2027

Member Handbook

This document applies to AmeriHealth Caritas Next individual and family health plans both on and off the Health Insurance Marketplace®.

AmeriHealth Caritas Next

A product of AmeriHealth Caritas VIP Next, Inc.

www.amerihealthcaritasnext.com/de

ACDE-PY27-HB-V1

Welcome to AmeriHealth Caritas Next

Thank you for choosing us as your health insurance plan.

Here, **Care Is the Heart of Our Work.®**

We are a mission-based health plan dedicated to serving those in need. We're excited to join you in your health care journey to lead your most fulfilling life.

As our member, you have access to a lot of benefits to help you stay healthy today, tomorrow, and for whatever is next. This Member Handbook will help you understand them.

Help in other languages and formats

We want every member to understand and use their benefits. If English is not your first language, or if you have a hearing, vision, or speech disability, we can help. We offer many options to help you communicate with us:

- Our TTY phone number: **711**
- Qualified American Sign Language interpreters
- Closed captioning
- Written materials in large print, translated to another language, or in another accessible electronic format

We offer interpreter services and alternate formats at no cost.

Call Member Services to ask for help in your preferred language or format.

Ayuda en otros idiomas y formatos

Queremos que todos los miembros conozcan y utilicen sus beneficios. Si el inglés no es su idioma principal, o tiene dificultades para escuchar, ver o hablar, podemos ayudar. Contamos con diversas opciones para ayudar a que se comunique con nosotros.

- Nuestro teléfono TTY: **711**
- Intérpretes calificados del lenguaje de señas estadounidense
- Subtitulado.
- Materiales escritos en letra grande, traducidos a otro idioma o en un formato electrónico accesible.

Ofrecemos servicios de interpretación y formatos alternativos sin costo.

Llame a Servicios al Miembro para pedir ayuda en su idioma o formato de preferencia.

¿Tiene preguntas? Estamos a su disposición. Comuníquese con nosotros: **www.amerihealthcaritasnext.com/de**

Servicios al Miembro: **1-833-590-3300** (**TTY 711**), de lunes a viernes de 8 a. m. a. 6 p. m., hora del Este

Contents

Contact us

Visit us online. Our website can serve your needs 24/7.
www.amerihealthcaritasnext.com/de

Keep these phone numbers close by.

Member Services

1-833-590-3300 (TTY 711)
Monday through Friday, 8 a.m. to 6 p.m.

Call when you need to:

- Choose or change your primary care provider (PCP).
- Replace a lost member ID card.
- Ask about your monthly premium.
- Ask questions, like ones about benefits or services.

Payment Center

1-833-780-1403
24 hours, seven days a week

Rapid Response and Outreach Team

1-866-577-0833 (TTY 711)
Monday through Thursday, 8 a.m. to 7 p.m.
Friday, 8 a.m. to 5 p.m.

Use for care coordination and urgent requests.

988 Suicide & Crisis Lifeline

988

Pharmacy Member Services

1-833-733-7967 (TTY 711)
Monday through Friday, 8 a.m. to 6 p.m.

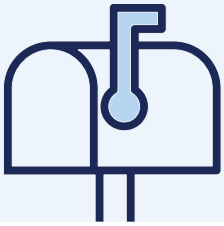
Virtual Care 24/7

1-888-989-0680 (TTY 1-800-770-5531)
24 hours, seven days a week
Use only for non-emergency medical care.

Call **911** for emergencies.

State grievance resolution

The Delaware Department of Insurance
1-800-282-8611



Keep these addresses handy.

Member Services

AmeriHealth Caritas Next
P.O. Box 7332
London, KY 40742-7332

Payment Center

AmeriHealth Caritas Next
P.O. Box 37071
New York, NY 10087

Rapid Response and Outreach Team

AmeriHealth Caritas Next
P.O. Box 7418
London, KY 40742-7418

Member appeals

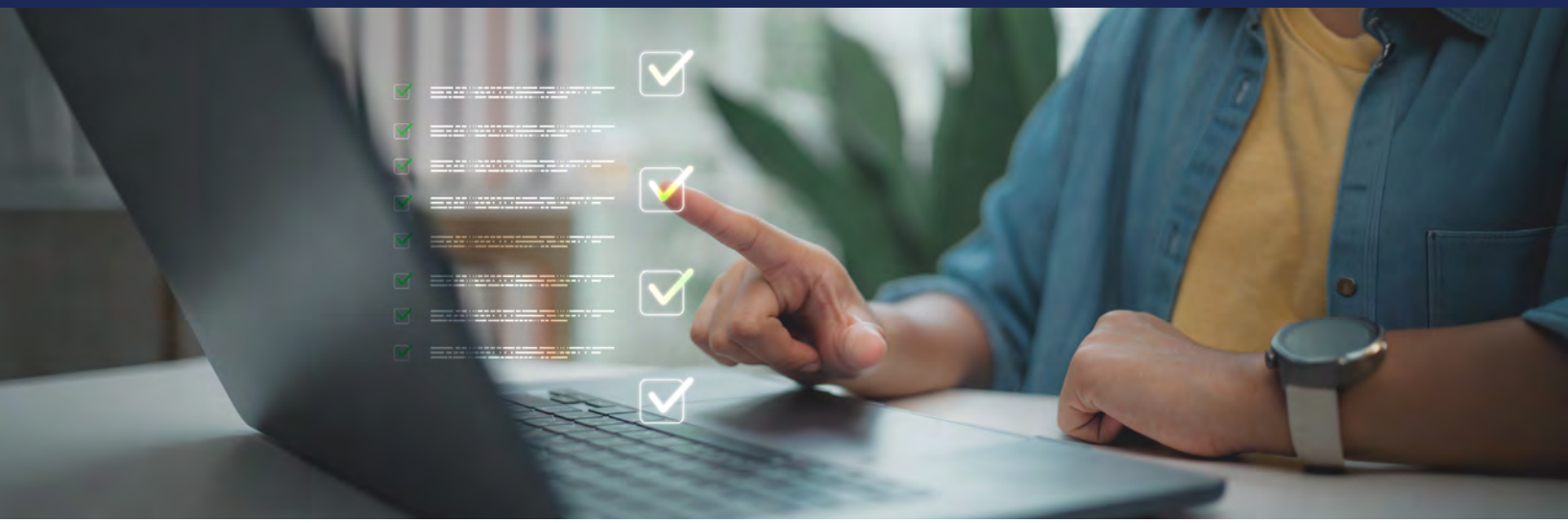
AmeriHealth Caritas Next
P.O. Box 7135
London, KY 40742-7135

Member grievances

AmeriHealth Caritas Next
P.O. Box 7430
London, KY 40742-7430

External reviews for appeals or grievances

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



Important plan documents

This Member Handbook can help you on your health care journey. It is not a legal contract. We offer a variety of other documents to help you understand and manage your insurance coverage. You can find many of these on our website or call Member Services to ask for a copy.

Welcome kit

When you became a member, we sent you a welcome kit. We sent it either to your email address or to your home. The packet included:

- **Letter welcoming you to the plan**
- **Summary of Benefits and Coverage (SBC).** This document briefly discusses your covered benefits and out-of-pocket costs, including copayments, coinsurance, and deductibles.
- **Member ID card.** This is a plastic card issued to each member with their own specific information. You should **always** carry this. You may need to present this card each time you get care or need to fill a prescription. If you lose your ID card, call Member Services or order a new one on your member portal.
- **Welcome brochure.** This describes key points about your plan and the benefits it offers to help you stay healthy, as well as benefits you may need when you are not.

Additional important documents

These documents set forth the terms of your coverage. If you have any questions about them, please call Member Services. We're happy to help. These documents are also available on our website for immediate access.

- **Evidence of Coverage (EOC).** This document is your primary source of information and is binding upon your health plan (us) and you as a member. Sometimes we call it a "policy." The EOC explains:
  - What health care services and prescription drugs your insurance covers and how to get access to them
  - Your rights and responsibilities as a member
  - Specific timelines for prior authorizations, claim processing, or appeals.
- **Schedule of Benefits (SOB).** This easy-to-read guide summarizes the services set forth in your EOC. It can help you understand what could be covered or denied and if there is a member responsibility for those services. If there is a conflict between any term in the SOB, this handbook, and the EOC, the EOC is the definitive source.
- **Privacy forms.** You have control over who has access to your personal health information. We offer these forms for you to limit or grant access to your protected health information. Call Member Services for help with choosing the right form for your needs.

Claim documents

Member Reimbursement Medical Claim Form

If you pay up-front for services and the doctor or provider is not billing us on your behalf, this form allows you to ask us to reimburse you for those services. This generally occurs when you receive previously approved out-of-network services. More information about out-of-network services can be found on page 17 of this handbook. In-network providers are contractually required to bill us for you, so you will not need this form for in-network services. If you need it, you can find it on our website or call Member Services.

Explanation of Benefits (EOB)

Most health care providers will bill us when you receive services from them. That bill from a provider to us is a "claim." When we finish processing a claim, we send you an EOB, a document that explains our decision. Your EOB will tell you:

- The member who got the service
- The provider who billed for the service
- The date the service was received
- A description of the service
- The discount we negotiated
- The amount we paid for the service
- How much you may be responsible for paying
- Any reason we would have rejected the claim
- Your EOB explains what health care services were billed; what amount your plan paid, if any; and what you may need to pay. **Your EOB is not a bill.** You should not pay us for any amount on your EOB. Instead, reach out to the provider's office to set up payment with them.

Each month we will generate an EOB for claims we have most recently processed. You can find your EOBs online by logging into the member portal on our website. If you need help, you can call Member Services.

Important: Review your EOBs to be sure you are being charged for the right services and the right amounts. Your review can help us and your provider prevent fraud.

If you get a bill from a provider for more than the amount the EOB shows as your responsibility, or for services you did not get, call your provider first to make sure the bill is up to date. If you cannot fix the issue with your provider, call Member Services.

What's Next?
Steps to get started

1

Look for your member ID card in the mail.

- Always keep this card with you.
- You will receive one card for each member of your family.
- You can order new cards on our website in your member portal or by calling Member Services.

2

Create your online member portal account.

Easily get your claims history, benefit details, and more information about your health online. Simply go to our website to get started.

- Click **Member Portal** from the menu.
- Sign up with your member ID number (on your ID card).
- Create a user ID and password.
- Download our mobile app for access at your fingertips.

Learn more about this step in **Getting connected** on the next page.

3

Choose a primary care provider (PCP).

Your PCP is a physician, nurse practitioner, or other medical care professional who focuses on your wellness. They can help you access many health care services.

Select your PCP today! Here are two ways:

- Log in to your member portal account.
- Call Member Services for help.

Getting connected

Member portal

The member portal is a secure website that can help you stay connected with us. It's easy to use, and it can help you take charge of your health.

Creating your member portal account

To find the portal, go to the **For Members** menu on our website. Click **Member Portal** in the dropdown. If you are a first-time user, you will need to sign up. Have your member ID card ready for your member ID number. Then choose a user ID and password. If you have already signed up, just log in.

Using the member portal can help you manage your health

We know not everyone likes to have their questions answered over the phone. That's why we've made some options available online. The member portal is available 24 hours a day, seven days a week. Through it, you can:

- Read a variety of health articles. This information can help you learn more about how to live a healthy life.
- Get your claims history.
- Change your PCP at any time.
- View premium information available for subscribers (policyholders).
- Get your benefit details.
- Get up to six months of your prescription history, find in-network pharmacies, providers, and more.

Download our mobile app

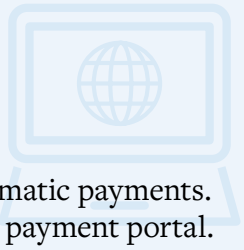
Manage your health care, wherever you are. View your digital member ID card, find health care providers, and look up your health benefits right on your phone.

Paying your monthly premium

Your monthly premium is the amount you pay each month to keep your health insurance coverage active. We will send you a billing invoice each month. It will tell you how much to pay and when your payment is due.

Ways to pay

Pay online



Pay online using a credit card, debit card, or bank account. You can find the steps for doing this on your invoice.

You can choose to make a one-time payment or set up automatic payments. Visit our website and click **Pay Now** for access to our guest payment portal.

You can also log into your member portal for payment options. Subscribers can view invoices and billing history here.

Pay by phone

Use our automated phone payment system, available 24/7.

1-833-780-1403

Pay by mail

Mail a check or money order using the information included with your billing invoice.

To help ensure we can process your payment on time:

- Write your member account number on your check or money order.
- Include the needed information from your invoice.
- Mail your payment at least 10 days before the due date.

What to know

- Premiums are due monthly.
- Each invoice will list the payment due for the month ahead.
- Your coverage begins once we receive your first premium payment.
- It may take some time for your payment to post to our system. If you need access to care right away, please call Member Services.

What happens if I miss a payment?

Missing a payment can affect your coverage, but you may have time to fix it.

We offer a grace period for payments you miss after you pay your first premium. The grace period allows you some time after a missed payment to bring your account up to date.

- Your coverage may continue during the grace period.
- We will send notices to let you know your payment is late and what steps to take.

Premium payment grace periods

After you pay your first premium, you will have a grace period after each payment's due date. Your Evidence of Coverage outlines the specific length of time you have. Your grace period may be longer if you have a federal subsidy. A subsidy is sometimes called an Advance Premium Tax Credit (APTC).

If we do not receive full payment by the end of the grace period:

- Your coverage may end as of the last month paid in full.
- We will notify you if your insurance coverage is behind or ending.
- If coverage ends for nonpayment, you may only be able to enroll again during a special enrollment period or the next open enrollment period.

More to know about grace periods:

- We may process your claims during the first month of a grace period if your policy includes an APTC subsidy.
- Claims payments for services in later months of the grace period may be delayed or even denied.
- We may let your providers know if we might deny your claims.

Frequently asked questions (FAQs)

1. How can I replace my ID card?

- Access a virtual version of your card on our mobile app.
- Order a replacement card on the member portal.
- Request a replacement card by calling Member Services.

2. What is a network provider?

- A network provider is a doctor, pharmacy, hospital, clinic, or other health care provider who has a contract with us to provide health care services to our members.

  Generally, for services to be a payable benefit, you must receive them from an in-network provider.

3. How can I find an in-network provider?

- Visit our website, select **For Members** from the menu, and then choose **Find a Provider, Pharmacy, or Drug.**
- Call Member Services and ask for a list of providers in your area.

4. Where can I find important documents?

- We sent you some documents, either electronically or through the mail, when you signed up for coverage. You can find these in your welcome kit.
- We also provide general documents for all members on our website. When you visit it, just select **For Members** and then **Forms and Documents.**
- We provide documents specific to your plan on the member portal.

5. How do I update my health plan on changes to my family?

- Family changes may include:
  - Moving
  - Getting married or divorced
  - Birthing or adopting a child
  - Changing contact information
- If you purchased your plan through the Health Insurance Marketplace, report your changes to them. Just visit **healthcare.gov** or call **1-800-318-2596.**
- If you purchased your plan directly from us or through an agent: You can update your details with the team who signed you up.
  - Unsure whom to contact? Please call Member Services.

6. Which document tells me my cost?

- The Schedule of Benefits (SOB), available on the member portal, explains the costs you share with the plan for your care.
- The Summary of Benefits and Coverage (SBC), sent with your welcome kit, is also available on the member portal.
- Your monthly invoice will show the cost of your premium that is due for the upcoming month.
- You can also ask for each of these documents from Member Services.

Your quick guide to care

Use this chart as an easy reference guide to your care options.
You can learn more about these options in the sections that follow.

Primary care provider (PCP)

Your PCP helps you stay healthy through regular checkups that may catch problems early. Your PCP can also answer many of your health questions. You can also make an appointment with them when you are sick.

Virtual care services (telehealth)

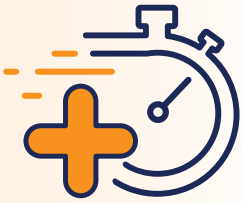
When you need a PCP's care from the comfort of home, or your PCP is not available, you may be able to get a virtual care visit. In some circumstances, we cover Virtual Care 24/7 visits at no cost to you.

Specialist care

Specialists are experts in treating specific health conditions beyond the care your PCP might provide.

Urgent care

If you need care quickly for an injury or illness that is not life-threatening and your PCP isn't available, an urgent care center visit can help.



Emergency room care

An emergency means your health or life is at serious risk. If this happens, call **911** or go to the nearest ER right away.

Choosing a primary care provider (PCP)

Having a great doctor who understands you and your needs is an important part of improving your health. You can choose your own in-network PCP by logging into the member portal or calling Member Services to find in-network options.

If you don't choose a PCP for yourself or other members on your plan, we are happy to select one for you. Of course, you are welcome to change your PCP at any time, for any reason.

Each family member enrolled in your plan can have a different PCP, or you can choose one PCP to take care of the whole family. There are different types of providers who can serve as your PCP. For example, a pediatrician treats children. Family practice doctors can treat the whole family; internal medicine doctors typically treat adults. Women may also prefer an OB/GYN for their PCP. We support all of these PCP options.

Need a list of in-network providers who offer what you're looking for? Visit our website. Choose **For Members** and then **Find a Provider, Pharmacy, or Drug.**

How a primary care provider (PCP) helps you

Having a trusted PCP means better care and peace of mind. With their support, you're more likely to stay healthy. They can help you:

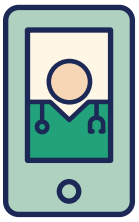
- Feel comfortable sharing concerns with a provider you know.
- Get regular care and screenings to help catch problems while they're small.
- Have all your health history in one place.
- Need the ER less often.
- Lower your overall health care costs.

Rewards program

We know how important it is to have a provider you trust to manage your care. We also want to reward you for taking the next step to improve your health! For each year you have a routine checkup with your PCP and complete your online Health Risk Assessment, we will send you a rewards debit card as our thank-you!

If your provider leaves our network

If your provider leaves our network, we will tell you as soon as we can. If the provider who leaves our network is your PCP, we will let you know of their departure and help you choose a new PCP.



Virtual care services (telehealth)

You can get health care from home virtually. Virtual care, sometimes called telehealth, lets you connect with a provider by phone or video to address many common health needs. This option may help you get care sooner, take less time away from work or other activities, and avoid exposure to other patients. Availability and services may vary by provider and location. Check with your provider to confirm they offer virtual options.

Important: Only use virtual care services for non-emergency medical care. If you have an emergency, dial **911** or go to an ER right away.

You may be able to have virtual care any time, day or night, with Virtual Care 24/7 covered at no cost to you. To learn more, log in to the member portal, call Member Services, or review your Schedule of Benefits (SOB).

Virtual Care 24/7
1-888-989-0680 (TTY 1-800-770-5531)
24 hours a day, seven days a week

Virtual care services with your regular providers may be subject to your cost share, meaning you may receive a bill or be asked to pay at the time of service.

Specialist care

A specialist is a doctor who is trained and practices in a specific area of medicine (for example, a cardiologist or a surgeon). If you need specialized care that your PCP cannot offer, your health plan allows you to see any in-network specialist you choose without a referral, although some specialists may still require that your PCP refers you before seeing you.

There are some treatments and services that your specialist must ask us to approve before you can get them. If you have questions about an upcoming test or treatment, please call Member Services.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP, but you will need our approval. To learn more or ask to choose a specialist as your PCP, call Member Services. We will work with you to help coordinate the care you need.

Out-of-network providers

When a provider does not participate with us, they are considered **out-of-network providers**. We generally will not pay for out-of-network claims when you choose to see an out-of network provider, and you may be responsible for paying the provider's bill in full. However, there are some limited exceptions to this rule. If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This specialist will be an out-of-network provider.

Before you see this specialist, you may need an **out-of-network referral** from your PCP or another network provider. We need to approve any out-of-network referral. You can talk to your PCP about this or call Member Services to discuss your needs and learn more.

Urgent care

You may have an injury or illness that is not an emergency (not life-threatening) but still needs quick attention and care. If you need such care but your PCP isn't available, going to an urgent care clinic is a great choice.

To find the nearest urgent care that is in network, visit our website. Choose **For Members** and then **Find a Provider, Pharmacy, or Drug.** As another option, you can call Member Services.

Emergency room (ER) care

An emergency medical condition is a situation in which your life could be threatened or you could be hurt permanently if you don't get care right away.

If you believe you have an emergency, call **911** or go to the nearest ER.

Some examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop
- A bad burn
- Trouble breathing, convulsions, or loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever, or vomiting
- A drug overdose

You do not need approval from your plan or your PCP before getting emergency care. You also do not need to use our hospitals or doctors. Out-of-network rules do not apply in an emergency room, or for additional services there that are needed to become stable.

Remember: Use the ER only if you have an emergency. If you have questions, call your PCP or Member Services.

Care outside of your service area

Your plan includes benefits for:

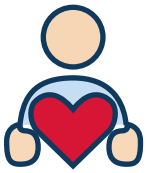
- Medically necessary urgent care outside of your area
- Emergency medical care within and outside of the U.S. and its territories

Your Evidence of Coverage has more information on these benefits.

Technology for medical procedures

We're always looking at new medical procedures and methods to make sure our members get safe, up-to-date, high-quality medical care. We have a team of doctors who review new health care technologies and the nationally recognized clinical guidelines. They decide if new technologies should become covered services. We don't cover investigational technologies, methods, or treatments still undergoing research.

Your benefits



Covered benefits at a glance

- A **primary care provider** (**PCP**) focused on your health, who can help in treating illnesses and injuries, writing prescriptions, and managing your overall wellness
- **Medical services** in an emergency room, urgent care clinic, or ambulance, even with out-of-network providers
- **Hospitalization**, including surgery and overnight stays in the hospital
- **Pediatric care** for children who are members
- Full coverage for **prenatal and postnatal** visits — no deductibles
- Coverage for your **prescription drugs**
- **Virtual care** visits at any time, day or night, with Virtual Care 24/7 are covered at no cost to you.

Preventive services

Preventive care helps you stay healthy. You can receive some preventive care services at no cost to you when the services:

- Come from in network providers.
- Meet federal requirements. (A list of these services is on the next page.)

Check in for a checkup!

Well visits are an important part of preventive care. These visits are regular checkups with your PCP, even when you feel well. Checkups, tests, and screenings can help find health concerns early, when they are easier to treat. Your plan provides full coverage for you to have one well visit each year. Check with your PCP about when you and other members of your family should have well visits.

Below we list many preventive care services that we cover in full. We cover any preventive services required by federal and state laws. Your deductible, copayment, or coinsurance amounts will not apply if these services are received from a network provider. As a reminder, if you seek preventive services from an out-of-network provider, you may be responsible for the entire amount. The list does not include all preventive services or limitations. If you would like to know more, please call Member Services.

Screenings and counseling

Everyone

- Blood pressure
- Depression (age 12+)
- Hepatitis B (for some people teens and older)
- HIV (15 to 65 years)
- Obesity screening and counseling
- Alcohol and tobacco use screening and counseling (teens and older)

Age 18+

- Cholesterol (for some adults)
- Colorectal cancer (45 to 75 years)
- Diabetes (Type 2) (40 to 70 years for some adults)
- Hepatitis C

Women age 18+

- Bone density (for some women)
- Breast cancer (40+ years)
- Cervical cancer/Pap test (21 to 65 years)
- Chlamydia (for some women)
- Sexually transmitted infections counseling (for some women)
- Urinary tract infection or incontinence

Women who are or may become pregnant

- Breastfeeding support
- Gestational diabetes (for some women)
- Hepatitis B (at the first prenatal visit)
- Maternal or postpartum depression
- Preeclampsia (for some women)
- Rh incompatibility

Children (birth to age 18)

- Autism (18 and 24 months)
- Behavioral assessments
- Developmental assessments (under age 3)
- Drug, alcohol, and tobacco use (teens)
- Hearing (newborns)
- Hematocrit or hemoglobin
- Hemoglobinopathies or sickle cell (newborns)
- Hypothyroidism (newborns)
- Lead
- Sexually transmitted infection (STI) screening and counseling
- Vision

Vaccines (shots)

Everyone

- Chickenpox (varicella)
- Diphtheria, tetanus, and pertussis (DTaP)
- Flu (influenza)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Measles
- Meningococcal
- Mumps
- Pneumococcal
- Rubella

Birth to age 18

- Haemophilus influenza type b
- Inactivated poliovirus
- Rotavirus

Age 19+

- Shingles (for some adults)

Sources:
"Preventive Care Benefits for Adults," Healthcare.gov, https://www.healthcare.gov/preventive-care-adults, accessed April 1, 2026.
"Preventive Care Benefits for Women," Healthcare.gov, https://www.healthcare.gov/preventive-care-women, accessed April 1, 2026.
"Preventive Care Benefits for Children," Healthcare.gov, https://www.healthcare.gov/preventive-care-children, accessed April 1, 2026.

Behavioral health benefits

Your coverage provides access to whole-person care, including behavioral health care.

Behavioral health care includes:

- Mental health, which is your emotional, psychological, and social well-being. Depression and anxiety are examples of mental health issues.
- Treatment and rehabilitation for alcohol and drug use, sometimes called substance use disorder.

If you or someone you care for is in immediate danger, call **911** right away.

If you or someone you care for is experiencing emotional distress, mental health concerns, or thoughts of self harm, help is available. Call or text **988**, the Suicide & Crisis Lifeline. The Lifeline offers free and confidential support, 24 hours a day, 365 days a year.

You do not need prior authorization for emergency behavioral health care.

Your Evidence of Coverage has more details on our behavioral health services. If you believe you may need more intensive behavioral health services than your plan will provide, like psychiatric residential treatment facilities or assertive community treatment, talk with your primary care provider or call Member Services.

Bright Start® maternity program

We want to support you in having the healthiest pregnancy possible. We will:

- Assist you with choosing a provider who is right for you.
- Help you arrange prenatal and postpartum visits.
- Assign a maternity Care Manager to support you throughout your pregnancy.
- Provide you with information and resources to help you and your baby get off to a healthy start.

Benefit limitations

Some services have limits on how often they can be used, such as a set number of visits or days. Your Schedule of Benefits lists these limits. If your service use reaches a limit, the plan will not cover more uses of that service until the next plan year. If this happens, you will be responsible for the full cost of the excess services.

Your pharmacy benefits

We strive to provide you with high-quality and cost-effective drug coverage.

We use our pharmacy benefit manager (PBM) to help manage your prescription drug benefits, including specialty medicines.

- To receive coverage for your prescription medicines, you will need to get them filled from a network pharmacy. You can fill prescriptions at a retail network pharmacy, through our mail-order network pharmacy, or by a network specialty pharmacy.
- You will need to show your member ID card when you fill or obtain your prescription medications. This allows the pharmacy to appropriately bill us for your medicine.
- If your plan includes a copayment, deductible, and/or coinsurance for medicines, the pharmacy may charge you that amount for your prescription when you get it. Please review your Summary of Benefits and Coverage to learn more about your costs.
- Your prescription drug benefits do not include all drugs and prescriptions. Some drugs must meet certain medical necessity guidelines before we can include them. Your provider must ask us for prior authorization (PA) before we will cover these drugs.
- Some medications will have limits on how much can be filled for you at one time. This is called a quantity limit (QL).
- Some medications will only be available if you have tried another option first and your provider has documented that attempt. This is called step therapy (ST).

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. For additional details please contact Member Services.

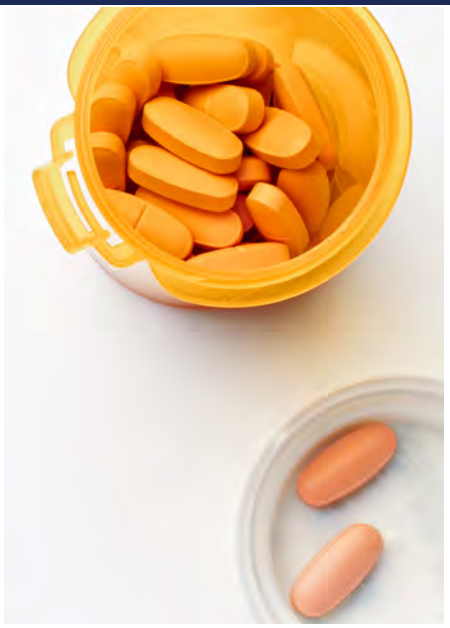
Using your prescription drug formulary

The list of prescription drugs covered under this plan is called a formulary. Our latest pharmacy benefit and formulary information is available on our website. Choose **For Members** from the website menu and then **Finding a Provider, Pharmacy, or Drug**, or you can call Member Services for help.

The formulary is a closed formulary. This means that products not listed on the formulary are not a payable benefit. However, you or your provider can still ask for medicines that are not on the formulary. Our prior authorization process may allow for exceptions in certain circumstances.

The formulary includes both brand (preferred and non-preferred) and generic (preferred and non-preferred) drugs. It lists them in tiers that represent different out-of-pocket costs. Please refer to your Summary of Benefits and Coverage to learn more about copays and deductibles.

Covered prescription drugs and supplies



The prescription drug benefits cover many different therapeutic classes of drugs, which you can find on our website. Choose **For Members** from the website menu and then **Finding a Provider, Pharmacy, or Drug**. You can search the drug list there in any of these ways:

- Search by the first letter of the medicine name.
- Type part of the generic (chemical) or brand (trade) name.
- Choose the therapeutic class of the medicine.

The Evidence of Coverage and drug formulary outline additional pharmacy benefits and exclusions.

Formulary changes

The formulary is occasionally subject to change. If a change negatively affects a medicine 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	Tier 2	Tier 3	Tier 4
Preferred Generic Drugs	Preferred Brand Drugs	Non-Preferred Brand and Non-Preferred Generic Drugs	Specialty Drugs

Formulary Tier Explanation (All Other Plans)

Tier 1a	Tier 1b	Tier 2	Tier 3	Tier 4a	Tier 4b
Preferred Generic Drugs	Non-Preferred Generic Drugs	Preferred Brand Drugs	Non-Preferred Brand and Non-Preferred High-Cost Generic Drugs	Specialty Drugs	Non-Preferred Specialty Drugs

Please see your Summary of Benefits and Coverage for copay and coinsurance amounts.

For our latest pharmacy benefit and formulary information, please visit our website or call Member Services.

Pharmacy formulary tools

Our pharmacy benefits manager may use certain tools to help ensure your safety and so that you get the most appropriate medicine at the lowest cost to you. These tools include prior authorizations, step therapy, quantity limits, age limits, and the generic drug program.

Prior authorizations (PA)

Some drug products have limited usage, may have certain safety concerns, or are extremely expensive. The plan may restrict the coverage of these products. When that happens, your prescribing provider will need to get prior authorization from us for you to use such drugs. The formulary lists when a drug needs prior authorization.

Step therapy (ST)

Step therapy is a type of prior authorization program that uses a stepwise approach. This means that members need to use the most therapeutically appropriate and cost-effective medicines before the plan will cover other medicines. If your provider finds that the first medicine is not right for your health condition and that you may medically need a different one, they can ask us for approval for you to use the other medicine.

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 of a medicine than we cover.

We can waive quantity limits under certain circumstances, like during a state of emergency or disaster.

Age limits

Age limits are designed to prevent potential harm to members and promote appropriate use. We base the approval criteria on information from the U.S. Food and Drug Administration (FDA), medical literature, actively practicing consultant physicians and pharmacists, and appropriate external organizations.

If a prescription does not meet FDA age guidelines, we will not be able to cover it without a prior authorization. Your provider can ask for 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 prior authorization. Note that some generic drugs are high cost and may also require prior authorization. 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. If a provider feels a new-to-market drug is medically necessary for you before we have reviewed it, they can ask for an approval for you to use the drug.

Nonformulary drugs

The plan's formulary drug products are all approved by the FDA and widely used in the medical community. While the plan covers most drugs, it does not cover a small number of drugs because there are safe, effective, and more affordable alternatives to treat the same conditions. 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.

Noncovered drugs with over-the-counter alternatives

We do not cover certain prescription medicines that you can buy without a prescription, or "over-the-counter." These drugs are often called OTC medicines.

In addition, when OTC versions of a medicine are available and can provide the same therapeutic benefits, we may not cover any of the prescription medicines in the same class of drugs. For example, nonsedating antihistamines are a class of drugs that give relief for allergy symptoms. Because many nonsedating OTC antihistamines are available, we do not cover them.

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

Prior authorizations and exceptions

For formulary drugs that have restrictions like prior authorization, step therapy, quantity limits, and age limits, your provider may ask for a prior authorization. For non-formulary drugs, your provider can make non-formulary exception requests.

For both formulary and non-formulary requests, our pharmacy benefit manager (PBM) will review the supporting documentation and make a decision about coverage.

If the PBM approves the requested drug, the plan will cover it according to our medical necessity guidelines. If the PBM approves a request for a nonformulary drug, the plan will cover it on the highest applicable tier.

If the PBM does not approve the request, then you, your authorized representative, or your provider can appeal the decision.

To learn more about the approval or appeals process, please refer to your Evidence of Coverage.

Filling prescriptions

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, mail-order pharmacy, and specialty pharmacy

You can use our pharmacy locator on our website to find a participating pharmacy for all types of medications. This includes:

- Pharmacies local to your home
- Pharmacy options when traveling
- Mail-order pharmacies that ship to your home
- Specialty pharmacies

Specialty drug program

We have designated specialty pharmacies that can provide special medicines to treat certain conditions. These pharmacies also have clinicians who can provide support services for members. Some medicines are only available at a specialty pharmacy. Medicines may be added to this program from time to time. Specialty pharmacies can dispense up to a 30-day supply of medicines at one time, and they may deliver the supply by mail to either the member's home or doctor's office. This is not part of the mail-order pharmacy benefit. Extended-day supplies and copayment savings do not apply to these designated specialty drugs.

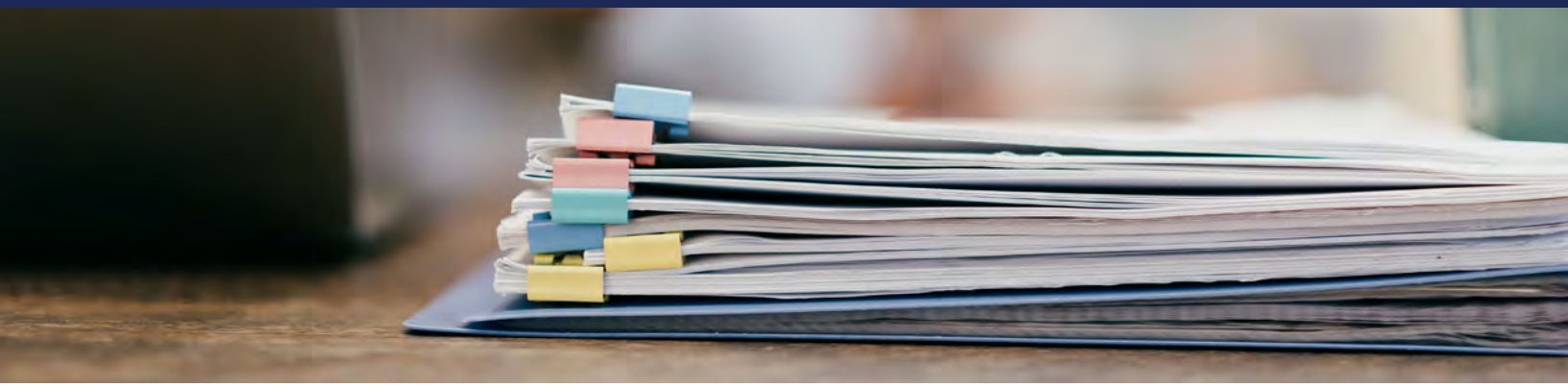
School supplies

In some cases, you may need to leave medical supplies with your child's school. We allow additional quantities of the following items, subject to your usual cost share:

- Insulin
- Insulin needles
- Lancets
- Test strips
- One glucometer
- Alcohol swabs
- Glucagon
- Inhalers
- Diastat
- Epinephrine injection solution auto-injector (generic for EpiPen)
- Spacers

COVID-19

The plan covers FDA-approved COVID-19 vaccines at $0 copay according to FDA-approved indications and age. To learn more about COVID-19 vaccines, please visit our website or call Member Services.



Understanding your costs

Claims and explanations of benefits

A **claim** is a request for a benefit for items or services that the plan may cover. These can include reimbursement of a health care expense. You or your health care provider can submit claims to us.

An **explanation of benefits** (**EOB**) is a statement you receive after we process a claim. It shows the amount the plan paid and what you may owe as a remaining balance.

A member receives a medical service.

Provider bills the health plan for that service, known as a claim.

We process the claim according to the member's benefits.

We send an EOB that shows charges, payments, and any balance still due.

Other terms related to claims

Allowed amount: This is the maximum amount we will pay for a covered health care service. It is also sometimes called an "eligible expense," "payment allowance," or "negotiated rate."

Balance billing: This is when a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-participating provider). A network provider (participating provider) may not bill you for covered services.

Reimbursement: This is when we pay money back to you for health care costs you've already paid out of pocket. Reimbursement helps you get back what you spent on covered medical treatments, supplies, or prescriptions. You should not be paying out of pocket to providers for payable, in-network services except for any deductible, copay, or coinsurance you may owe as required by your health plan. If you see an out-of-network provider that has been prior authorized to provide you with a specific service, you may have an initial out-of-pocket cost for which we will reimburse you.

Understanding claims and reimbursements

Sometimes, we need to use official terms when talking about claims and reimbursements. This section shares those kinds of details. If you have any questions about this material, please call Member Services.

Claims

We are careful to ensure that there is no provider fraud, and we will perform audits of provider bills to verify that services and supplies billed were furnished and that proper charges were made.

Network provider claims

A 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 the service is covered, we will reimburse your provider directly.

Out-of-network provider claims

For out-of-network services to be considered, prior authorization must be obtained prior to the service being rendered unless the service is for emergency services, emergency ambulance transportation, or urgent care services, as described in your Schedule of Benefits and Evidence of Coverage. If such services do not relate to emergency or urgent care, the out-of-network provider must provide information to us as to why you cannot seek the same care with an in-network provider. You or your provider are required to give notice of any claim for services rendered by an out-of-network provider.

Claim forms

When we receive the notice of claim from you, indicating you need reimbursement, we will direct you to where you can access a claim form or send you a claim form by mail if you request it. Medical reimbursement claims forms should be mailed to the address on the form.

All claims sent by your provider will be submitted on a standard form that all providers use or in a format that is designed for that purpose, whether submitted in writing or electronically.

Please refer to the Evidence of Coverage to learn more about submitting a claim for reimbursement and payment time frames.

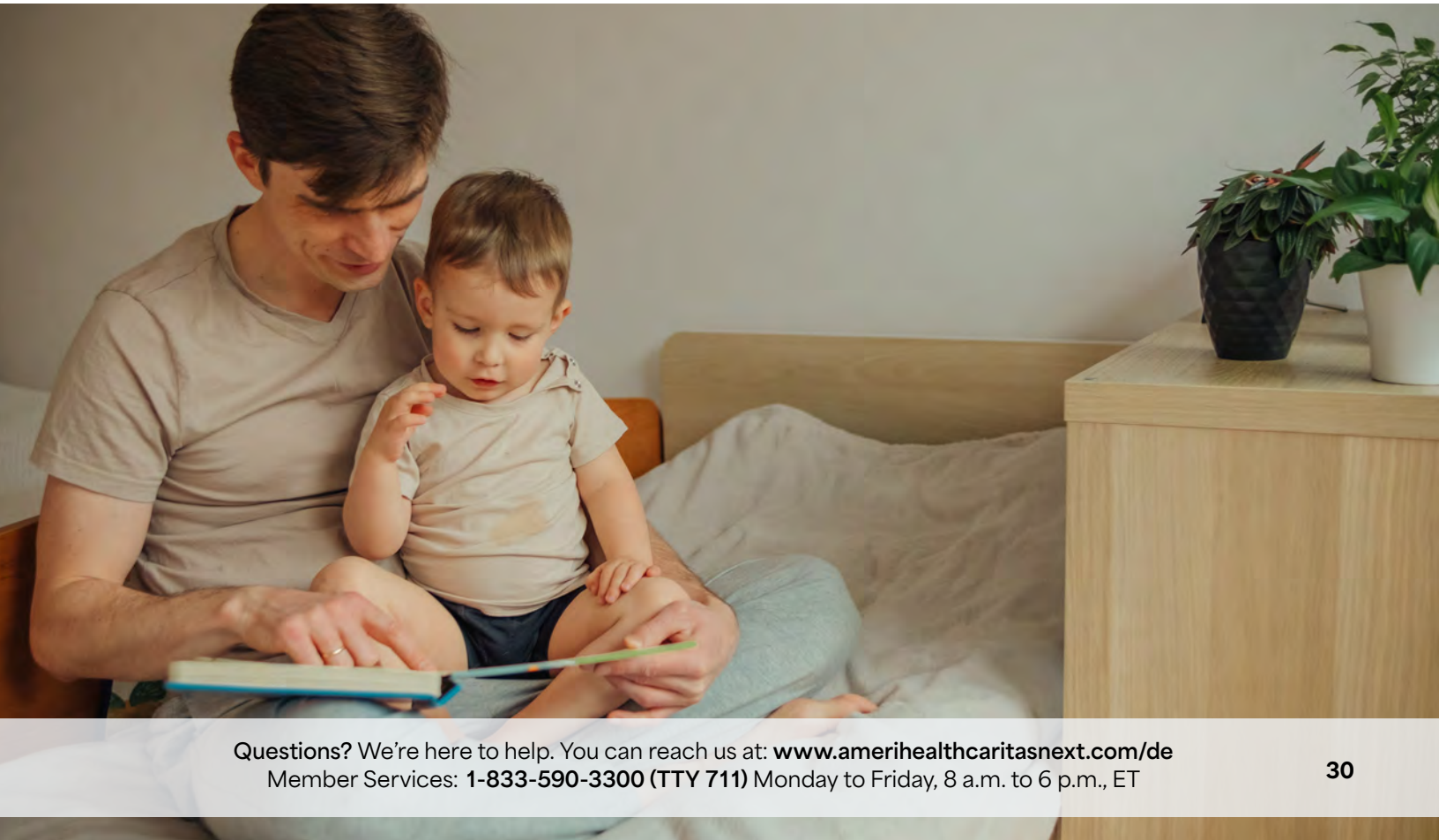
Cost sharing

Cost sharing means you and your health plan each pay part of the costs for covered services. Your share, called "out-of-pocket costs," includes copayments, deductibles, and coinsurance. Family cost sharing is when you pay for deductibles and other out-of-pocket expenses for your family. Premiums, penalties, and services not covered by your plan are not part of cost sharing.

Deductible: This is the amount you pay during a coverage period (usually one year) for covered health care services before your plan starts to pay. An overall deductible applies to all or almost all covered items and services. A plan may have an overall deductible with also separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, you must pay $1,000 before your plan starts to pay for any covered care or products you receive.)

Coinsurance: This is your share of costs for a covered health care service. A coinsurance is calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance, plus any deductibles you owe. (For example, if the allowed amount for an office visit is $100 and you've already met your deductible, your coinsurance payment of 20% would be $20. We would pay the rest of the allowed amount.)

Copayment: This is a fixed amount (for example, $15) that you pay for a covered health care service. You would usually pay this when you receive the service. The amount can vary by the type of covered health care service.



Right care, right time

Care Management

We have programs to help you stay healthy. Our programs help members who have multiple health and/or chronic conditions. These members may qualify for complex care management. People with other conditions, like being pregnant or having a mental health concern, can benefit from our health programs, too.

Caregivers and providers can refer members to these Care Management programs. You can also refer yourself. You do not need a referral from someone else to access the programs.

Some members have complex care needs or might need a higher level of care than they currently receive. In these cases, the member, their caregiver, or their provider can find out more and ask for these services by:

- Calling the member's Care Manager or Member Services
- Visiting our website

Continuing care

If you enroll in our plan and are already receiving care or have services scheduled with a provider who is not in our network, please contact Member Services before your appointment. We will review your request to determine whether you qualify for a continuity of care exception, which may allow you to continue seeing an out-of-network provider for a limited period of time.

Continuity of care exceptions are approved only in specific circumstances and for defined time frames.

Similarly, the continuity of care exception may apply if you are seeing an in-network provider while enrolled with us and they leave our network. More information about these circumstances can be found in your EOC, or Member Services can explain the process to you.

It is important to remember that, except in emergency situations, services received from out-of-network providers without prior authorization are not covered.

Utilization Management

It's important to us that you get the care you need, when you need it.

We use our Utilization Management program to help ensure you receive appropriate, affordable, and high-quality care for your overall wellness. Our Utilization Management program focuses on both the medical necessity and the outcome of physical and behavioral health services. To do this, we use prospective, concurrent, and retrospective reviews. For all decisions, we use documented clinical review criteria based on sound clinical evidence. We periodically evaluate our criteria to ensure they stay effective. We obtain all information we need to make medically necessary utilization review decisions, including relevant clinical information. Retrospective review includes the review of claims for emergency services to determine whether the applicable prudent layperson standards have been met.

Prior authorizations

We will need to approve some treatments and services before you receive them. We may also need to approve some treatments or services for you to continue receiving them. This is called a prior authorization.

Your provider will need to get services authorized, even if an authorization previously existed. If you have questions about prior authorizations, please call Member Services.

Prior authorization process

To ask for a prior authorization, you or your provider can call Member Services. Providers can also submit requests online through their provider portal.

To get approval for these treatments or services, the following steps need to occur:

- We will work with your provider to collect information to help show us that the service is medically necessary.
- Our nurses, doctors, and behavioral health clinicians review the information.

If we approve the request, we will let you and your health care provider know.

If we do not approve the request, we will send a letter giving the reason for the decision to you and your health care provider.

You can appeal any decision we make. If you receive a denial and would like to appeal it, talk with your provider. Your provider will work with us to determine if there were any problems with the information that we received.

Getting help with plan decisions

Appeals

Sometimes we may decide to deny, limit, or discontinue a request your provider makes for you for benefits or services offered by our plan. This decision is called an adverse benefit determination. We will send you a letter to let you know of any **adverse benefit determination**. You have 180 days from the date on your letter to ask for an appeal.

An appeal is your request to your health plan to review a decision that denied all or part of a benefit or payment.

You can ask us for an appeal yourself. You may also ask a friend or a family member with proper authorization, your provider, or a lawyer to help you.

When you ask for an appeal, we have 30 days for pre-service requests and 60 days for post-service requests to give you an answer. You can ask questions and give any updates that you think will help us approve your request. You might send us new medical documents from your providers, for example. You may do this in person, in writing, or by phone. Your provider may also send us this information directly.

You can contact Member Services 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.
- **Phone:** Call Member Services and ask for an appeal.

When you appeal, you and any person you have authorized to help you can see the health records and criteria we used to make the decision. If you choose to have someone help you, you must give them written permission to do so.

Expedited (faster) appeals

You or your provider can ask for a faster review of your appeal when a delay will cause serious harm to your health or to your ability to regain your good health. This faster review is called an **expedited appeal.** To learn more about standard and expedited appeals, please refer to your Evidence of Coverage.

External reviews for appeals

If you disagree with a final internal appeal decision, you may have the right to request an external review. An external review is conducted by an independent organization that is not part of your health plan.

- External reviewers look at your case and decide whether the service should be covered.
- The health plan has to follow their decision.
- External review options and organizations may vary by state.

Your appeal decision notice will explain how to ask for an external review and where to send your request. You can learn more about external reviews in your Evidence of Coverage.

Grievances

We hope our health plan and care options serve you well. However, if you experience a problem with your health care, you can file a grievance.

A grievance is your notice to your health plan that you are unhappy with your health plan, health care provider, or care services. A grievance is sometimes called a complaint.

If you have a grievance, you can:

- Write to us at the address in the **Contact us** section.
- Call Member Services.

Most problems can be solved right away. Whether we solve your problem right away or need to do some work, we will record your call, your problem, and our solution. We will write to let you know when we have received your grievance. We will also write to let you know when we have finished working on your grievance.

If our Evidence of Coverage or other documentation clearly state that coverage doesn't include a specific benefit, your frustration about that exclusion does not count as a grievance.

You can ask an authorized family member or friend, your provider, or a legal representative to help you with your grievance. We can also help in many ways, such as if you have a hearing or vision impairment, need translation services, or need help filling out forms. Please call Member Services.

We handle grievances by the guidelines in our Evidence of Coverage (EOC). To learn more about how grievances are handled, resolved, how long they might take, and more, you can find the EOC on our website or by calling Member Services.

You can also contact a state agency for help with insurance questions and concerns. Please refer to the **Contact us** section for their details.

At any time, you can ask for free copies of any records and other information we have that relate to your written grievance. These include the credentials of any health care professional we asked for advice. To obtain these copies, please call Member Services.

Expedited grievance

If your grievance regards a decision or action on our part that could significantly increase risk to your life, health, or ability to regain maximum function, you can file a request for an expedited grievance with our Member Services department. You can contact us by phone or in writing.

Expedited reviews will be evaluated by an appropriate clinical peer or peers. We will notify you orally of the determination within 72 hours or as expeditiously as possible, after receipt of the expedited review request. We will then send written confirmation to you within two business days. Expedited reviews will meet all requirements of non-expedited reviews as described in our grievance procedures and per state law.

We will handle these issues per the guidelines in our Evidence of Coverage (EOC).

Member rights and responsibilities

Your rights

As a member, you have the right to:

- Receive information about the health plan, its benefits, services included or excluded from coverage policies, and network providers' and members' rights and responsibilities. Written and web-based information that is provided to you must be readable and easily understood.
- Be treated with respect and be recognized for your dignity and right to privacy.
- Participate in decision-making with providers regarding your health care. This right includes candid discussions of appropriate or medically necessary treatment options for your condition, regardless of cost or benefits coverage.
- Voice grievances or appeals about the health plan or care provided and receive a timely response. You have a right to be notified of the disposition of appeals or grievances and the right to further appeal, as appropriate.
- Make recommendations regarding our member rights and responsibilities policies by contacting Member Services in writing.
- Choose providers, within the limits of the provider network, including the right to refuse care from specific providers.
- Have confidential treatment of personally identifiable health or medical information. You also have the right to access your medical record in accordance with applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive health care services without discrimination based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.
- Formulate advance directives. The plan will provide information concerning advance directives to members and providers and will support members through our medical record-keeping policies.
- Obtain a current directory of network providers upon request. The directory includes name, professional qualifications, specialty, medical school attended, residency 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 to those complaints within a reasonable period of time.
- Appeal a decision to deny or limit coverage through an independent organization. You also have the right to know that your provider cannot be penalized for filing a complaint or appeal on your behalf.
- Obtain assistance and referrals to providers who are experienced in treating your disabilities if you have a chronic disability.

- Have candid discussions of appropriate or medically necessary treatment options for your condition, regardless of cost or benefits coverage, in terms that you understand, including an explanation of your medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If you are unable to easily understand this information, you have the right to have an explanation provided to your designated representative and documented in your medical record. The plan does not direct providers to restrict information regarding treatment options.
- Have services accessible when medically necessary, including availability of care 24 hours a day, seven days a week, for urgent and emergency conditions.
- Call **911** in a potentially life-threatening situation without prior approval from the plan, and to have the plan pay per contract for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Continue receiving services from a provider who has been terminated from the plan's network (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the provider is terminated for reasons that would endanger you, 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 you understand.
- 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.

Your responsibilities

As a member, you have the responsibility to:

- Communicate, to the extent possible, information that the plan and network providers need to care for you.
- Follow the plans and instructions for care that you have agreed on with your providers; this responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Understand your 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 as you expect to receive.
- Keep scheduled appointments or give adequate notice of delay or cancellation.

Glossary of terms

allowed amount — the maximum amount we will pay for a covered health care service. It is also sometimes called an "eligible expense," "payment allowance," or "negotiated rate."

appeal — a request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part)

claim — a request for a benefit for items or services that the plan may cover. These can include reimbursement of a health care expense. You or your health care provider can submit claims to us.

coinsurance — your share of costs for a covered health care service. A coinsurance is calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. We would pay the rest of the allowed amount.)

copayment — a fixed amount (for example, $15) that you pay for a covered health care service. You would usually pay this when you receive the service. The amount can vary by the type of covered health care service.

cost sharing — when you and your health plan each pay part of the costs for covered services. Your share, called "out-of-pocket costs," includes things like copayments, deductibles, and coinsurance. Family cost sharing is when you pay for deductibles and other out-of-pocket expenses for your family. Premiums, penalties, and services not covered by your plan are not part of cost sharing.

deductible — the amount you pay during a coverage period (usually one year) for covered health care services before your plan starts to pay. An overall deductible applies to all or almost all covered items and services. A plan may have an overall deductible with also separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, you must pay $1,000 before your plan starts to pay.)

emergency medical condition — an illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you don't get medical attention right away. If you don't get immediate medical attention, you could reasonably expect one of the following:

- Your health would be put in serious danger.
- You would have serious problems with your bodily functions.
- You would have serious damage to any part or organ of your body.

emergency room care (**emergency services**) — services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

excluded services — health care services that your plan doesn't pay for or cover

formulary — a list of drugs your plan covers. A formulary may include the amount of your share of the cost for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand-name drug tiers and different cost-sharing amounts will apply to each tier.

grievance — a complaint that you communicate to your health insurer or plan

health insurance — a contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

hospitalization — care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

hospital outpatient care — care in a hospital that usually does not require an overnight stay

Marketplace — a virtual store for health insurance where individuals, families, and small businesses can:

- Learn about their plan options.
- Compare plans based on costs, benefits, and other important features.
- Apply for and potentially receive financial help with premiums and cost sharing based on income and other factors.
- Choose a plan and enroll in coverage.

This is also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). This help is available online, by phone, and in person.

maximum out-of-pocket limit — yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. This applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

medically necessary — health care services or supplies (including habilitation) needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine

minimum essential coverage — Minimal essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

network — the facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services

network provider (**preferred provider**) — a provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

out-of-network provider (**non-preferred provider**) — a provider who doesn't have a contract with your plan to provide services for which your health plan generally does not cover costs (except in certain circumstances). If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. These providers may also be called "non-preferred" or "non-participating" providers.

out-of-pocket limit — the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges (where appropriate), or health care services that your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

premium — the amount that must be paid for your health insurance or plan. You usually pay it monthly, quarterly, or yearly.

premium tax credits — financial help that lowers your taxes to help you and your family pay for private health insurance. You may be eligible for this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

prescription drug coverage — coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

prescription drugs — drugs and medications that by law require a prescription (written authorization or "script" for the drug from your provider)

preventive care (**preventive services**) — routine health care, including screenings, checkups, and patient counseling, to prevent or discover illness, disease, or other health problems

primary care provider (**PCP**) — a physician, including an MD (Medical Doctor) or DO (Doctor of Osteopathic Medicine); nurse practitioner; clinical nurse specialist; or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services

prior authorization (**preauthorization**) — a decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment (DME) is medically necessary. We may require prior authorization for certain services before you receive them, except in an emergency. Sometimes called "preauthorization," "prior approval," or "precertification." Prior authorization isn't a promise that your health insurance or plan will cover the cost.

provider — an individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. We may require the provider to be licensed, certified, or accredited as required by state law.

screening — a type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition

specialist — a provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions

specialty drug — a type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

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