 19904]

- [Phone: **1-302-674-7310** or toll-free in Delaware: **1-800-282-8611**
- Fax: **1-302-739-6278**
- Email: consumer@delaware.gov
- http://www.delawareinsurance.gov/]

Filling prescriptions at the pharmacy
Retail pharmacy — You can fill up to a 90-day supply.
Mail-order pharmacy — You can fill up to a 90-day supply.
Specialty pharmacy — You can fill up to a 30-day supply.

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

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

For Retail pharmacy, Mail-order pharmacy and Specialty pharmacy

You can use our pharmacy locator [pharmacy locator link for the specific state] for all of your in-network pharmacy needs whether you need a local pharmacy, a pharmacy when you are traveling, a pharmacy to mail your prescriptions to your home, or a specialty pharmacy.

COVID-19

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

For details on the latest formulary information on COVID-19 vaccines, please visit [https://www.amerihealthcaritasnext.com/de/members/find-a-provider-or-pharmacy.aspx] or call us at [**1-833-590-3300** (**TTY 711**)].

School supply

AmeriHealth Caritas Next allows school supplies for the following medications:

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

- Epinephrine injection solution auto-injector (generic for Epipen)
- Spacers

For our latest pharmacy benefit and formulary information, please visit [https://www.amerihealthcaritasnext.com/de/members/find-a-provider-or-pharmacy.aspx] or call us at [**1-833-590-3300** (**TTY 711**)]

Additional Covered Health Services and Programs

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

Disease management or wellness programs

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

Healthy rewards program

AmeriHealth Caritas Next makes available to you an optional healthy rewards program at no cost to you, which allows you to earn incentives and rewards for completing different activities. Please note this is an incentive and rewards program and it does not offer any rebates, discounts, abatements or credits, or a reduction of premiums.

Optum Obstetrical Homecare program

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

Tobacco cessation program

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

Weight Watchers program

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

Exclusions and Limitations

Covered health services must be administered by a **network provider** unless you receive prior authorization for **out-of-network** services. In order for a benefit to be paid the **covered health services** must be **medically necessary** for diagnosis or treatment of an illness or injury or be covered under the preventive **health care services** section of this **policy**.

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

- Any care that extends beyond traditional medical management or **medically necessary** inpatient confinements for conditions such as learning disabilities, behavioral problems, personality disorders, factitious disorders, sleep disorders, or intellectual disabilities. Examples of care that extend beyond medical management include, but are not limited to, the following:
    - Educational services such as remedial education including tutorial services or academic skills training
    - Neuropsychological testing including educational testing such as I.Q. tests, mental ability, and aptitude tests unless these tests are for an evaluation related to medical treatment
    - Services to treat learning disabilities, behavioral problems, or intellectual disabilities
- Any **covered health service**, supply, or device that would otherwise be at no cost in the absence of coverage by this **policy**
- Any **experimental** or **investigational** treatments or unproven services. This exclusion does not apply to **National Coverage Determination Services**
- Any items or services related to personal hygiene or convenience whether or not they are specifically recommended by a **network provider** or **out-of-network provider,** such as air conditions, humidifiers, physical fitness equipment, stair glides, elevators/lifts or barrier free home modifications
- Any medical and/or recreational use of cannabis or marijuana
- Any prescription or over-the-counter drugs not on the **formulary** unless an exception is granted
- Any prescription vitamins, except vitamins prescribed during **pregnancy**, and fluoride vitamins, or as indicated as covered in the **formulary**
- Any rehabilitative occupational and physical therapy services which are not intended to improve your condition in a reasonable and predictable amount of time
- Any services not identified as a **covered health service** under this **policy**; you will be responsible for payment in full for any services that are not **covered health services**
- Care given by a family member or person living with you

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

health care benefit:

- Care not prescribed in the approved treatment plan
- Chemotherapy and radiation therapy
- Chronic condition care
- Dietary care
- Disposable supplies
- **Durable medical equipment**
- Homemaker services such as housekeeping and cooking
- Imaging services
- Inhalation therapy
- Laboratory tests
- Prescription drugs except home infusion services
- Volunteer care

- The following are not covered under this **policy's hospice** benefit:
  - Care not prescribed in the approved treatment plan
  - Financial, legal, or estate planning
  - Homemaker services such as housekeeping, food and meal preparation, and cooking
  - **Hospice** care in an acute care facility unless the **member** receiving **hospice** care requires services in an inpatient setting for a limited amount of time not prescribed as a part of an approved treatment plan.
  - Private duty nursing
  - Respite care
- The following **skilled nursing facility** services are not covered under your policy:
  - Convalescent care
  - Custodial care
  - Domiciliary care
  - Intermediate, rest, or homelike care
  - Long-term care admissions
  - Protective and supportive care
- Services provided by a naturopathic **physician**

- Tinnitus maskers
- Treatment received outside the United States, except for a medical **emergency** while traveling in accordance with the **emergency services** section of this **policy**

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

- Any charges incurred due to failure to keep a scheduled appointment or charges for lack of completion of a claim form
- Any examinations, tests, screenings or any other services required by:
    - For employment or government-related diagnostic testing, laboratory procedures, screenings, or examinations
    - A university, school, or college in order to enter school property or a particular location regardless of reason
    - A governmental body for public surveillance purposes
- For **behavioral health** and **substance use disorder** services related to:
    - Court-ordered services required for parole or probation
    - Marital and relationship counseling
    - Testing for aptitude or intelligence
    - Testing for evaluation and diagnosis of learning abilities
- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this **policy** or for correction of a birth defect in a child
- For dental services. We will inform **members** of the availabilities of stand-alone pediatric dental plans during the plan selection and enrollment process
- For expenses related to television, phone, or expenses for other persons
- For fetal reduction surgery
- For immunization or exam services required for foreign travel or employment purposes
- For nontraditional alternative or complementary medicine not consistent with conventional medicine. These include, but are not limited to, acupuncture; hydrotherapy; hypnotism; and alternative treatment modalities including, but not limited to, boot camp, equine therapy, wilderness therapy, and similar programs
- For routine or periodic physical examinations, except as otherwise set forth in this **policy**; the completion of forms or the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital

examinations, physicals for employment, school, camp, travel or sports, except as mandated by Delaware law

- For services required as a result of a court order or other tribunal unless determined to be **medically necessary** by your **network physician** or coverage is required by federal or Delaware state law
- For services related to surrogate parenting
- For standby availability of a medical **provider** when no treatment is rendered
- For the reversal of sterilization or vasectomies
- For treatment of injuries sustained while participating in organized collegiate sports, professional or semiprofessional sports, or other recreational activities for which the **subscriber** and/or **dependent** is paid to participate
- Services or supplies are provided prior to the **effective date** or after the termination date of this **policy**, except as noted under the Eligibility and Termination section of this **policy**

Grievances/Complaints and Appeals

Sometimes AmeriHealth Caritas Next may decide to deny or limit a request your **provider** makes for you for **benefits** or services offered by our plan. To keep you satisfied, we provide processes for filing a **grievance/complaint** and **appeals**. You have the right to file a **grievance/complaint**, file an **appeal**, and right to an external review with respect to certain **adverse benefit determinations** or **appeals** not decided in your favor.

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

If you need help with filing a **grievance/complaint** or an **appeal**, we will help walk you through the process. This includes help with completing forms, providing interpreter and translation services, or providing TTY support and ancillary aid. Additionally, free letter translations are available on request. This service is provided to you at no charge by contacting our Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays]

Grievances/Complaints

You, your authorized representative, or your **provider** can file a **grievance/complaint** with us. You can do so in writing or over the phone. If the provider files a **grievance/complaint** on behalf of the member and we do not have record of the members' consent; the **grievance/complaint** team will need to secure the members consent for the **grievance/complaint**. **Grievances/Complaints** must be submitted within one year after the date of occurrence of the action that initiated the **grievance/complaint**. The **grievance/complaint** process is voluntary.

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

[Member Grievances/Complaints

AmeriHealth Caritas Next

PO Box 7430

London, KY 40742-7430]

On filing your **grievance/complaint**, please include any information you believe supports your case. We will carefully consider the issue(s) you have raised, and we will never charge you anything to file a **grievance/complaint**. Filing a **grievance/complaint** will also never affect your **benefits**.

Once we have received your **grievance/complaint,** we will send you written acknowledgement of receipt within two business days of receiving it.

After we research your concern, we will send you and, if applicable, your authorized

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

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

- The qualifications of the person or persons who reviewed your **grievance/complaint**.
- A statement from the reviewers summarizing the **grievance/complaint**.
- The reviewers' decision in clear terms and the basis for the decision.
- A reference to any documentation used as a basis for the decision.

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

At any time, you can request free copies of all records and other information we have relevant to your written **grievance/complaint**, including the name of any health care professional we consulted. To obtain copies, please contact Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.]

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

Standard appeals of an adverse benefit determination

You or your authorized representative, including your provider can file an **appeal** of an **Adverse Benefit Determination** verbally by calling Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.],or in writing to [PO Box 7135, London, KY 40742-7135]. We must receive a signed authorized representative form in order to process an appeal from your provider. An **appeal** must be filed within 180 days from the date of our written notice denying your claim or your request for service. The **appeal** procedure is voluntary on the part of the **member** and an **appeal** may be initiated and/or proposed by the **member** or authorized representative. We will also help you with filing the written **appeal** if you need it.

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

Once your appeal request is received, we will begin researching your **appeal**. Within five business

days after receiving a request for a standard, non-expedited **appeal**, we will provide you with the name, address, and phone number of the coordinator and information on how to submit written material. You or your authorized representative will be allowed to access any medical records or other documents we have that relate to the subject of the **appeal** at no cost to you. You can ask for these records and documents by calling our Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays] If your review required **physician** review, the physician reviewing your **appeal** will:

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

You can provide evidence to support your **appeal** by phone, in writing, or in person. Once we have made a decision on your **appeal**, we will send you written notice in a culturally and linguistically appropriate manner of the decision no later than 15 calendar days after receiving your **appeal** for determinations concerning whether a requested benefit is covered pursuant to your **policy**, and within 15 calendar days for all other instances. If your **appeal** concerns continuation of a service that you are currently receiving, you can continue receiving the services being appealed either until the end of the approved treatment period or the determination of the **appeal**.

You may be financially responsible for the continued services if the **appeal** is not approved. You can request continued services by calling Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.]. Note: You cannot request an extension of services after the original authorization has ended. For more details, please contact Member Services.

Expedited appeals

An expedited **appeal** can be requested by you, your authorized representative, or your **provider** either verbally or in writing. You can file a request for an expedited **appeal** with our Member Services team by phone at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays],or in writing at [AmeriHealth Caritas Next, P.O. Box 7135, London, KY 40742-7135]. An expedited **appeal** will be made available when a non-expedited **appeal** would reasonably appear to seriously jeopardize the life or health of a **covered person** or jeopardize the **covered person's** ability to regain maximum function or in the opinion of a **physician** with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Your **provider** can also file a verbal request for an expedited **appeal**. We will not require written follow-up for a verbal request for an expedited **appeal**. We may require documentation of the medical justification for an expedited **appeal**.

We will assign your request for an expedited **appeal** to a **clinical peer**. You will have the opportunity to provide evidence in support of your **appeal** by phone, in writing, or in person.. If

we deny the request for the **appeal** to be processed in an expedited manner, we will handle the request as a standard **appeal** and will send written notice to you or your authorized representative that we have denied your request for an expedited **appeal**. You have the right to submit a **grievance/complaint** if the expedited **appeal** request is handled as a standard **appeal**.

We will, in consultation with a doctor provide expedited review and communicate the decision verbally to you, your authorized representative, or the **provider** who initiated the request as soon as possible, but not later than 72 hours after receiving the request. We will send a written notice of our determination to you, your authorized representative, or the **provider** who initiated the request within 48 hours of receipt of all information necessary to complete the review. If the expedited review is a concurrent review determination, we will remain liable for the coverage of **health care services** until the **covered person** has been notified of the determination. We are not required to provide an expedited review for retrospective **Adverse Benefit Determinations**.

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

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

Independent external review procedure

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

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

When processing your request for external review, we will require you to provide a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

If you have any questions or concerns regarding the independent external review process, please contact Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8-a.m. to 6 p.m. ET, excluding holidays.]

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

Exhaustion of internal appeals

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

- You completed our **appeal** process and received a **Final Determination** from us; or
- You received notification that we have agreed to waive the exhaustion requirement; or
- We did not issue a written decision within the time frames outlined in the expedited and standard **appeals** section of this **policy** after receiving all information necessary to complete the a**ppeal** unless you or your authorized representative agreed to a delay; or
- You submit an expedited external review request at the same time as an expedited internal **appeal** with us.

Eligibility for independent external review

For your request to be eligible for external review:

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

If your request for a standard external review is related to a retrospective **Adverse Benefit Determination** (an **Adverse Benefit Determination** that occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed our internal review process and receive a written **Final Determination** notice. An expedited external review is not available for retrospective **Adverse Benefit Determinations**.

Standard external review requests

Your request for standard external review must be submitted in writing to AmeriHealth Caritas Next within four months of receiving our notice of **Final Determination** that the services in question are not approved. You can submit this request to us at the following address [AmeriHealth Caritas Next, PO BOX 7135, London, KY 40742-7135] or fax the request to [1-833-356-7329].

Expedited external review requests

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

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

Expedited external review requests must be submitted within four months from the date on your **Final Determination** notice. You can submit your request either verbally by contacting Member Services at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays], or in writing at the following address [

AmeriHealth Caritas Next, PO Box 7135, London, KY 40742-7135] or fax the request to [833-356-7329].

IURO assignment

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

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

IURO review and decision

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

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

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

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Claims and Reimbursement

Claims

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

Network provider claims

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

Out-of-network provider claims

In order for **out-of-network** services to be covered, **prior authorization** must be obtained prior to the service being rendered unless described elsewhere in this document. You or your **provider** are required to give notice of any claim for services rendered by an **out-of-network provider**. No payment will be made for any claims filed by a **member** for services rendered by an **out-of-network provider** unless you give written notice of such a claim to AmeriHealth Caritas Next within 180 days of the date of service. Failure to submit a claim within this time does not invalidate or reduce any claim if it was not reasonably possible for you to file the claim within that time, provided that the claim is submitted as soon as reasonably possible. In no event, except in the absence of legal capacity of the **member**, may the claim be submitted later than one year from the time the claim submittal was originally required.

Notice of claim

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

To give notice of a claim, please call us at the phone number listed on your member ID card to obtain a claim form. You must sign the claim form before we will issue payment to a **provider** or reimburse you for **covered health services** received under this **policy**. You must complete a claim form for services rendered by an **out-of-network provider** and submit it, together with an itemized bill and proof of payment, to [AmeriHealth Caritas Next, PO Box 7427 London, KY 40742-7427].

Reimbursement

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

Claim forms

When we receive the notice of claim, we will direct you to where you can access a claim form for filing a proof of loss or send you a claim form by mail if you request it. If these forms are not given to you within 15 days, you will meet the proof of loss requirements by giving AmeriHealth Caritas a written statement of the nature and extent of the loss within the time limits stated in the Proofs of loss section.

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

Proofs of loss

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

Time and payment of claims

Claim payments for **benefits** payable under this **policy** will be processed immediately upon receipt of a proper proof of loss. Clean claims are claims submitted by a **provider** for payment for health care services provided to an enrollee that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. AmeriHealth Caritas Next will notify your **provider** within 30 calendar days of any deficiencies in the claim submitted and describe any remedy necessary to establish a clean claim. AmeriHealth Caritas Next will pay or deny the claim within 15 calendar days from the date of receipt of information from your provider to remedy the claim. Failure of AmeriHealth Caritas Next to notify your provider of deficiencies within the above timeframe will establish the submitted claim as a clean claim.

For covered, non-emergency services provided by an **in-network provider**, AmeriHealth Caritas Next will pay or deny a clean claim within 30 calendar days, from the date of receipt of the claim. We will cover **emergency services**, emergency air and ground ambulance services, and urgent care services, without the need for **prior authorization**, and without regard to whether or not the health care provider furnishing the **emergency services,** emergency air and ground ambulance services, or urgent care services, are a participating provider or a participating emergency facility. All other out-of-network services require **prior authorization**. AmeriHealth Caritas Next will pay or deny a clean claim for covered emergency services, air and ground ambulance services, urgent care services, and non-participating provider services, within 30 calendar days of receipt of the claim. Payments for **emergency services**, emergency air and ground ambulance services, urgent care services, or authorized out-of-network **covered health services**, with an **out-of-network provider** or an **out-of-network facility** will be made directly to the **out-of-network provider** or

out-of-network facility who provided such services.

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

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, including asexuality and pansexuality; 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

Name, Professional qualifications, specialty, medical school attended, residency completion board certification status, addresses, phone numbers, and a listing of **providers** who speak languages other than English.

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

Member responsibilities

A **member** has the responsibility to:

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

General Provisions

Entire policy

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

Modifications

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

Time limits on certain defenses

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

Non-waiver

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

Conformity with state laws

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

Nondiscrimination

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

Continuation of benefit limitations

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

Protected health information (PHI)

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

We protect all oral, written, and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. Our Notice of Privacy Practices describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit [https://www.amerihealthcaritasnext.com/de/privacy-notice.aspx] or call our Member Services team at [1-833-590-3300 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.]

Our relationship with providers

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

Legal Actions

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

Change of beneficiary

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

Misstatement of age

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

Physical examinations and autopsy

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

Subrogation

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

Congenital defects and anomalies

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

Appendix A - Coordination of Benefits

Coordination of this Contract's Benefits with Other Benefits

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

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

Definitions

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

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

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

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

B. **This plan** – This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

B.

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

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

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

Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
    a) For a dependent child, whose parents are married or are living together, whether or not they have ever been married:

        - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

        - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

    b) For a dependent child, whose parents are divorced or separated or not living together, whether or not they have ever been married:

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

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

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

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

            - The Plan covering the Custodial parent;

            - The Plan covering the spouse of the Custodial parent;

            - The Plan covering the non-custodial parent; and then

            - The Plan covering the spouse of the non-custodial parent.

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

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

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

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

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

Effect on the benefits of this plan

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

deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

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

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

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

Appendix B - Coordination of Benefits Summary

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

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

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

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

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

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

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

Your Own Expenses

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

Your Spouse's Expenses

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

Your Child's Expenses

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

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

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

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

Other Situations

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

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

How We Pay Claims When We Are Secondary
We will be secondary whenever the rules do not require us to be primary.

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

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

- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.

- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-

certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

HOW TO CONTACT US

Method	Member Services — contact information
Call	[1-833-590-3300] Calls to this number are free. Hours of operation: [Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays]
TTY	[711] Language Services are also provided Calls to this number are free.
Fax	[1-866-329-3367]
Write	Mailing address: [PO Box 7424, London, KY 40742-7424]
Website	[https://www.amerihealthcaritasnext.com/de/index.aspx]