2027 EVIDENCE OF COVERAGE

AmeriHealth Caritas Louisiana, Inc.

Individual Member Health Maintenance Organization (HMO) Policy

This is your contract with AmeriHealth Caritas Louisiana, Inc. Please read it carefully. If you are not satisfied, return the policy with written notice of your cancellation request, to our agent or us within 10 days after you receive it. All premiums paid will be refunded, less claims paid, and the policy will be considered null and void from the effective date.

The effective date of this policy is January 1st, 2027, unless a different effective date is confirmed during your application and enrollment process. This guaranteed renewable policy will renew and continue in force on January 1 of each year, at your option, if you pay the required premium, unless the policy is terminated earlier by you or by us as described elsewhere in this document.

Important cancellation information: Please read the provision entitled "Eligibility and Termination" found on page 29 of this policy.

Thank you for choosing to enroll for coverage with AmeriHealth Caritas Next a product of AmeriHealth Caritas Louisiana, Inc! When this Evidence of Coverage document says we, us, our, health plan, or plan, it means AmeriHealth Caritas Louisiana, Inc.. 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.

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, copayment, deductibles, 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 guaranteed renewable policy will renew and continue in force on January 1 of each year, at your option, 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, premiums, cost-sharing arrangements, and other materials are filed each year for approval by the Louisiana Department of Insurance (LDI). As such, your premiums 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 LDI has approved the increase.

AmeriHealth Caritas Next may modify your health benefit plan at the time of renewal. If we modify your plan, we will send you written notice of the modification of coverage no later than 60 days prior to the effective date of the modification.

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 1-833-282-2252 (TTY 711), 8 a.m. – 6 p.m. CT, Monday through Friday excluding holidays.

AmeriHealth Caritas Louisiana, Inc.

Loretta Lenko

Loretta Lenko, President Exchange

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Definitions of important words used in this document

- **Adverse determination** – An adverse determination is any of the following:
    - A determination by a health insurance issuer or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer or its designee utilization review organization of a covered person's eligibility to participate in the health insurance issuer's health benefit plan.
    - Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan
    - Coverage has been rescinded (whether or not the rescission has an adverse effect on any particular benefit at that time).
    - If AmeriHealth Caritas Next refused to provide benefits to a covered person for a prescription drug it will be considered an adverse determination if:
        - The drug is not included in AmeriHealth Caritas Next’s formulary and
        - The covered person’s prescribing provider has determined the drug is medically necessary
- **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 who we have contracted with to provide virtual care services to our members. Our preferred vendor contracts with providers to render virtual care services to our members.

- **Annual enrollment period** — A set time each fall when members can change their health plan. Generally, the annual enrollment period begins the November prior to the health plan year.

- **Appeal** — An appeal is a disagreement with our decision to deny a request for coverage of health care services or prescription drugs, or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we do not pay for a drug, item, or service you think you should be able to receive.

- **Applied behavioral analysis –** The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

- **Approved clinical trials** — A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer, or other life-threatening disease or condition and is described in any of the following ways:

  Federally funded trials — The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  - The National Institutes of Health.
  - The Centers for Disease Control and Prevention.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare & Medicaid Services.
  - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.

- A federally funded general clinical research center
- The Coalition of National Cancer Cooperative Groups.
- The FDA in the form of an investigational new drug application.
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- **Authorized representative** –

i. A person to whom a covered person has given express written consent to represent the covered person. It may also include the person's treating provider if the covered person appoints the provider as his authorized representative and the provider waives in writing any right to payment from the covered person other than any applicable copayment or coinsurance.

ii. A person authorized by law to provide substituted consent for a covered person.

iii. An immediate family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.

- **Basic health care services** - Emergency care, inpatient hospital and physician care, outpatient medical and chiropractic services, and laboratory and x-ray services. The term shall include optional coverage for mental health services for alcohol or drug abuse. The term shall also include coverage for low protein food products.

- **Behavioral health**— The diagnosis and treatment of a mental or behavioral disease, disorder, or condition listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM),* as revised, or any other diagnostic coding system, whether or

not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin.

- **Benefit period** —A benefit period is one calendar year from January 1st to December 31st each year. If you enrolled with a qualifying event through a special election period, the beginning of your benefit period is your effective date and will end on December 31st.

- **Benefits** — Your right to payment for covered health services available under this policy.

- **Bone mass measurement** – A radiologic or radio isotopic procedure or other scientifically proven technologies performed on an individual for the purpose of identifying bone mass or detecting bone loss.

- **Brand name drug**— A prescription drug is manufactured 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 manufactured and sold by other drug manufacturers and are generally unavailable until after the patent on the brand name drug has expired.

- **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 supplies 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 decide medical necessity and appropriateness of health care services and supplies. They are based on sound clinical evidence that is periodically evaluated to ensure ongoing efficacy.

- **Coinsurance** — An amount you may have to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage of the allowed amount (for example, 20%).

- **Complaint** — The formal name for making a complaint is filing a grievance. The complaint process is only used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. (See *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 **Appeals**)

- **Complication of pregnancy** — Medical conditions whose diagnoses are separate from pregnancy but may be caused or made more serious by pregnancy, resulting in the mother's life or health being in jeopardy or making a live birth less viable. Examples include:
  - Abruption of placenta;
  - Acute nephritis;
  - Emergency cesarian section, if provided in the course of treatment for a complication of pregnancy;
  - Kidney infection;
  - Placenta previa;
  - Poor fetal growth;
  - Preeclampsia or eclampsia.
- **Correctable infertility medical condition** – Includes coverage for diagnosis and treatment of a correctable medical condition otherwise covered by the policy because the condition results in infertility.
- **Copayment/copay** — A set dollar amount you may have to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $25 or $30 for a doctor's visit or prescription drug. A copayment is not a coinsurance. Coinsurance is defined elsewhere in this document.
- **Cost-sharing -** Any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.
- **Covered health services** — All of the health care services identified as payable in this Evidence of Coverage that are medically necessary and ordered or performed

by a provider that is legally authorized or licensed and appropriately credentialed to order or perform the service. With regard to prescription drugs, covered health services means drugs or supplies used to treat medical conditions, such as disposable needles and syringes when dispensed with insulin, or chemotherapeutic drugs.

- **Covered person, member, or you** – A policyholder, subscriber, enrollee, or other individual covered by this health benefit plan. Includes another person (authorized representative), other than the covered person's provider, who is authorized to act on behalf of a covered person.

- **Deductible** — The amount you must pay for health care or prescriptions each year before our health plan begins to pay.

- **Delivery and all inpatient services for maternity care –** Health care services due to the delivery and maternity care of mother and child(ren) in an inpatient setting.

- **Denial of a claim or request for services**

  - A denial of a prior authorization (PA) for covered benefits.

  - A denial of a request for benefits because the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient, or is not provided in or at the appropriate health care setting or level of care.

  - A denial of a request for covered services on the grounds that the treatment or service is experimental or investigational.

  - A denial of excluded benefits, when evidence is supplied there is a reasonable medical basis that the contractual exclusion does not apply.

- **Department** — The Louisiana Department of Insurance (LDI)

- **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, a court ordered placement, 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 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.
  - Serious disfigurement of such person.
  - 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.
- **Enrollee** - An individual who is enrolled in a health maintenance organization.
- **Enrollment date** – The date of enrollment, or if earlier, the first day of the waiting period for the enrollment.
- **Evidence of Coverage (EOC) and disclosure information/Certificate of Coverage** — Any certificate, agreement, or contract issued to an enrollee setting out the coverage to which the enrollee is entitled by reason of payment of a prepaid charge.
- **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 decided by the plan:
  - 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.

- Evaluation of reliable evidence shows that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

- No reliable evidence shows that the service is effective in clinical diagnosis, evaluation, management, or treatment of the condition.

- The service is subject to oversight by an Institutional Review Board.

- The service is the subject of ongoing clinical trials to decide its maximum tolerated dose, toxicity, safety, or effectiveness.

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

- **Formulary/formulary drugs** — A list of medications we cover. Generally, products that are on the formulary cost less than products that are not on the formulary.

- **Generic drugs** — A prescription drug approved by the Food and Drug Administration (FDA) as having the same active ingredients as the brand name drug. Generally, a generic drug works the same as a brand name drug and costs less.

- **Grievance** – In a health insurance issuer's internal claims and appeals process, a written complaint or oral complaint, if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding any of the following:
    - Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.
    - Claims payment, handling, or reimbursement for health care services.
    - Matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

- **Habilitation services** — Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-

language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

- **Health benefit plan** – Means any of the following, if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement.

  Health benefit plan does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. Health benefit plan also does not mean any of the following kinds of insurance:

  - Accident.
  - Coverage issued as a supplement to liability insurance.
  - Credit.
  - Dental or vision.
  - Disability income.
  - Hospital income or indemnity.
  - Insurance under which benefits are payable with or without regard to fault and that is required by law 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** – Any person who is licensed, registered, or certified under the laws of another state to provide health care services in the ordinary care of

business or practice or a profession or in an approved education or training program; a health care facility to operate as a health care facility; or a pharmacy.

- **Health care services** – Any services rendered by providers which include but are not limited to medical and surgical care; psychological, optometric, optic, chiropractic, podiatric, nursing, and pharmaceutical services; health education, rehabilitative, and home health services; physical therapy; inpatient and outpatient hospital services; dietary and nutritional services; laboratory and ambulance services; and any other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability. Health care services shall also mean dental care, limited to oral and maxillofacial surgery as performed by board qualified oral and maxillofacial surgeons. The term shall also include an annual Pap test for cervical cancer and minimum mammography examination and coverage for low protein food products.

- **Health Maintenance Organization** - Any corporation organized as either a business corporation or a nonprofit corporation and domiciled in this state which undertakes to provide or arrange for the provision of basic health care services to enrollees in return for a prepaid charge. The health maintenance organization may also provide or arrange for the provision of other health care services to enrollees on a prepayment or other financial basis. A health maintenance organization is an insurer. A health maintenance organization shall not be considered an insurer for any other purpose.

- **Hearing aids** – Includes external or implantable aids and services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of maintenance and repair, except where required by Louisiana Law.

- **Home health aide** — 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 carrying out prescribed exercises). Home health aides do not have a nursing license or provide therapy.

- **Home health care services**— 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 supply these services.
- **Hospice services**— 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.

- **Iatrogenic infertility** – An impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

- **Inpatient hospital services (e.g., hospital stay)**— 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 which supplies 24-hour nursing services by registered nurses. Hospital does not mean health resorts, spas, or clinic at schools or camps.

- **Inpatient physician and surgical services** – Physician and surgical services performed with the expectation that the patient remains in the hospital for one or more nights.

- **Inpatient rehabilitation facility** — A facility that supplies rehabilitative health services on an inpatient basis, as authorized by law.

- **Insurer** – An entity that writes a health benefit plan and that is an insurance company subject to Louisiana laws.

- **Louisiana's Commissioner of Insurance** - The Commissioner of insurance for the state of Louisiana.

- **Managed care plan** – A plan operated by a managed care organization which provides for the financing and delivery of health care and treatment services to individuals enrolled in such plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection, standards, or both. A managed care plan shall also mean a plan that has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

- **Maximum out-of-pocket**— The most that you pay out-of-pocket during the calendar year for network covered services, including deductibles and any cost-sharing amounts you pay, and prescription drugs count toward the maximum out-of-pocket amount. Out-of-network services for emergencies, emergency transportation and urgent care are included in the out-of-pocket total.

- **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 state 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 get covered health services, who has enrolled in our health plan, who has paid any necessary premium or on whose behalf any necessary premium has been paid, and whose enrollment has been confirmed. A member includes the subscriber and any dependents.

- **Network** — The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to supply covered services to our members. They also agree to accept our payment and any health plan cost-sharing as payment in full.

- **Network pharmacy** — A pharmacy where members of our health plan can get their prescription drug benefits. We call them network pharmacies because they contract with our health plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

- **Network provider** — Providers who have an agreement with our health plan to supply covered services to our members and to accept our payment as payment in full. Our health plan pays network providers based on the agreements we have with the providers. Network providers may also be referred to as health plan or participating providers.

- **Newly born/newborn**- Infants from the time of birth until age one month or until such time as the infant is well enough to be discharged from a hospital or

neonatal special care unit to his home, whichever period is longer.

- **Out-of-network provider** or **out-of-network facility** — A provider or facility with which we do not have an agreement to coordinate or supply covered services to members of our health plan. Out-of-network providers are not employed, owned, or run by our health plan and are not under contract with us to deliver covered services to you.

- **Out-of-pocket costs** — (See **Cost Sharing**) A member's cost-sharing requirement to pay for a part of services or drugs received or any deductible amount is also referred to as the member's out-of-pocket cost-share.

- **Partial hospitalization** — Services received from a free-standing or hospital-based program that supplies 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** - (See **Network Provider**)

- **Plan year** — This is typically a calendar year, but if your first effective date is other than January 1, your initial plan year will be less than 12 months, starting on the effective date and running through December 31 of the same year.

- **Policy** — The document that describes the agreements between the health plan and the member. Your policy includes this document, the Schedule of Benefits, your application, and any amendments or riders. Sometimes your policy is called a contract.

- **Premium** — The periodic payment to AmeriHealth Caritas Louisiana Inc. for health and/or prescription drug coverage.

- **Primary Care Provider (PCP)** — The contracted doctor or other provider (e.g., a physician in family medicine, general medicine, internal medicine, or pediatric medicine; advanced practice nurse; certified nurse practitioner; or physician's assistant) you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she may also talk with other doctors and health care providers about your care and refer you to them.

- **Prior authorization**— Advance approval to get services or certain drugs that may or may not be on our formulary. Some network medical services are covered only

if your doctor or other network provider gets prior authorization from our health plan.

- **Prosthetics and orthotics** — These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

- **Prosthetic services** — the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. It includes any necessary clinical care.

- **Provider/physician** — Any physician, hospital, or other person, organization, institution, or group of persons licensed or otherwise authorized in this state to furnish health care services.

- **Quantity limits** — A tool to limit the use of selected drugs for quality, safety, or for use. Drugs may be limited by the amount that we cover per prescription or for a defined period of time.

- **Rehabilitation services** — These services include physical, speech, occupational, and language therapy. Services may be provided on an inpatient or outpatient basis and may be subject to limitations as outlined in the Schedule of Benefits.

- **Routine patient care costs for approved clinical trials** — Any of the cost of health care services, treatments, or testing that are incurred as part of the protocol treatment being provided to the patient for purposes of the clinical trial. It does not include the following items:

    - The cost of non-health care services that a patient may be required to receive as a result of the treatment being provided pursuant to the clinical trial.

    - Costs associated with managing the research data associated with the clinical trial.

    - The cost of investigational devices or drugs not required to be covered under state law.

- Costs not otherwise covered under this policy for non investigational treatments.

- **Schedule of Benefits** — A document of coverage that identifies the member, applicable copayment, coinsurance, deductibles, maximum out-of-pocket amount, and benefit limits for covered health services. Any time we issue a new Schedule of Benefits, it will replace any prior Schedule of Benefits on the effective date of the new version Schedule of Benefits.

- **Serious and complex condition or illness** — An acute condition or chronic illness that requires specialized treatment over a period of time to avoid injury, or impairment that results in, or is likely to result in, any of the following:

  - Death;

  - Loss of limb, or disfigurement;

  - Other serious harm that creates life-threatening complications/conditions;

  - Pain that is severe, and more than quickly passing; or

  - Significant decline in physical, mental, or psychosocial functioning that is not due solely to the normal progression of a disease or aging process.

- **Service area** – The geographic area approved by the agency within which an insurer is authorized to offer a health insurance policy.

- **Severe mental illness**- A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychosis, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by Louisiana law (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under seventeen (17) years of age; Rett's Disorder; and Tourette's Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic mental disorders, to be determined by AmeriHealth Caritas Next. The definition of mental disorder shall be the basis for determining benefits notwithstanding whether the conditions

are genetic, organic, chemical, or biological, regardless of cause or other medical conditions.

- **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, foster care, court ordered placement, divorce, or marriage.

- **Stabilize** – To provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.

- **Standard fertility preservation services** – Oocyte and sperm preservation procedures that are consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

- **Step therapy** (**ST**) — Also known as a “fail first protocol” is a type of prior authorization for drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions.

- **Subscriber** -The person who is responsible for payment to a health maintenance organization or whose employment or other status, except for family dependence, is the basis for eligibility for enrollment in the health maintenance organization.

- **Temporarily medically disabled mother** A woman who has recently given birth and whose physician has advised that normal travel would be hazardous to her health.

- **Therapeutic equivalents** — A contraceptive drug, device, or product that is all 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 centers or facilities** — Services supplied to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgent care services may be furnished by network providers or out-of-network providers when network providers are temporarily unavailable or inaccessible.
- **Utilization review** - A set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:
    - **Ambulatory review**. Utilization review of services performed or provided in an outpatient setting.
    - **Case management**. A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.
    - **Certification**. A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.
    - **Concurrent review**. Utilization review conducted during a patient's hospital stay or course of treatment.

- **Discharge planning**. The formal process for deciding, 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 conducted before services, an admission, or a course of treatment including any required precertification for medical necessity.

- **Retrospective review**. Utilization review of medically necessary services and supplies that are conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to decide whether the prudent layperson standard.

- **Second opinion**. An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

- **Utilization review organization –** An entity that conducts utilization review under a managed care plan but does not mean an insurer performing utilization review for its own health benefit plan.

Eligibility and Termination

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

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

Eligible dependents

The following persons may 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 Louisiana, who resides within the service area.
- Your natural child or a legally adopted child who is less than 26 years of age.
- Newborn children can be added as a dependent to your policy at any time prior to birth or at birth, to be effective upon the birth.
- Stepchildren.
- Children awarded coverage pursuant to an administrative or court order.
- Grandchildren less than 26 years of age, who are in the legal custody of and residing with the grandparent
- Foster children.
- Your legally adopted child from placement in the home
- Any unmarried child less than 26 years of age who is placed in the home of an insured following execution of an act of voluntary surrender in favor of the insured or the insured's legal representative shall be considered a dependent child of the insured effective on the date on which the act of voluntary surrender becomes irrevocable.

Coverage for dependent children includes coverage for illness, injury, congenital defects, and premature birth.

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 the following are true:

- The child is and stays incapable of earning a living.
- The child is chiefly dependent on you for support and maintenance
- 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.

For the child to stay eligible, you must supply our health plan and the federal Exchange written proof that the child is mentally, physically, or developmentally disabled, depends upon you for most of their support, and is incapable of earning a living. You have 31 days from the date the child reaches age 26 to do this. We may periodically ask you to confirm that your child's condition has not changed. We will not ask more frequently than annually after the two-year period following the child's attainment of the limiting age.

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 prior to the effective date are covered.

If you were previously a member of an 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. Events that may qualify for a special enrollment period include:

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

Enrolling dependents

Dependents who experience a qualifying event, as defined by state and federal law, can be enrolled into our health plan outside of the open enrollment period during a special enrollment period. A dependent who becomes aware of a qualifying event may enroll during the 60 calendar days before or after the effective date of the event, but coverage won't begin earlier than the day of the qualifying event.

If a dependent is not enrolled when they first become eligible, the dependent must wait until the next open enrollment period to enroll unless they enroll under the special enrollment period. This requirement is waived when a parent must enroll a child due to an administrative or a court order. Minor children (newborn, foster, court ordered placement, or adopted) are covered for birth defects or abnormalities. Eligibility for your dependent child will last until the end of the calendar year that the child turns 26.

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

due or any documentation to show the effective date of the qualifying event with the application.

A newborn dependent child of the subscriber is automatically covered for the first 30 days of life. If you want to continue enrollment of the newborn beyond the 31st day, you will need to enroll the newborn within 31 days of the date of birth.

Any change in dependents, whether it be from foster care, court ordered placement, placement for adoption or actual date of adoption will be considered a special enrollment period and will allow enrollment for 60 days prior to and 60 days after the date of the placement or actual date of adoption.

Changes in eligibility

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

End of coverage — termination of enrollment

If your coverage ends for any of the reasons below, your last day of coverage will be the last day of the month for which you have paid your premium. End of coverage for you will also end coverage for any dependents that may be enrolled in our health plan under this policy. If your coverage ends, we will send you written notice 60 days before terminating your coverage. Reasons for ending coverage may include any of the following:

- Discontinuation of all our plans in the Louisiana Exchange, in which case we will give you 180 days advance written notice before ending coverage. We will file the notice and the discontinuance of our plans with the Commissioner of Insurance.

- Discontinuation of this plan, but only if the coverage is being discontinued uniformly without regard to any health status related factor of enrolled individuals or individuals who may become eligible for such coverage. We will

give you 90 days advance written notice before ending coverage and extend the option to purchase any other individual health insurance coverage currently being offered in the service area. We will file the notice and the insurance product being discontinued with the Commissioner of Insurance.

- For an enrolled dependent, the end of the calendar year in which they turn 26.

- The individual has committed fraud or made an intentional misrepresentation of material fact under the terms of the coverage, including improper use of your member ID card. Such health insurance coverage may not be cancelled except with 30 days prior notice to the enrollee or insured.

- If premiums are not paid when they are due and your grace period described in the payment of premiums section of this policy is exhausted, we will give you 15 days' advance written notice of pending termination prior to ending coverage.

- The enrollee is no longer eligible for coverage in a Qualified Health Plan through the Marketplace Exchange.

- The enrollee changes from one Qualified Health Plan to another during an annual open enrollment period or special enrollment period.

- The enrollee was enrolled in a Qualified Health Plan without their knowledge of consent by a third party with no connection to the Marketplace Exchange.

- Loss of eligibility if you are no longer living in or working in the service area served by our plan.

- The death of the subscriber, although dependents may continue coverage under a new policy.

- You give us written notice asking us to cancel this policy for you and/or your dependents. If you have already paid any premiums in advance for any months after the date of termination, we will refund or credit that amount within 30 days of the request for termination. In the case of retroactive terminations, we will not refund or credit any premium when claims have been submitted for dates of service after the requested date of termination.

- In the case of an enrollee requested termination, the last day of enrollment through the Marketplace Exchange is:

    i. The termination date specified by the enrollee, if the enrollee provides reasonable notice;

    ii. If the enrollee does not provide reasonable notice, fourteen days after the termination is requested by the enrollee; or

    iii. At the option of the Marketplace Exchange, on the date on which the termination is requested by the enrollee, or on another prospective date selected by the enrollee; or

    iv. If the Marketplace Exchange does not require an earlier termination date, at the option of the AmeriHealth Caritas Next, on a date on or after the termination is requested by the enrollee that is less than 14 days after the termination is requested by the enrollee, if the enrollee requests an earlier termination date; or

    v. At the option of the Marketplace Exchange, for an individual who is newly determined eligible for Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the service area of the Marketplace Exchange, the day before the enrollee's date of eligibility for Medicaid, CHIP, or the Basic Health Program.

    vi. The retroactive termination date requested by the enrollee, if specified by applicable State laws.

Recission of coverage

A rescission of coverage is the cancellation or discontinuance of coverage that has a retroactive effective date. For example, a cancellation that treats a policy as void from the time of the individual's enrollment is a rescission. AmeriHealth Caritas Next will not rescind coverage unless the covered person performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of this policy. AmeriHealth Caritas Next will provide at least 30 days advance written notice to each individual who would be affected before coverage is rescinded.

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. Refer to your monthly billing statement for your premium amount.

Enter your monthly **premium** rate here: $_____

The rate of payment entered above is a part of this contract per Louisiana law.

Premium payments are due in advance for each calendar month. Monthly payments are due on or before the first day of each month for coverage for that month. After paying your first premium, you will have a grace period of 31 days after the next premium due date (three months for those receiving a federal premium subsidy [Advance Premium Tax Credit] to pay your next premium amount. Coverage will remain in force during the grace period. If we don't receive full payment of your premium within the grace period, your coverage will end as of the last day of the last month for which a premium has been paid. 15 days prior to the end of the grace period, we will notify the subscriber by first class mail of the nonpayment of premium and pending termination as well as notify the subscriber by mail 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 proper 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 by mail of the nonpayment of premiums, and any providers of the possibility of claims being denied when the member is in the second and third months of their grace period, if applicable. We will notify the United States Department of Health and Human Services of such non-payment.

If a physician or healthcare provider or their representative requests information regarding a covered persons eligibility, coverage, healthcare benefits, or the status of a claim or claims for a date of service while the covered person is in their second or third month grace period, AmeriHealth Caritas Next will clearly identify that the covered person is in the grace period and provide additional information. If we inform the physician or healthcare provider or their representative that the covered person is eligible for services, but the covered person is in the grace period, AmeriHealth Caritas Next will pay claims for covered health services in accordance with this policy.

We will continue to collect federal premium subsidies from the U.S. Department of the Treasury for the subscriber and any enrolled dependents but, if applicable, will return subsidies for the second and third months of the grace period at the end of the grace period if the premium amount owed is not paid and coverage ends for the subscriber and any dependents. A subscriber cannot enroll again once coverage ends this way unless they qualify for a special enrollment period or during the next open enrollment period.

Premium payments from third-party payors

AmeriHealth Caritas Next will not refuse the receipt of a premium payment when such payment is made by a third party to this policy provided that the payment is made from or pursuant to a fund or grant established by any one of the following:

- The Ryan White HIV/AIDS Program pursuant to Title XXVI of the Public Health Service Act;
- Indian tribes, tribal organizations, or urban Indian organizations;
- State or federal government programs;
- The American Kidney Fund.

Reinstatement

If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the insurer, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this policy. If the insurer or its agent requires an application, the insured will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless the insurer has previously written the insured of its disapproval.

The reinstated policy will cover only loss that results from an accidental injury sustained after the date of reinstatement or sickness that starts more than 10 days after such date. In all other respects, the rights of the insured and the insurer will remain the same, subject to any provisions noted on or attached to the reinstated policy. Any premiums the insurer accepts for a reinstatement will be

applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

Certificate of Creditable Coverage

We will provide you with a Certificate of Creditable Coverage when you or your dependent's coverage ends under this policy, or you exhaust continuation of coverage. Please keep this certificate of creditable coverage in a safe place. You can also request a Certificate of Creditable Coverage while you are still covered under this policy and for up to 24 months following the end of your coverage by calling 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays.

How To Use Your Health Plan

Our plan uses network providers to supply covered services to you. This means that we will not pay for services you might receive from out-of-network providers unless you have an emergency medical condition, or we authorize services from an out-of-network provider because the medically necessary services you need are not available from a network provider. An out-of-network provider is a provider whom AmeriHealth Caritas Next does not have a contractual agreement with. You can find a network provider online through our provider directory at:

https://www.amerihealthcaritasnext.com/view-plans/find-a-provider-or-pharmacy.

You can also call our Member Services number at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays. Network providers are not employed by 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 services rendered are within the scope of practice of a duly licensed optometrist, podiatrist, licensed clinical social worker, certified substance use counselor, dentist, chiropractor, psychologist, psychiatrist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage counselor, or physician assistant, these services are included in your benefits and eligible for reimbursement.

You can see any network specialist you choose without a referral. If you use a network provider, the provider will bill us for any covered health services they provide. You will be responsible for paying any deductibles, copayment, and coinsurance as outlined in your Schedule of Benefits. You will also be required to pay for any non-covered health services. The insurer will not provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

This means that we will not pay for services you might receive from out-of-network providers unless you have an urgent or 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 network cost share.

NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

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 a network facility) without the informed consent of the member or precertification. If the member receives incorrect information from the plan about a provider's network status, they will only be charged the network cost share. If a provider or health care facility leaves our network, the plan will continue to pay for covered health services at the member's network cost share for three months.

Choosing a primary care provider (PCP)

Once you enroll, you and any covered dependents in this plan must choose a PCP. You are permitted to designate any participating provider within our network who is available to accept patients. 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. They must 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 a network pediatrician as the PCP for any covered dependents younger than age 18.

Continuity/transition of care

Subject to prior authorization and medically necessary criteria review, for 90 days after the effective date of a new member's enrollment (or until treatment is completed, if less than 90 days), we will cover out-of- network covered health services with your treating provider for any medical or behavioral health condition currently being treated at the time of the member's enrollment in our plan. If the member is pregnant and in their second or third trimester, pregnancy-related services will be covered through 60 calendar days postpartum.

If a network provider or network facility stops participating in our network, or in the event a network provider contract or agreement is terminated, the network provider or network facility becomes 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 at your network cost share 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 three months. 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.

In order to receive these services, you must obtain prior authorization from the health benefit plan. Pregnant members who have been diagnosed as being in a high-risk pregnancy or are past the second or third trimester of pregnancy and started prenatal care with a provider or facility who stops participating in our network can continue receiving pregnancy-related services, including postpartum care through delivery and postpartum care related to the pregnancy and delivery. This continuity of care allowance time does not apply to providers whose participation as network providers has been terminated for cause by the plan.

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

Medical necessity

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

Prior authorization

Certain services or supplies may need to be reviewed before you receive them to make sure they are medically necessary and being provided by a network provider. If you are receiving services from a network provider, the provider will be responsible for obtaining any necessary prior authorization before you receive services. If the PA is denied and the provider still provides you with these services, the provider cannot bill you for these denied services unless you agree to receive services at a self-pay rate.

If you are obtaining services outside of our service area or from an out-of-network provider, you will need to make sure that any necessary PA has been received before receiving services. If you do not, the service may not be covered under this plan. Coverage will also depend on any limitations or exclusions for this plan, payment of premium, eligibility at the time of service, and any deductible or cost-sharing amounts. If you do not obtain PA before an elective admission to a hospital or certain other facilities, you may be responsible for all charges related to services that fail to meet PA requirements.

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

https://www.amerihealthcaritasnext.com/la/providers/resources/prior-authorization-lookup

Physical health services <u>requiring</u> prior authorization

- All out-of-network services excluding emergency services
- All services that may be considered experimental and/or investigational
- All miscellaneous services
- All unlisted or miscellaneous items, regardless of cost
- Biomarker testing
- Chemotherapy
- Cochlear implantation
- Congenital cleft lip and palate, oral and facial surgery, or orthodontic services
- Dental services and anesthesia
- DME:
  - All unlisted or miscellaneous items, regardless of cost

  - DME leases or rentals and custom equipment
  - Items with billed charges equal to or greater than $750, 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
- Gastric restrictive procedures or surgeries
- Gastroenterology services
- Genetic testing including but not limited to BRCA1 and BRCA2 to detect an increased risk for breast and ovarian cancer when recommended by a healthcare provider.
- 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. PA 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 services
- Hyperbaric oxygen
- Hysterectomy
- Inpatient hospital services:
  - All inpatient hospital admissions, including medical, surgical, long-term acute, skilled nursing, and rehabilitation
  - Elective transfers for inpatient and/or outpatient services between acute care facilities
  - Medical detoxification
- Medically necessary contact lenses
- Pain management including, but not limited to:
  - Epidural steroid injections
  - External infusion pumps
  - Implantable infusion pumps
  - Nerve blocks

  - Radiofrequency ablation
  - Spinal cord neurostimulators
- Personal care services, or help with activities of daily living including bathing, eating, dressing, toileting, and walking
- Postmastectomy inpatient care
- Reconstructive breast surgery (following a mastectomy)
- 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 PA.
  - Computed tomography (CT) scan
  - Magnetic resonance imaging (MRI)
  - Magnetic resonance angiography (MRA)
  - Nuclear cardiac imaging
  - Positron emission tomography (PET) scan
- Transplants, including transplant evaluations

Physical health services that <u>do not</u> require prior authorization

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

The following services will not require PA:

- 48-hour observation stays (except for maternity delivery and cesarean section surgery — physician notification is required)
- Dermatology
- Dialysis

- Electrocardiograms (EKGs)
- Emergency care (network and out-of-network)
- Family planning services
- Low-level plain film X-rays
- Pediatric routine vision services
- Postoperative pain management (must have a surgical procedure on the same date of service)
- Rehabilitation services and habilitative services (chiropractic services and speech and language, occupational, and physical therapy).
- Standard fertility preservation services for up to three years.
- Treatments provided as part of clinical trials
- Women's health care by network providers (OB/GYN services)

Mental/Behavioral health/substance use disorder services <u>requiring</u> 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
- Professional treatment services in facility-based crisis programs
- Psychiatric inpatient hospitalization
- Psychological testing

Mental/Behavioral/substance use disorder health services that <u>do not</u> require prior authorization

- Diagnostic assessment
- Medication-assisted treatment (MAT)
- Mental health or substance dependence assessment
- Diagnosis and assessment for severe mental health
- Outpatient psychiatric, substance use disorder, and medication management services not specified as requiring precertification. For specific services, please have your provider refer to the Prior Authorization Lookup Tool at

https://www.amerihealthcaritasnext.com/la/providers/resources/prior-authorization-lookup

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

Utilization Management

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

We will:

- Routinely assess the effectiveness and efficiency of our utilization review program.
- Coordinate the utilization review program with our other medical management activities, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.
- Provide covered persons and their providers with access to our review staff via a toll-free phone number or collect call whenever any provider is required to be available to provide services that may require prior certification or authorization to any plan member. The department's clinical staff and medical directors are available and accessible to all providers and members from 8 a.m. to 5 p.m., Monday through Friday, Eastern time (ET), with the exception of company-observed holidays, by calling our toll-free number at 1-844-214-2473. Utilization Management clinical staff are available on call after normal business hours, weekends, and holidays by calling 1- 833-282-2252. A toll-free fax line is available

to receive inbound communications from providers 24 hours a day, seven days a week, at 1-844-412-7887. TTY and language assistance is also available at 711.

- Limit our requests for information to only that information needed to certify or authorize the admission, procedure, or treatment, length of stay, and frequency and duration of health care services.
- Provide written procedures for making utilization review decisions and notifying covered persons of those decisions.
- Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

We will review service requests for medical necessity. Within the following time frames, we will communicate our review determination, whether adverse or not, to you, and your provider after we obtain all necessary information about the admission, procedure, or health care service being requested, also including, but not limited to, clinical notes, clinical evaluations, and second opinions from a different clinician.

- Concurrent requests are decided and communicated within 24 hours from the date of receipt of all necessary information. In the case of a determination to certify an extended stay or additional services, we will provide an initial notification of our certification to the provider rendering the service either by telephone or electronically within twenty-four hours of making the concurrent review certification and will provide written confirmation to the covered person and the provider within three business days of making the certification. We will include in the initial and written notifications the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

- Urgent care prospective requests are decided and communicated as soon as possible, taking into account medical needs, but will not exceed two business days or 72 hours from the date of receipt.

    - A prospective request is considered urgent if it is determined that a delay in the decision could reasonably appear to seriously jeopardize the life or health of the member or jeopardize the member's ability to regain maximum function; or, in the opinion of a physician with knowledge of

the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

- We will offer an expedited review to the provider requesting a prospective prior authorization if the request for services is related to the diagnosis or treatment of cancer. We will communicate our decision on the prior authorization request to the provider as soon as possible, but in all cases no later than two business days from the date of receipt of the expedited request. If we need additional information, we will communicate our decision to the provider as soon as possible, but no later than 48 hours from date of receipt of the additional information.

- Nonurgent care prospective requests are decided and communicated within five business days from the date of receipt.
  - Decisions for nonurgent care prospective prior authorization requests which were not requested as expedited review for services related to the diagnosis or treatment of cancer will be communicated no later than five calendar days from the date of receipt. If we need additional information, we will communicate our decision to the provider as soon as possible, but no later than two business days from date of receipt of the additional information.

- Retrospective requests are decided and communicated within 30 calendar days from the date of receipt.

Notification of utilization management decisions will be consistent with Louisiana law and our policies. If the request for utilization review is not accompanied by all necessary information required by the AmeriHealth Caritas Next, we will inform you and your provider of the need for additional information within one calendar day of receipt of request. We will give you and your provider two business days to submit the necessary information. In cases where you or your provider will not release necessary information, we may deny certification of an admission, procedure, or service.

If a provider or member fails to provide the requested information in the required timeframe, we may deny certification or authorization of the requested service.

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

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

- Any request by a member or provider to extend the course of treatment beyond the prescribed time or number of treatments. In certain situations, we will make a benefit determination as soon as possible. This is the case when a delay in the decision could reasonably appear to:

    - Seriously jeopardize the life or health of the member

    - Seriously jeopardize the member's ability to regain maximum function

    - In the opinion of a physician with knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that the member is requesting

In making a concurrent decision, we will take any urgent medical needs into account. As long as we receive the request at least 24 hours before the expiration of the prescribed period of time or number of treatments, we will notify the member and the member's provider of the benefit determination within 24 hours of receipt of request. This is true whether the benefit determination is adverse or not. Notification of any adverse determination for 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 determination, we will notify the member and the member's provider and send written or electronic confirmation of the adverse 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 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. We remain responsible for covered health care services until you have been notified of the adverse determination.

If we issue an adverse 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 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 Member Services at 1-833-282-2252 (TTY 711), 8 a.m. – 6 p.m. CT, Monday through Friday 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 or alternative 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. You may be subject to cost-sharing amounts that may result in excess consumer cost burden for things like covered prescription drugs. Any amounts considered in excess, AmeriHealth Caritas Next will notify you of the excess cost burden through your coverage agreement or formulary.

- 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.

- AmeriHealth Caritas Next does not impose any annual or lifetime limits on the dollar amount of covered Essential Health Benefits for any covered person.

Covered Health Services

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

- The amount you must pay for these covered health services (including any deductible, copayment, and/or coinsurance).
- Any limits that apply to these covered health services (including visit, day, and dollar limits on services).
- Any limit to the amount you are required to pay in a calendar year (out-of-pocket maximum amount).
- The Schedule of Benefits and other policy documents are available on request by contacting our Member Services team at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays. You may also access **policy** documents online at https://www.amerihealthcaritasnext.com/de/members/forms-and-documents.aspx

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

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.

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

Abortion services

We will only cover therapeutic abortion services when a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed. A therapeutic abortion is the interruption of a pregnancy before the 20th week of gestation because it endangers the mother's life or health.

The following medically necessary abortion services are covered by your health benefit plan:

I. A medical procedure performed with the intention to save the life or preserve the health of an unborn child.
II. The removal of a dead unborn child or the inducement or delivery of the uterine contents in case of a positive diagnosis, certified in writing in the woman's medical record along with the results of an obstetric ultrasound test, that the pregnancy has ended or is in the unavoidable and untreatable process of ending due to spontaneous miscarriage, also known in medical terminology as spontaneous abortion, missed abortion, inevitable abortion, incomplete abortion, or septic abortion.
III. The removal of an ectopic pregnancy.
IV. The use of methotrexate to treat ectopic pregnancy.
V. The performance of a medical procedure necessary in good faith medical judgment or reasonable medical judgment to prevent the death or substantial risk of death to the pregnant woman due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman. However, the physician shall make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of her unborn child in a manner consistent with reasonable medical practice.
VI. The removal of an unborn child who is deemed to be medically futile. The diagnosis shall be a medical judgment certified by two qualified physicians and recorded in the woman's medical record. The medical procedure shall be performed in a licensed ambulatory surgical center or hospital.

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

We will cover ambulance transportation services, including air or surface transport of a newly born to nearest available hospital or neonatal special care unit for treatment of illnesses, injuries, congenital defects, and complications of premature birth. Transportation includes coverage for covered temporarily disabled mothers of the ill newly born when accompanying the ill newly born to the nearest available hospital or neonatal special care unit.

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

- Cost of transporting a newborn to and from the nearest available facility that is appropriately staffed and equipped to treat the newborn's condition, when the transportation is certified by the attending physician as necessary to protect the newborn's health and safety
- From an acute facility to a subacute facility or setting
- From an out-of-network hospital or facility to a 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 network cost-share. Nonemergency air transportation requires PA.

Attention deficit disorder

We will cover services for the diagnosis and treatment of attention deficit/hyperactivity disorder. The diagnosis and treatment for attention deficit/hyperactivity disorder is covered when rendered or prescribed by a network provider or other appropriate network health care provider licensed in this state and received at a network facility.

Autism spectrum disorders (ASDs)

We will cover ASD services. Covered health services include the assessment, diagnosis, and treatment of ASDs, including:

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

Certain services for ASD may need prior authorization.

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, to Include genetic and molecular markers for cancer and other conditions, 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 is not covered. Coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples. Coverage applies to the covered biomarker test itself and is not conditioned on laboratory classifications or credentialing standards unrelated to the performance of the covered test.

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

Bone mass measurement services are covered for the diagnosis and treatment of osteoporosis. The covered person must be:

- An estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment
- An individual receiving long-term steroid therapy
- An individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies

This service requires 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.

Cardiac rehabilitation – (See **Habilitation services and rehabilitation services)**

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 (including Osteopathic services)

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

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

- Infusion therapy or chelation therapy
- 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

AmeriHealth Caritas Next will not deny a covered person's participation in an approved clinical trial nor will AmeriHealth Caritas Next discriminate against a

covered person based on their participation in a clinical trial. We will provide coverage of routine patient care costs for approved clinical trials. Please refer to the definition of approved clinical trials in the Definitions of important words used in this document section of this policy for additional information.

Routine patient care costs for approved clinical trials are any of the cost of health care services, treatments, or testing that are incurred as part of the protocol treatment being provided to the patient for purposes of the clinical trial. It does not include the following items:

- The cost of non-health care services that a patient may be required to receive as a result of the treatment being provided pursuant to the clinical trial.
- Costs associated with managing the research data associated with the clinical trial.
- The cost of investigational devices or drugs not required to be covered under state law.
- Costs not otherwise covered under this policy for non-investigational treatments.

Costs of investigational treatments and costs of associated protocol-related patient care shall be covered if all of the following criteria are met:

1. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
2.
    a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
    b. The service must be a for routine patient care costs for approved clinical trials as defined in this policy.
3. The treatment is being provided in accordance with an approved clinical trial by this policy. Please refer to the approved clinical trials definition in the Definitions of important words used in this document section of this policy.
4. The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a

multiple project assurance contract approved by the office of protection from research risks.

5. The facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

6. There is no clearly superior, non-investigational approach.

7. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.

8. The patient has signed an institutional review board-approved consent form.

Congenital anomaly, including cleft lip/palate

We will cover medically necessary care, treatment, and correction of cleft lip and cleft palate. Coverage includes but is not limited to:

- Oral and facial surgery, surgical management, and follow-up care.
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances.
- Orthodontic treatment and management.
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.
- Speech-language evaluation and therapy.
- Audiological assessments and amplification devices.
- Otolaryngology treatment and management.
- Psychological assessment and counseling.
- Genetic assessment and counseling for patients and parents.

We will also cover procedures to treat bones or joints of the jaw and facial region caused by a congenital or developmental deformity, disease, or injury.

Contraceptive injections – (See **Family planning services**)

Dental services/anesthesia/accident-related dental

The dental services benefit provides coverage for evaluation, imaging, clinical examination, and dental extractions that are medically necessary to reduce the risk of infection, eliminate infection, or treat tooth loss or decay as a part of a pre-cancer treatment screening for a covered person diagnosed with cancer. These dental services are covered when performed as a part of a pre-treatment medical clearance protocol for a member who is scheduled to undergo cancer treatment. This coverage does not include services for routine preventive dental care, including cleaning and sealants.

General anesthesia and hospitalization services are covered when a network provider determines these services are needed to ensure the safe delivery of necessary dental care for a covered person who:

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

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

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

Anesthesia benefits are not covered for treatment rendered for temporomandibular joint (TMJ) disorders.

Accident-related dental services are covered, and coverage includes office visits 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.

AmeriHealth Caritas Next will not:

- Prevent any covered person from selecting the dentist of their choice to furnish the dental care services offered by the policy, plan, or interfere with such selection.
- Deny any dentist the right to participate as a contracting provider for such policy or plan.
- Authorize any person to regulate, interfere, or intervene in any manner in the diagnosis or treatment rendered by a dentist to their patient.
- Require that any dentist make or obtain dental x-rays or any other diagnostic aids; however, nothing herein shall prohibit requests for existing dental x-rays or any other existing diagnostic aids for the purpose of determining benefits payable under a health insurance policy.

Dental services are limited to the least costly treatment. Benefits are paid based on usual customary and reasonable fees. AmeriHealth Caritas Next shall pay or reimburse benefits for non-contracting dentists at the same rate of payment as contracted providers. AmeriHealth Caritas Next is not required to make payment or reimbursement in an amount that is greater than the amount or fee charged by the providing dentists under your policy.

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

Diabetes services

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

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

Diagnostic services — outpatient

We cover laboratory, x-ray, and radiology services done to diagnose illness, disease or injury. Outpatient diagnostic services or imaging may be given at a hospital, alternate facility, or physician's office. Specific diagnostic services for 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)

We cover medically necessary DME ordered or provided by a physician. DME may require a PA, and we reserve the right to approve rental instead of purchase of the DME. Examples of DME include, but are not limited to, crutches, orthotics (including for positional plagiocephaly), prosthetics, and wheelchairs. We will provide coverage for prescription and nonprescription enteral formulas for home use when prescribed by a network provider for the treatment of inherited

diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. This includes coverage for amino acid-based elemental formulas, regardless of formula method, to treat a child aged two years or younger. Coverage applies if the child has been diagnosed by a board-certified allergist or board-certified gastroenterologist and the treating physician issues a written order stating that the amino acid-based elemental formula is medically necessary to treat the child for any of the following:

1. Immunoglobulin and non-immunoglobulin mediated allergies to multiple food proteins.
2. Severe food protein-induced enterocolitis syndrome.
3. Eosinophilic disorders, as evidenced by the results of a biopsy.
4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Emergency services

We will cover emergency medical services needed to evaluate and treat an emergency medical condition. These services may include a hospital or facility charge, supplies, and associated professional services. If you are admitted to the hospital from the emergency room, any applicable copay for emergency room services will not apply. If you are admitted to an out-of-network hospital from the emergency room, you must notify us within 24 hours. When you are stabilized, we will transfer you by ambulance to the closest appropriate network hospital or facility.

Emergency services and some post-stabilization services received from an out-of-network provider will be covered at the network benefit level. The out-of-network provider is prohibited from billing you more than your network cost-share. In no case will the payment be made directly to the patient, insured or enrolled.

Prior authorization for pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure shall be inapplicable to an emergency medical condition.

AmeriHealth Caritas Next will not retrospectively deny or reduce payments to a provider for emergency medical services of an insured, enrollee, or covered

person even if it is determined that the emergency medical condition, initially presented is later identified through screening as not an actual emergency except in the following cases:

- Material misrepresentation, fraud, omission, or clerical error.
- Any payment reductions due to applicable co-payments, co-insurance, or deductibles which may be the responsibility of the insured.
- Cases in which the insured does not meet the emergency medical condition definition unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.

Emergency transportation/ambulance – (See **Ambulance)**

Family planning services

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

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

- Abortion, unless required by state law
- Fetal reduction surgery
- Reversal of sterilization or vasectomies
- Services related to surrogate parenting

Genetic testing

We will cover medically necessary genetic or molecular tests for cancer including but not limited to tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomic testing, whole exome and genome sequencing, and biomarker testing. Please refer to the Biomarker testing section of this policy for additional information. Coverage includes genetic

tests which test for the presence of BRCA1 or BRCA2 gene mutations. In addition, coverage is provided for genetic testing to diagnose SCN2A-associated medical conditions when ordered by a treating physician or advanced practice provider and determined to be medically necessary by your **health benefit plan**. Coverage is provided to treat SCN2A-associated medical conditions including but not limited to:

1. Anti-seizure medications and other pharmacologic therapies
2. Rehabilitative and habilitative services including physical, occupational, speech, and behavioral therapies
3. Medically necessary durable medical equipment, assistive technology, and adaptive devices
4. Nutritional, feeding, and gastrointestinal management services
5. Any additional treatment determined to be medically necessary by the treating physician or advanced practice provider

Habilitation services and rehabilitation services

- **Habilitation services**

  Medically necessary services for habilitation, including speech and language therapy, occupational therapy, and physical therapy, must be ordered by a physician and delivered by appropriately licensed medical personnel. Services must be provided to help a person keep, learn, or improve the 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.

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

- **Inpatient rehabilitation services**

  Helps people return to daily life and live in a normal or near-normal way. These services performed within an inpatient setting may include physical therapy, occupational therapy, speech and language therapy, cognitive therapy, and mental health rehabilitation services. 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**

  We will cover medically necessary services for rehabilitation, including speech, occupational, and physical therapy, cardiac rehabilitation, and pulmonary rehabilitation. Services 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.

  These services must help the covered person return to daily life and live in a normal or near-normal way.

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

Hearing aids

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 services

We will cover certain services received in the home from a certified/licensed home health agency when ordered by a physician. Examples of these services

include skilled care, physical/ occupational/speech and language/respiratory therapy, social work services, and home infusion. Services must only be provided on a part-time, intermittent basis and cannot be solely for helping with activities of daily living.

Please refer to your Schedule of Benefits for more information on your home health care benefit and limitations that may apply.

We will cover home visiting services provided after the birth of a child. Home visiting services are evidence-based deliveries of services to families of newborns, or families expecting newborns, provided by trained professionals in the home that begin anywhere from before the 28th week of pregnancy and up to six weeks after the birth of a child and continuing from up to two to five years after childbirth.

Hospice services

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

Hospital services

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

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

Outpatient **hospital** services for **emergency** care are covered per the **emergency services** section above. Treatment performed outside the **hospital** will be paid the same as if performed in a hospital, provided it would have been covered on an inpatient basis.

Inherited Metabolic Disorders – PKU

We will provide coverage for low protein food products for the treatment of inherited metabolic diseases, if the low protein food products are medically necessary, and are obtained from a source approved by AmeriHealth Caritas Next.

Inpatient 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 PA. Treatment may require inpatient services when they cannot be adequately provided on an outpatient basis.

We will provide coverage for pre-admission testing.

Inpatient physician and surgical services

This plan covers inpatient physician and surgical services for the treatment of an illness or injury and associated services and supplies for this care, including anesthesia, subject to PA.

Interpreter expenses for the hearing impaired

Services of a qualified interpreter/transliterator are covered when the member needs such services in connection with medical treatment or diagnostic consultations if the services are required because of a hearing impairment or a language communication failure. These services are not covered if the medical treatment or consultation is not covered.

Laboratory outpatient and professional services

We cover outpatient laboratories and professional services performed to diagnose illness, disease or injury.

Lymphedema services

We will provide coverage the following services to treat and diagnose lymphedema:

- Physician services to diagnose lymphedema

- Multilayer compression bandaging systems
- Custom or standard-fit gradient compression garments.

Mammogram – (See **Preventive care/services/immunizations**)

Mastectomy and breast cancer reconstruction

Medical and surgical benefits are provided for mastectomy including contralateral prophylactic mastectomies 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 a unilateral or bilateral mastectomy has been performed.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.
- Surgery and reconstruction of the other breast to produce symmetrical appearance.

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

Breast reconstruction is covered regardless of the time elapsed between the mastectomy and the reconstruction. These benefits will be provided subject to the same deductibles, and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information, please

contact 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays.

AmeriHealth Caritas Next will not do any of the following:

- Deny a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this provision.

- Penalize or otherwise reduce or limit the reimbursement of an attending provider or provide monetary or nonmonetary incentives to an attending provider, to induce such provider to provide care to an insured or enrollee in a manner inconsistent with this Section.

- Require that the mastectomy procedures and reconstructive procedures be performed under the same policy or plan.

- Reduce or limit coverage benefits to a patient for the reconstructive procedures performed pursuant to this Section as determined in consultation with the attending physician and patient.

Mental/Behavioral health inpatient services

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

We provide coverage for voluntary inpatient treatment for a patient with a perinatal psychiatric diagnosis. Perinatal psychiatric diagnosis means a psychiatric disorder requiring inpatient treatment during pregnancy through one year postpartum, which includes one year after a pregnancy loss. Covered services include inpatient admission, including overnight stays, medications resulting from treatments, including infusions and prescriptions, and counseling services. All decisions regarding voluntary inpatient treatment following a perinatal psychiatric diagnosis shall be made solely by the attending physician, physician assistant, psychiatrist, psychologist, medical psychologist, or nurse practitioner in consultation with the patient. All levels of maternal mental health inpatient treatment as provided in this policy will be considered medically

necessary and will not be excluded from coverage. The treating physician, physician assistant, psychiatrist, psychologist, medical psychologist, or nurse practitioner must consider recognized evidenced based standards, such as guidelines of InterQual or Milliman Care Guidelines (MCG), in making treatment recommendations. AmeriHealth Caritas Next will not deny coverage for voluntary inpatient treatment for a patient with perinatal psychiatric diagnosis that is consistent with these standards.

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

Mental/Behavioral health outpatient services

We will cover certain outpatient mental/behavioral health services.

Examples include:

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

Mental/behavioral health 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.

Nutritional counseling – (See **Preventive care/screenings/immunizations)**

Osteoporosis

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

Other practitioner office visit (nurse, physician assistant)

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 up to the limits of this policy 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 PA. Covered services performed in an ambulatory surgery center will be covered if such service would have been covered under the policy as an eligible inpatient service.

Outpatient hospital services

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

Outpatient hospital services for emergency care are covered per the Emergency services section above. Treatment performed outside the hospital will be paid the same as if performed in a hospital, provided it would have been covered on an inpatient basis.

Outpatient surgery physician/surgical services

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

Pediatric vision services

We cover pediatric vision services through the last day of the month in which a child turns age 19. Covered services include:

- One comprehensive low-vision exam every five years, low-vision aids and four follow-up care visits
- One routine eye exam per calendar year
- One pair of eyeglasses or contact lenses per calendar year for children. 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.
- Choice of glass or plastic lenses, lenticular lenses, fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses, polycarbonate lenses scratch resistant coating and low vision benefits.
- Minor repairs to eyeglasses
- Replacement lenses and frame

AmeriHealth Caritas Next will not discriminate in the amount of either:

- Medical eye care or vision care benefits available to an insured, participant, or other person entitled to such benefits, whether provided by an optometrist or physician, in instances where the services performed are within the lawful scope of practice of both professions.

- Reimbursements or payments to the provider of such medical eye care or vision care services, whether performed by an optometrist or physician, in instances where the services performed are within the lawful scope of practice of both professions.

Your cost share responsibility for pediatric vision services will be equal to or less than the cost to see an allopathic or osteopathic physician. Please refer to the Schedule of Benefits for additional information and any limitations.

Pregnancy services/prenatal and postnatal care

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

Your coverage for the length of a maternity and newly born hospital stay or follow-up care outside of the hospital will not be limited to a time period less than what is determined to be medically necessary by your treating obstetrical care provider and pediatric care provider per prevailing medical standards and consistent with guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. Coverage for the mother's hospital length of stay in connection with childbirth for the mother or newly born child, following a normal vaginal delivery, may not be less than forty-eight hours. The hospital length of stay in connection with childbirth for the mother or newly born child, following a cesarean section, may not be less than ninety-six hours.

We will provide coverage for post-delivery care for a mother and her newborn. The post-delivery care includes a postpartum assessment and newborn assessment which can be provided at a network hospital, attending office, outpatient maternity center, or in the home by a network qualified licensed health care professional trained in mother and baby care. This coverage also includes physical assessment of the newborn and the mother, and any medically necessary clinical tests and immunizations, in keeping with the prevailing medical standards.

Complications of pregnancy

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

Doula services

A doula is an individual who has been trained to provide physical, emotional, and educational support, but not medical or midwifery care, to pregnant and birthing women and their families before, during, and after childbirth. We cover maternity support services provided by a doula to pregnant and birthing women before, during, and after childbirth. This coverage is subject to annual deductibles, member cost share responsibilities, and is limited to $1,500 per pregnancy.

Prescribed donor human milk

We cover inpatient and outpatient benefits for up to two months for medically necessary pasteurized donor human milk upon prescription of an infant's pediatrician or licensed pediatric provider stating that the infant is medically or physically unable to receive maternal human milk or participate in breastfeeding, or the infant's mother is medically or physically unable to produce maternal human milk in sufficient quantities. This coverage is limited to inpatient and outpatient donor human milk obtained from a member bank of the Human Milk Banking Association of North America.

Preventive care/screening/immunization

We cover any preventive services required by federal and state laws or regulations. Your deductible, copayment, or coinsurance amounts will not apply if these services are received from a network provider. Services 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 and Evidence of Coverage.

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

- Abdominal aortic aneurysm screening for men ages 65 – 75 who have ever smoked.
- Annual Pap test and screening colonoscopy
- Cervical cancer screening — Examination and laboratory tests for early detection and screening including annual Pap smear, liquid-based cytology, and human papillomavirus detection; this will follow the American Cancer Society guidelines.

- Colorectal cancer screening is any test or screening provided in accordance with the most recently published recommendations established by the American Cancer Society or the National Comprehensive Cancer Network for the ages, family histories, and frequencies referenced in such recommendations. Annual examinations and laboratory tests for colorectal cancer are covered for any member who is age 45 or older or is younger than age 45 but is at high risk for colorectal cancer. Any colonoscopy conducted for the purpose of colorectal cancer screening is classified as a preventive care screening service, irrespective of whether a polyp or other tissue is excised during the procedure. Any subsequent colonoscopy recommended by your healthcare provider as a result of findings from the routine colorectal cancer screening is considered a routine colorectal cancer screening if provided in accordance with the recommendations by the American Cancer Society or the National Comprehensive Cancer Network.

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

- We cover a minimum mammography examination which is a mammographic examination, including but not limited to digital breast tomosynthesis (DBT), performed no less frequently than the following schedule and criteria of the American Society of Breast Surgeons provides:

  A.

  1. Baseline mammogram for any woman who is 35 or older, but younger than 40.

  2. For women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation, an annual MRI starting at age twenty-five and annual DBT mammography starting at age thirty. Such examinations shall be in accordance with recommendations by National Comprehensive Cancer Network guidelines or the American Society of Breast Surgeons Position Statement on Screening Mammography no later than the following policy or plan year following changes in the recommendations.

3. Annual DBT mammography and access to MRI supplemental imaging starting at age thirty-five upon recommendation by the treating physician if the covered woman has a predicted lifetime risk greater than twenty percent by any validated model published in peer reviewed medical literature.

B. Annual DBT mammogram for any woman who is forty years of age or older.

1. Supplemental imaging (breast ultrasound initial, followed by MRI if inconclusive) is covered if recommended by your treating network provider for women with increased breast density (C and D density).

2. Annual MRI supplemental imaging, if recommended by your network treating physician, for women with a prior history of breast cancer below the age of fifty or with a prior history of breast cancer at any age and dense breast (C and D density).

We will cover at no cost to you any diagnostic imaging such as a diagnostic mammogram, contrast-enhanced mammogram, breast magnetic resonance imaging, or breast ultrasound screening for breast cancer designed to evaluate an abnormality in the breast that is any of the following:

1. Seen or suspected from a screening examination for breast cancer.

2. Detected by another means of examination.

3. Suspected based on the medical history or family medical history of the individual or additional factors that may increase the individual's risk of breast cancer.

- Nutritional counseling with a registered dietician

- 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). This includes the services of a qualified lactation care provider.

- Preventive care and screenings for women according to guidelines supported by HRSA.

- Prostate cancer screening, including digital rectal examination and prostate-specific antigen testing for men over the age of 50 years and for men between the ages of 40 to 49 years, is included in accordance with the most recently published guidelines from the National Comprehensive Cancer Network. Routine prostate preventative care coverage includes a minimum of one routine annual visit; a second visit shall be permitted based upon medical need and follow-up treatment within sixty days after either visit if related to a condition diagnosed or treated during the visits. Any coverage required for this prostate cancer screening does not require any cost-sharing amount, including deductibles, coinsurance, copayment, or similar out-of-pocket expenses.

- 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. This coverage includes basic immunization series for children up to age six.

- Skin cancer screenings - We cover at no cost to you one annual skin cancer screening performed by a network practitioner licensed in accordance with Louisiana state law, including a dermatologist, an osteopathic physician, or an advanced practice registered nurse who is under the supervision of a dermatologist.

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 visit to treat an injury or illness

We cover office visits for primary care and/or to treat or diagnose illness, disease, or injury.

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 a home setting. Private duty nursing care is not covered when in an inpatient or acute hospital.

Prosthetic and orthotic devices

We provide coverage for prosthetics, prosthetic services, and orthotics. These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function. 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.

Proton therapy or proton beam therapy

We cover proton therapy or proton beam therapy for the treatment of cancer as recommended by the American Society for Radiation Oncology practice guidance.

Pulmonary rehabilitation – (See **Habilitation services and rehabilitation services)**

Radiation

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.

Reconstructive surgery

Reconstructive surgery is surgery performed to restore normal appearance and function to body parts malformed by a disease or medical condition. (See **Mastectomy and breast cancer reconstruction**)

Routine eye exam for children (See **Pediatric vision)**

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.

Second opinion

You have the right to seek a second medical opinion with a physician of your choice if you dispute AmeriHealth Caritas Next's or your network physician's opinion on the reasonableness or medical necessity of surgical procedures or you are experiencing a serious injury or illness. If you see a network physician, you will not be charged more than the specialist cost share, and prior authorization will not be required. See your Schedule of Benefits for more information on cost share requirements for specialist services. Out-of-network services are only covered if AmeriHealth Caritas Next determines the service cannot be provided within our network. To receive services out-of-network you will have to obtain prior authorization from AmeriHealth Caritas Next.

Skilled nursing facility services

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

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

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

Sleep studies

Home or laboratory sleep studies that are medically necessary and associated professional claims are eligible for coverage. Only sleep studies performed in the home or sleep studies performed in a sleep laboratory that is accredited by the Joint Commission, or the American Academy of Sleep Medicine (AASM) are eligible for coverage.

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

Specialist visits

Office visits for specialty care services are covered.

Standard fertility preservation services

Iatrogenic infertility is an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

We cover medically necessary expenses for standard fertility preservation services when medically necessary treatment may directly or indirectly cause iatrogenic infertility or when a covered person who has been diagnosed with cancer for which necessary cancer treatment may directly or indirectly cause iatrogenic infertility. We will cover up to three years of storage costs to store oocytes and sperm after extraction. Please refer to your schedule of benefits for additional information.

State of emergency out-of-state coverage

We cover healthcare services for a covered person diagnosed with a disease or condition which requires the covered person to receive life-sustaining treatments, including but not limited to, chemotherapy, radiotherapy, dialysis, and heart surgery, if the covered person is forced to temporarily relocate to another state when the governor declares a state of emergency. In the case of emergency services and any ancillary emergency healthcare services, we provide access to services twenty-four hours per day, seven days per week.

Substance use disorder inpatient services

Inpatient 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 substance use services in parity with medical or surgical benefits within the same classification or subclassification.

Substance use disorder outpatient services

We will cover certain outpatient substance use services. Examples include:

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

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.

PA is required for use-deterrent opioid analgesic drug products.

Telehealth services – (See **Virtual care services)**

Transplant

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.

AmeriHealth Caritas Next will not refuse to consider an application to provide solid organ transplantation in any preferred or exclusive provider network by any transplant center located in the state provided the following conditions are met:

- The transplant center team is certified by the United Network for Organ Sharing, for organ transplantation and certified under Title XVIII of the Social Security Act or in the absence of such certification, other appropriate standards utilized by the majority of health insurance issuers in this state.
- The transplant center is certified under Title XVIII of the Social Security Act or, in the absence of such certification, other appropriate standards utilized by a majority of health insurance issuers in this state.
- The transplant center accepts payment at the same rate paid to other transplant centers located outside of Louisiana with whom the health insurance issuer has a contract for such services.
- The transplant center agrees to perform all medically necessary services associated with a transplant at no additional cost to the insured or enrollee regardless of any lifetime benefit limits or other limitations on coverage.

AmeriHealth Caritas Next will not refuse to consider an application to provide hematopoietic cell transplantation in any preferred or exclusive provider network by any transplant center located in the state provided the following conditions are met:

- The transplant center is certified by the Federation for the Accreditation of Hematopoietic Cell Therapy (FAHCT) or by at least one of the following National Institutes of Health sponsored cooperative groups: the Southwest Oncology Group (SWOG), the Eastern Cooperative Oncology Group (ECOG), or the Cancer and Leukemia Group B (CALGB), for adult patients; and the Pediatric Oncology Group (POG) or Children's Cancer Group (CCG) for pediatric patients.

- The transplant center accepts payment at the same rate paid to other transplant centers located outside of Louisiana with whom the health insurance issuer has a contract for such services.

- The transplant center agrees to perform all medically necessary services associated with hematopoietic cell transplantation at no additional cost to the insured or enrollee regardless of any lifetime benefit limits or other limitations on coverage.

AmeriHealth Caritas will not do any of the following:

- Deny coverage to a covered person solely on the basis of the person having a disability.

- Deny a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this Section.

- Penalize or otherwise reduce or limit the reimbursement of an attending provider or provide monetary or nonmonetary incentives to an attending provider, to induce such provider to furnish care to an insured or enrollee in a manner inconsistent with this Section.

- Reduce or limit coverage benefits to a patient for the medical services or other services related to organ transplantation performed pursuant to this Section as determined in consultation with the attending physician and patient

Urinary and sexual dysfunction treatment

We will cover medical and surgical treatment of urinary and sexual dysfunction resulting from the treatments chosen by a patient diagnosed with cancer in consultation with your network attending physician. This coverage includes

procedures correcting urinary and sexual dysfunction resulting from treatments, including penile injections, external pumps, and surgical implants.

Urgent care centers or facilities

Covered health services include medically necessary services by a network provider or out-of-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 network or out-of-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 network provider. Certain specialty services including pediatrics are not eligible for AmeriHealth Caritas Next Virtual Care 24/7.

Virtual care services or remote monitoring services from any other professional provider such as an occupational or physical therapist 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. AmeriHealth Caritas Next will cover healthcare services performed via transmitted electronic imaging or telemedicine/virtual care at your applicable cost share outlined on your schedule of benefits. The payment, benefit, or reimbursement to the provider who provides these services will be no less than seventy five percent of the reasonable and customary amount of payment, benefit, or reimbursements which that provider receives for an intermediate office visit. You can check with your provider to see if virtual care services are available.

For more information regarding your virtual care benefit please visit https://www.amerihealthcaritasnext.com/la/members/benefits/virtual-care.

Well baby visits and care – (See **Preventive care/screening/immunizations)**

X-rays, diagnostic imaging, and imaging (CT/PET Scans, MRIs)

We will cover 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.

We also cover Imaging (CT/PET Scans, MRIs) services. These services may require authorization. See the **Physical health services requiring prior authorization** section of this policy.

Prescription drug benefits

AmeriHealth Caritas Next strives to provide you with high-quality and cost-effective drug coverage. Coverage of prescription drugs include all benefits associated with the cost of the drugs including applicable taxes and fees minus your member cost share responsibility.

We use AmeriHealth Caritas Next's Pharmacy Benefit Manager (PBM) to help manage your prescription drug benefits, including specialty medications. For drugs that you administer yourself, you can fill your prescription medications at 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.

AmeriHealth Caritas Next does not prohibit or limit a covered person from selecting a pharmacy or pharmacist of their choice to be a provider under this policy to furnish pharmaceutical services or pharmaceutical products offered or provided by this policy. We will not interfere with your selection of a pharmacy or pharmacist, provided that your chosen pharmacy or pharmacist agrees in writing to provide pharmaceutical services and pharmaceutical products that meet all the terms and requirements, including the same administrative, financial, and professional conditions and minimum contract term of one year if requested, that apply to all other pharmacies and pharmacists who have been designated as providers under this policy.

If you need a physician-administered drug, AmeriHealth Caritas Next and our PBM will not refuse to authorize, approve, or pay a participating provider for providing covered physician-administered drugs and related services to covered persons. We will not condition, deny, restrict, refuse to authorize or approve, or reduce payment to a participating provider for a physician-administered drug when all criteria for medical necessity are met, because the participating provider obtains physician-administered drugs from a pharmacy that is not a participating provider in our network. The drug supplied shall meet the supply chain security controls and chain of distribution set by the federal Drug Supply Chain Security Act. We will not require a covered person to pay an additional fee, or any other increased cost-sharing amount in addition to applicable cost-sharing amounts payable by the covered person as designated within the health benefit plan to

obtain the physician-administered drug when provided by a participating provider.

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. AmeriHealth Caritas Next uses one drug formulary for all plans within the state. AmeriHealth Caritas Next develops and maintains its formulary and other Pharmaceutical Benefit Management procedures through its Pharmacy and Therapeutic (P&T) Committee. AmeriHealth Caritas Next's P&T committee includes members who represent a sufficient number of clinical specialties including practicing physicians, pharmacists, and other practicing health care professionals to meet the needs of its covered members.

AmeriHealth Caritas Next ensures that its formulary is based on the recommendations of its P&T committee and covers at least the greater of:

(1) One drug in every United States Pharmacopeia (USP) category and class; or

(2) The same number of prescription drugs in each category and class as the essential health benefits (EHB) benchmark plan.

AmeriHealth Caritas Next's P&T committee reviews and approves updates and guidance related to the exceptions process, other utilization management processes, drug utilization reviews, and quantity limits and therapeutic interchanges. The P&T committee reviews and approves updates and changes to all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered medication, and reviews new FDA approved prescription drugs and new uses for existing prescription drugs. The P&T committee ensures the formulary includes a range of prescription drugs across a broad distribution of therapeutic categories and classes and makes recommendations for prescription drug regimens that treat all disease states, and does not discourage enrollment by any group of covered persons, and provides appropriate access to prescription drugs that included in broadly

accepted treatment guidelines and that are indicative of general best practices at the time.

All new molecular entities and FDA-approved drug products or indications covered under the pharmacy benefit are reviewed once released onto the market within 180 days of release. New evidence regarding a drug product or class; and the use and access of drug products prior to formulary review are also reviewed within 180 days of release. Pharmaceutical management procedures, drug utilization management criteria, and list of approved pharmaceuticals (formulary) in its entirety is reviewed at least once annually. Pharmaceutical review procedures include formulary placement of drugs within therapeutic classes, prior authorizations, step therapies, quantity limits, generic substitutions, drug utilization, and related activities that affect access.

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 or to find out if a drug is on our formulary, please visit:

> https://amerihealthcaritasnext.healthsparq.com/healthsparq/public/ or call us at 1-866-334-3523.

We will respond to requests for formulary information within three business days from the date of receipt of the request. The inclusion of a drug on the formulary does not guarantee that your network treating provider or authorized prescriber will prescribe the drug for a particular medical condition or mental illness.

The formulary is a closed formulary (i.e., products not listed are treated as non-formulary); 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 non-formulary 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 Schedule of Benefits for more information on copays and deductibles.

If you request information regarding coverage of a drug, we will determine whether the specific drug is included in our formulary within three business days from the date of request.

If a prescribed drug is denied based upon the drug's non-formulary status, we will provide the prescribing provider with a list of the alternative comparable formulary medications in writing and attach it to the denial of the prescription drug coverage. If the prescribed drug is excluded from coverage under your health benefit plan, and other drugs in the same class and used for the same treatment as the excluded drug are covered under the plan, we shall notify the prescribing provider of the covered drug.

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/la/members/find-a-provider-or-pharmacy

You can use the searchable drug list, to search by the first letter of your medication, by typing part of the generic (chemical) or brand (trade) names, or by selecting the therapeutic class of the medication you are looking for.

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

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

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

- 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 substantially accepted peer reviewed medical literature or 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 will not deny coverage for the treatment of metastatic or unresectable tumors or other advanced cancers with a medically necessary drug prescribed by a physician on the basis that the drug is not indicated for the specific tumor type or location in the body of the patient's cancer if the drug is approved by the United States Food and Drug Administration for the treatment of the specific mutation in a different type of cancer. We will not consider the treatment experimental or outside of your policy scope if the United States Food and Drug Administration has approved the drug for the specific genetic mutation, even if in a different tumor type. Coverage shall be included for a minimum initial treatment period of not less than three months. Coverage shall continue after the initial treatment period if the treating physician certifies that the drug is medically necessary based on documented improvement of the patient.

    - Orally administered anti-cancer medication: You will not be charged more than $80 per filled prescription, per 30 days supply, for any orally administered anti-cancer medication. This cost-share shall be applied toward your deductible, if applicable, and annual out-of-pocket maximum in the same manner as other covered benefits under this health benefit plan.

Included in the formulary are:

- Hormone replacement therapy (HRT) for perimenopausal and postmenopausal individuals

- Hypodermic syringes or needles when medically necessary

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 six months to five 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 DF200 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

Certain drugs or products (e.g., infused, injected, or implanted drugs or medical supplies such as wound care supplies) may be covered as a nonpharmacy benefit under your medical benefit.

What is not covered:

- Any drug products used exclusively for cosmetic purposes unless otherwise stated in this policy
- 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.
- 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 or sexual dysfunction unless your erectile or sexual dysfunction is resulting from the treatments, solely chosen by you due to a diagnosis of cancer in consultation with your network attending physician
- Drugs used for weight loss
- Bulk Chemicals
- Repackaged products

For our latest pharmacy benefit and formulary information, please visit:

https://www.amerihealthcaritasnext.com/la/members/find-a-provider-or-pharmacy or call us at 1-866-334-3523 (TTY 711).

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. Please refer to the **Renewal and continuation of coverage** section of this policy for additional information.

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.

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.

The duration of any step therapy or fail first protocol will not be longer than the customary period for the medication when the treatment is demonstrated by the

prescribing practitioner to be clinically ineffective. When AmeriHealth Caritas Next can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than the customary period for the medication to provide any relief or an amelioration to the covered person, the step therapy or fail first protocol may be extended for an additional period of time no longer than the original customary period for the medication.

AmeriHealth Caritas Next considers clinical review criteria and clinical practice guidelines that are developed and endorsed by a multidisciplinary panel of experts who manage conflicts of interest among the members of writing and review groups by doing all of the following:

- Requiring members to disclose any potential conflicts of interest with health coverage plans or pharmaceutical manufacturers and to recuse themselves from voting if they have a conflict of interest.
- Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus.
- Offering opportunities for public review and comments.
- Creating an explicit and transparent decision-making process.
- Basing decisions on high quality studies, research, peer-reviewed publications, and medical practice.
- Minimizing biases and conflicts of interest.
- Explaining the relationship between treatment options and outcomes.
- Rating the quality of the evidence supporting recommendations.
- Considering relevant patient subgroups and preferences.
- Considering the needs of atypical patient populations and diagnoses when establishing clinical review criteria.
- Recommending that the prescription drugs be taken in the specific sequence required by the step therapy protocol.

- Continuously reviewing new evidence, research, and newly developed treatments to update the clinical review criteria and clinical practice guidelines.

- If clinical practice guidelines are not reasonably available, any step therapy or fail first protocol established by a health coverage plan shall consider peer-reviewed publications or expert guidance from independent experts, which may include practitioners with expertise applicable to the relevant health 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. AmeriHealth Caritas Next will provide your prescribing practitioner with access to a clear and convenient process to expeditiously request an override of this step therapy restriction. An override of the restriction will be expeditiously granted by your health benefit plan if your prescribing practitioner, using sound clinical evidence, can demonstrate any of the following:

1. The preferred treatment required under the step therapy or fail first protocol has been ineffective in the treatment of the patient's disease or medical condition. The prescribing practitioner shall demonstrate to the health coverage plan that the patient has tried the required prescription drug while under his current or a previous health insurance or health coverage plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

2. The preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the patient and known characteristics of the drug regimen.

3. The preferred treatment required under the step therapy or fail first protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient.

4. The patient is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while

on his current health coverage plan or the immediately preceding health coverage plan, the patient received coverage for the prescription drug.

5. The required prescription drug is not in the best interest of the patient based on medical necessity as evidenced by valid documentation submitted by the prescriber.

6. The required prescription drug for postpartum depression under the step therapy or fail first protocol is not indicated by the United States Food and Drug Administration for postpartum depression on the prescription drug's approved labeling.

Once we receive your override request, AmeriHealth Caritas Next will review your request to determine if it meets the above criteria. We will communicate our decision within 72 hours of receipt of your override request. In cases where exigent circumstances exist, we will communicate our decision within 24 hours of receipt of your override request. If we fail to comply with these timelines, the override request will be considered approved. If approved, AmeriHealth Caritas Next will provide your prescribing provider with a clear authorization of coverage for the prescription drug prescribed by your prescribing provider, provided the drug is covered under your health benefit plan. A denial of an override request does not constitute a final adverse determination, and you will have the option to appeal. If your request is denied, AmeriHealth Caritas Next will provide you and your prescribing provider with the rationale for denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial. In addition, we will provide your prescribing provider with a list of the alternative comparable formulary medications in writing and attach it to the letter of denial of prescription drug coverage.

AmeriHealth Caritas Next will not use step therapy or fail first protocols as the basis to restrict any prescription benefit for the treatment of stage-four advanced metastatic cancer or associated conditions if at least one of the following criteria are met:

1.

A. The prescribed drug or drug regimen has the United States Food and Drug Administration approved indication.
B. The prescribed drug or drug regimen has the National Comprehensive Cancer Network Drugs and Biologics Compendium indication.

C. The prescribed drug or drug regimen is supported by peer-reviewed, evidenced-based medical literature.

2. The provisions of this section shall not apply if the preferred drug or drug regimen is considered clinically equivalent for therapy, contains the identical active ingredient or ingredients, and is proven to have the same efficacy. For purposes of this provision, different salts proven to have the same efficacy shall not be considered as different active ingredients.
3. For drugs prescribed for associated conditions as defined in this section, the treating healthcare provider shall inform the health coverage plan that the condition is a condition associated with stage-four advanced, metastatic cancer when requesting authorization.

Quantity limits (QL)

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

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

Age limits (AL)

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

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

Generic drugs

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

New-to-market drugs

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

Non-formulary drugs

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

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 non-formulary prescription drugs if the outpatient drug is prescribed by a network provider to treat a covered person for a covered chronic, disabling, or life-threatening illness if the drug:

- Has been approved by the 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; or
    - Substantially accepted peer-reviewed medical literature.

    and

- There are no formulary drugs that can be taken for the same condition. If there are formulary alternatives to treat the same condition, then documentation must be provided that the member has had a treatment failure with, or is unable to tolerate, two or more formulary alternative medications.

- Prescription drug samples, coupons, or other incentive programs will not be considered a trial and failure of a prescribed drug in place of trying the formulary-preferred or nonrestricted access prescription drug.

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

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

  You, your authorized representative, or your provider can visit our website to review the formulary and find covered drugs. You can access a searchable and a printable formulary on our website at:

  https://www.amerihealthcaritasnext.com/la/view-plans/searchable-drug-list/

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: 1-844-566-1661 for standard (nonurgent) requests 1-833-984-7329 for expedited (fast) requests (TTY 711)
- By mail:

  PO Box 516

  Essington, PA 19029
- By phone: 1-855-562-7287 (TTY 711)
- Hours of operation: Monday through Friday, 8 a.m. to 6 p.m. CT, excluding holidays

Members

- By phone: 1-866-334-3523 (TTY 711)
  Hours of operation: Monday through Friday, 8 a.m. to 6 p.m. CT, 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 for 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 1-833-282-2252 (TTY 711) if you need help with your appeal request. It is easy to ask us for an appeal by using one of the options below:

- Mail: Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 180 days after the date on this notice.
- Fax: Fill out, sign, and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax number listed on the form.
- By phone: Call 1-833-282-2252 (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 Review Organization (IRO).

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

Mail: Member Appeals
AmeriHealth Caritas Next
PO Box 7430
London, KY 40742- 7435

Phone: 1-833-282-2252 (TTY 711)

Fax: 1-833-873-2909

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

The Louisiana Department of Insurance is available to help insurance consumers with insurance related problems and questions. You may contact them at:

Louisiana Department of Insurance
Office of Consumer Advocacy & Diversity
Physical Address:
1702 N. Third Street
Baton Rouge, LA 70802

Mailing Address:

P. O. Box 94214
Baton Rouge, LA 70804-9214

Phone: 225-219-4775

Email: consumeradvocacy@ldi.la.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.

AmeriHealth Caritas Next will limit any required copayment or coinsurance applicable to specialty drugs to no more than one hundred and fifty dollars per

month for each drug up to a 30-day supply. This limit shall be applicable after

any deductible is reached and until the covered person's maximum out-of-pocket limit has been reached.

For Retail pharmacy, Mail-order pharmacy and Specialty pharmacy

You can use our pharmacy locator https://www.amerihealthcaritasnext.com/la/members/find-a-provider-or-pharmacy 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/la/members/find-a-provider-or-pharmacy or call us at 1-866-334-3523 (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/la/members/find-a-provider-or-pharmacy or call us at 1-866-334-3523 (TTY 711).

Renewal and continuation of coverage

If AmeriHealth Caritas Next proposes to change our coverage of a particular prescription drug or intravenous infusion, based on medical necessity we will give notice of the proposed change to a covered person currently using that prescription drug or intravenous infusion who we determine the change may affect if we have covered the drug or intravenous infusion for you within the preceding 60 days. Such notice will be sent 60 days prior to the effective date of the proposed change. Any covered person receiving such notice from us will have the right to appeal the proposed change during the 60-day notification period. In filing such an appeal, you will need to document that your physician or authorized prescriber considers continued use of the drug or intravenous infusion to be medically necessary. AmeriHealth Caritas Next shall offer to each covered person at the contracted benefit level and until your plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or medical illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. This provision does not prohibit your prescribing provider from prescribing a drug that is an alternative to a drug for which continuation of coverage is required by Louisiana law, if the alternative drug meets each of the following conditions:

1. The drug is covered under the health benefit plan.

2. The drug is medically appropriate for the covered person.

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. The 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.

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 loss program

AmeriHealth Caritas Next provides a weight loss program for members motivated to improve eating habits and lose weight. Our weight loss program is focused on members with a BMI of 30 kg/m2 or higher with associated chronic conditions including diabetes mellitus, hypertension and sleep apnea. Members can self-enroll or be referred by care management.

In accordance with the USPTF, AmeriHealth Caritas Next's weight loss program includes:

- Assessment by care management
- Telehealth visits with a registered dietician
- Referral to local resources for group weight loss support services,
- Behavioral management activities, such as weight-loss goals,
- Improving diet or nutrition and increasing physical activity,
- Addressing barriers to change,
- Self-monitoring, and
- Strategizing how to maintain lifestyle changes.

Exclusions and Limitations

Covered health services must be administered by a network provider unless you receive PA for out-of-network services with limited exceptions. For a benefit to be paid, the covered health service must be medically necessary for diagnosis or treatment of an illness or injury or be covered under the preventive health care services section of this policy.

This plan does not cover the following:

- Any care which extends beyond traditional medical management or medically necessary inpatient confinements for conditions such as learning disabilities, behavioral problems, or intellectual disabilities. Examples of care which extends beyond medical management include, but are not limited to, the following:
    - Educational services such as remedial education including tutorial services or academic skills training.
    - Neuropsychological testing including educational testing such as I.Q. tests, mental ability, and aptitude tests unless these tests are for an evaluation related to medical treatment.
    - Services to treat learning disabilities, behavioral problems, or intellectual disabilities.
- Any charges incurred due to failure to keep a scheduled appointment or charges for lack of completion of a claim form.
- Any covered health service, supply, or device that would otherwise be at no cost in the absence of coverage by this policy.
- Any experimental or investigational treatments or unproven services (except when bone marrow transplant procedures are recommended by a referring physician).
- Any items or services related to personal hygiene or convenience whether or not they are specifically recommended by a network provider or out-of-network provider, such as air conditions, humidifiers, physical fitness equipment, stair glides, elevators/lifts, or barrier free home modifications.

- Any medical and/or recreational use of cannabis or marijuana.
- Any prescription or over-the-counter drugs not on the formulary unless an exception is granted.
- Any prescription vitamins, except vitamins prescribed during pregnancy, and fluoride vitamins, or as indicated as covered in the formulary.
- Any prescription drugs that are a part of the standard fertility preservation services benefit.
- Any services that are 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.
- Bariatric surgery
- Care given by a family member or person living with you.
- Certain disorders, incontinence supplies, refractive laser eye surgery, and certain types of glasses and lenses.
- Dental services including but not limited to, routine preventive dental care, including cleaning and sealants unless otherwise covered by this **policy**.
- Diabetes prevention programs offered by out-of-network providers.
- Diagnosis and treatment of jaw joint problems 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
- Expenses, fees, taxes, or surcharges imposed by a provider or facility that are actually the responsibility of the provider or facility.

- Expenses for appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (for example, dynamic orthotic cranioplasty or molding helmets); except when the appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and expenses for devices necessary to exercise, train, or participate in sports.

- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this policy or for correction of a birth defect in a child. For inpatient admissions which are primarily for physical medicine or for diagnostic studies.

- For outpatient habilitative and rehabilitative services for which there is no reasonable expectation to keep, learn, or improve skills and functioning.

- For routine or periodic physical examinations, except as otherwise set forth in this document; the completion of forms or the preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as pre-marital examinations, physicals for employment, school, camp, travel, or sports, except as mandated by Louisiana 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 Louisiana state law.

- For treatment of sexual dysfunction not related to organic disease or injury.

- Gender affirming care for minors and sex-trait modification procedures for minors and adults. Sex-trait modification procedures are any pharmaceutical or surgical intervention intended to make an individual's physical appearance or body match their asserted gender identity, which differs from their sex assigned at birth.

- Home health - Services rendered by an adult congregate living facility, adult foster home, adult day care center, or a nursing facility.

- Incontinence supplies

- Infertility treatments except those listed under correctable infertility medical condition

- Prescription drugs and services to decrease weight loss including weight reduction programs.
- Refractive laser eye surgery such as laser-assisted in situ keratomileusis (LASIK)
- Reversal of a tubal ligation, a vasectomy, or any other method of sterilization
- Services provided by a naturopathic physician.

The following are not covered for at-home treatment or care under this policy's home health care benefit:

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

The following hospice benefits are not covered under your policy:

- Care not prescribed in the approved treatment plan.

- Financial, legal, or estate planning.
- Homemaker services such as housekeeping, food and meal preparation, and cooking.
- Private duty nursing.
- Respite care.

The following skilled nursing facility services are not covered under your policy:

- Convalescent care.
- Custodial care.
- Domiciliary care.
- Intermediate, rest, or homelike care.
- Long-term care admissions.
- Protective and supportive care.
- Treatment received outside the United States, except for a medical emergency while traveling in accordance with the emergency services section of this policy.

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

- Abortion, unless required by state law
- Any charges incurred due to failure to keep a scheduled appointment or charges for lack of completion of a claim form.
- Any examinations, tests, screenings, or any other services required by:
    - For employment or government-related diagnostic testing, laboratory procedures, screenings, or examinations;
    - A university, school, or college in order to enter school property or a particular location regardless of reason; or

- A governmental body for public surveillance purposes.

- Covered health benefits that are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay.

- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the member files a claim for said benefits or compensation.

- For any loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.

- For behavioral health and substance use disorder services related to:
  - Court-ordered services required for parole or probation.
  - Marital and relationship counseling.
  - Testing for aptitude or intelligence.
  - Testing for evaluation and diagnosis of learning abilities.

- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this policy or for correction of a birth defect in a child.

- For fetal reduction surgery.

- For 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 services related to surrogate parenting
- For standby availability of a medical provider when no treatment is rendered.
- For treatment of injuries sustained while participating in organized collegiate sports, professional or semiprofessional sports, or other recreational activities for which the subscriber and/or dependent is paid to participate.
- Services or supplies performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
- Services or supplies rendered by a provider who is a member of the member's immediate family.
- Services or supplies that are provided prior to the effective date or after the termination date of this policy, except as noted under the **Eligibility and Termination** section of this policy.

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 or appeal. You have the right to file a written grievance/complaint, file an appeal, and the right to an external review with respect to certain adverse 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 Member Services at 1-833-282-2252 (TTY 711), 8 a.m. – 6 p.m. CT, Monday through Friday excluding holidays.

The Louisiana Department of Insurance is available to help insurance consumers with insurance related problems and questions. You may contact them at:

Louisiana Department of Insurance,
Office of Consumer Advocacy & Diversity
Physical Address:
1702 N. Third Street,
Baton Rouge, LA 70802

Mailing Address:

P. O. Box 94214,
Baton Rouge, LA 70804-9214

Phone: 225-219-4775

Email: consumeradvocacy@ldi.la.gov

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. Grievance/complaint 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 can be provided to us at any time by you or your authorized representative by calling 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays or writing to Member Grievances, PO BOX 7435, London, KY 40742-7430.

Upon 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. We will provide you with this written notice within 30 calendar days from the date we received your grievance/complaint. These time limitations will be suspended if we notify you of the need for additional information to properly review your grievance/complaint and that the above-mentioned time frame will be extended by 14 days.

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, written in clear terms.
- A reference to any documentation used as a basis for the decision.

At any time, you can request free copies of all records and other information we have relevant to your written grievance/complaint, including the credentials of any health care professional we consulted.

To obtain copies, please call 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday 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, you can file a request for an expedited grievance/complaint with our Member Services department by phone 1-833-282-2252 (TTY 711) or in writing at PO BOX 7435, London, KY 40742-7435.

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 three business days. Expedited reviews will meet all requirements of non-expedited reviews as described in our grievance / complaint procedures and per state law.

Appeals

Standard appeals of an adverse benefit determination

You or your authorized representative, including your provider, can file an appeal of an adverse determination verbally by calling Member Services at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays or in writing at PO Box 7435, London, KY 40742-7435.

We must receive a signed authorized representative form 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, including their provider.

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

Once we have received your appeal, 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 Member Services at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday 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 30 calendar days for pre-service requests and 60 calendar days for post-service requests after receiving your appeal. If your appeal concerns continuation of a service that you are currently receiving, you can continue receiving the services being appealed either until the end of the approved treatment period or until the determination of the appeal.

You may be financially responsible for the continued services if the appeal is not approved. You can request continued services by calling Member Services at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday 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 department by phone at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays or by mailing to PO Box 7435 London, KY 40742-7435.

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 medical doctor, provide expedited review and communicate the decision verbally to covered members and their providers as soon as possible, but not later than 72 hours after receiving the request. We will communicate our decision in writing within three calendar days after verbal notification was provided. If the expedited review is a concurrent review

determination, we will remain liable for the coverage of health care services until the covered person has been notified of the determination. 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

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

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

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

If you have any questions or concerns regarding the independent external review process, please contact Member Services at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays.

The Louisiana Department of Insurance is available to help insurance consumers with insurance related problems and questions. You may contact them at:

Louisiana Department of Insurance
Office of Consumer Advocacy & Diversity

Physical Address:

1702 N. Third Street,
Baton Rouge, LA 70802

Mailing Address:

P. O. Box 94214,
Baton Rouge, LA 70804-9214

Phone: 225-219-4775

Email: consumeradvocacy@ldi.la.gov

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 appeal 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
    - This includes a request for coverage of a healthcare service which treatment is experimental or investigational and the covered person's treating physician certifies in writing that any delay in appealing the adverse determination may pose an imminent threat to the covered person's health, including but not limited to severe pain, potential loss of

life, limb, or major bodily function, or the immediate deterioration of the health of the covered person.

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 determination decision was issued;
- The service for which the adverse 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 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 determination (an adverse 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 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 or your

authorized representative can submit this request by faxing 1-833-873-2909 or writing to AmeriHealth Caritas Next, PO Box 7435 London, KY 40742-7435.

Expedited external review requests

An expedited external review of an adverse 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 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 of the date on your final determination notice. You can submit your request verbally by contacting Member Services at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays, by faxing at 1-833-873-2909, or writing to AmeriHealth Caritas Next, PO Box 7435 London, KY 40742-7435.

IRO external review eligibility determination

Within five business days of receipt of your request for a standard external review, and as immediately as reasonably possible for expedited external review requests, we will complete a review of your request to determine if you meet the following eligibility requirements for external review:

1. The covered person was covered through AmeriHealth Caritas Next at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

2. The health care service is the subject of an adverse determination or a final adverse determination.

3. The covered person has exhausted the health insurance issuer's internal claims and appeals process in accordance with state law.

4. The covered person has provided all the information and forms required to process an external review, including an authorization representative form if the request was filed on behalf of the member

Within the five business days allowed for the completion of the preliminary review, AmeriHealth Caritas Next will notify the Commissioner and the covered person or authorized representative of all of the following in writing:

a) The request is complete

b) The request is eligible for external review

If you do not meet the criteria for external review eligibility, we will notify you, your provider, or the authorized representative who submitted the request of our eligibility determination including the reasons for ineligibility. If a request is made for an expedited external review, we will make a determination of whether your request meets expedited requirements in consultation with a medical professional. If your request is not accepted for expedited review, we may either:

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

If you are dissatisfied with our decision, you may appeal the decision to the Louisiana's Commissioner of Insurance. To file an appeal of our decision you may contact:

Louisiana Department of Insurance
Office of Consumer Advocacy & Diversity

Physical Address:

1702 N. Third Street,
Baton Rouge, LA 70802

Mailing Address:

P. O. Box 94214,
Baton Rouge, LA 70804-9214

Phone: 225-219-4775

Email: consumeradvocacy@ldi.la.gov

IRO assignment

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

IRO review and decision

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

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

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

adverse determination decision for which you have already received an external review decision.

Claims and Reimbursement

Claims

AmeriHealth Caritas Next is not liable under this policy unless proper notice is furnished to you or someone acting on your behalf that covered health services have been rendered to a member. AmeriHealth Caritas Next will perform audits of provider bills to verify that services and supplies billed were furnished and that proper charges were made. Claims are paid at the usual and customary rates, or the rates AmeriHealth Caritas Next has negotiated with contracted network providers.

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.

Notice of claim

Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible, except in the cases of industrial policies such notice of claim must be given within ten days. The notice may be given to AmeriHealth Caritas Next at our home office or to 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. Send the completed form to AmeriHealth Caritas Next, PO Box 7411, London, KY 40742-7411.

Out-of-network provider claims

In order for out-of-network services to be covered, PA 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.

If you have a disability for which benefits may be payable for at least two years, at least once every six months after you have given notice of claim, you must give AmeriHealth Caritas Next notice that the disability has continued. You need not do this if you are legally incapacitated. The first six months after you file any proof or any payment or denial of a claim by AmeriHealth Caritas Next will not be counted in applying this provision. If you delay in giving this notice, your right to any benefits for the six months before the date which you give notice will not be impaired.

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 Next a written statement of the nature and extent of the loss within the time limits stated in the Proof 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.

Uniform claim forms

Notwithstanding any other law to the contrary, all claims will be processed in conformity with the uniform claim form issued by the Department of Insurance pursuant to state law.

Proof of loss

Written proof of loss must be given to AmeriHealth Caritas Next for which this policy provides any periodic payment that depends on continuing loss within 90 days after the end of each period for which 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 this time, AmeriHealth Caritas Next may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, 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

Indemnity claims payable under this policy for any loss other than loss of time on account of disability will be paid immediately upon receipt of written proof of such loss. Subject to written proof of loss, accrued indemnity claims for loss of time on account of disability will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately. 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 5 business days for electronic claims and 45 calendar days for nonelectronic claims of any deficiencies in the claim submitted and describe any remedy necessary to establish a clean 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 nonelectronic claims, if your **provider** does not submit your claim within 45 calendar days of your date of service, or date of discharge from a health care facility or institution, or resubmitted a claim because the original claim was not an accepted claim or not a clean claim, AmeriHealth Caritas Next will be pay or deny the claim within 60 days of receipt of the clean claim.

For covered, non-emergency services provided by an in-network provider, AmeriHealth Caritas Next will pay or deny a clean claim within 25 calendar days for electronic claims and within 45 calendar days for nonelectronic claims, 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**, emergency air and ground ambulance services, urgent care services, and non-participating provider services, within 25 calendar days for electronic claims and within 30 calendar days for nonelectronic claims, from the date 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.

Indemnity for loss of life and any other accrued indemnity claims unpaid at the insured's death will be paid to the beneficiary, if surviving the insured, and otherwise to the estate of the insured. All other indemnity claims will be paid to the insured. This policy, at the insurer's option, provides that if there is no beneficiary, or the beneficiary is the estate of the insured, or the insured or beneficiary is a minor or not competent to give a valid release, we may pay any amount not exceeding one thousand dollars, otherwise payable to the insured or his estate to any relative by blood or connection by marriage of the insured appearing to the insurer to which they may be equitably entitled, and may make payment of any amount not exceeding one thousand dollars, otherwise payable to the beneficiary to any relative by blood or connection by marriage of such beneficiary appearing to the insurer to which they may be equitably entitled. This policy, at the insurer's option, provides that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical, or surgical services may be paid directly to the hospital or person rendering such services; however, this policy does not require that the services be rendered by a particular hospital or person.

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 in writing.
- Choose providers within the limits of the provider network, including the right to refuse care from specific providers.
- Have confidential treatment of personally identifiable health or medical information. The member also has the right to have access to their medical record 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; immigration status; 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; HIV status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/or

expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.

- Formulate advance directives. The plan will provide information concerning advance directives to members and providers and will support members through our medical record-keeping policies.

- Obtain a current directory of network providers, on request. The directory includes; Name, Professional qualifications, specialty, medical school attended, residency completion board certification, addresses, phone numbers, and a listing of providers who speak languages other than English.

- File a complaint or appeal about the health plan or care provided with the applicable regulatory agency and receive an answer to those complaints within a reasonable period of time.

- Appeal a decision to deny or limit coverage through an independent organization. The member also has the right to know that their provider cannot be penalized for filing a complaint or appeal on the member's behalf.

- Members with chronic disabilities have the right to obtain 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 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 the endorsements and the attached papers, if any, and in case of industrial insurance, the written application, constitutes the entire contract of insurance. No producer has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed on or attached to the policy.

Cancellation by insured

If the insured shall at any time change their occupation to one classified by the AmeriHealth Caritas Next as less hazardous than that stated in the policy, AmeriHealth Caritas Next, upon written request of the insured, and at the insured's option, will either cancel the policy upon its surrender and refund the unearned premium or will reduce the premium rate accordingly and refund the excess pro rata unearned premium from the date of receipt of proof of such change of occupation.

Change of beneficiary

You can change the beneficiary at any time by giving AmeriHealth Caritas Next written notice. The beneficiary's consent is not required for this or any other change in the policy unless the designation of the beneficiary is irrevocable.

Conformity with state laws

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

Consent of beneficiary

Consent of the beneficiary is not required for the surrender or assignment of this policy, nor for change of beneficiary, nor for any other changes in this policy.

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.

Coverage for covered person detained in a correctional facility

We will provide coverage to covered persons who are detained in a correctional facility if they have not been adjudicated or convicted of a criminal offense. The provisions only applies if the detainee has valid health care coverage in effect at the time the medical treatment is received and any premiums for such coverage are current.

Extension of time limitations

If any limitation of this policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this policy is less than that permitted by law of the state, district, or territory in which the insured resides at the time this policy is issued, such limitation is extended to agree with the minimum period permitted by such law.

Illegal occupation

AmeriHealth Caritas Next is not liable for any loss which results from the insured committing or attempting to commit a felony or from the insured engaging in an illegal activity.

Legal actions

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Misstatement of age or sex

If the insured's age or sex has been misstated, the benefits will be those the premium paid would have purchased at the correct age or sex.

Modifications

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

Non-waiver

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

Nondiscrimination

AmeriHealth Caritas Louisiana, Inc. does not discriminate based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; immigration status; 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; 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.

Nonduplication of coverage

AmeriHealth Caritas Louisiana, Inc. will not duplicate benefits which are payable through any workers' compensation, occupational disease, employers' liability or similar law, or payable pursuant to the Louisiana Automobile Reparations Reform Act (motor vehicle no-fault plan or similar law), and any national, state, or other governmental plan not limited to civilian governmental employees or their families. Nonduplication may involve an interrelation, as related above and as appropriate to the coverage afforded, with other benefit programs including but not limited to individual or family insurance, group insurance, hospital service, medical service,

group practice, individual practice, and other prepayment plans, employee or employer benefit organizations, union or association welfare plans, Medicare, Louisiana Automobile Reparations Reform Act (motor vehicle no-fault plan or similar law), and similar benefit programs.

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.

Physical examinations and autopsy

AmeriHealth Caritas Next, at its own expense, has the right to have you examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

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 contact us at 1-833-282-2252 (TTY 711), 8 a.m. - 6 p.m. CT, Monday through Friday excluding holidays or visit our website at:

https://www.amerihealthcaritasnext.com/la/privacy-notice.

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, 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 securing 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.

Time limit on certain defenses

After three years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the three-year period.

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 two 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.

NOTICE: You can request a copy in either paper form or electronic form of Appendix C, which provides an explanation for secondary plans on the purpose and use of the benefit reserve and how secondary plans calculate claims.

How to contact us

Method	Member Services
Call	1-833-282-2252 Calls to this number are free. Hours of operation: 8 a.m. - 6 p.m. CT Monday to Friday, excluding holidays
TTY	711 Calls to this number are free.
Fax	1-844-329-2252
Write	Mailing address: PO Box 7438 London, KY 40742-7438
Website	https://www.amerihealthcaritasnext.com/la/index.asp

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Notice of Nondiscrimination

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; or sex, including sex characteristics, including intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). AmeriHealth Caritas Next does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. AmeriHealth Caritas Next provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. If you need these services, contact the Member Services number on the back of your card. If you believe that AmeriHealth Caritas Next has failed to provide these services or discriminated in another way, you can file a grievance with AmeriHealth Caritas Next, Attention: Grievances, P.O. Box 7430, London, KY 40742- 7430, fax: **1-844-329-2252,** or email **acaexchangegrievance@amerihealthcaritas.com.**

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

OTH-NDN(2027)-LA

We speak your language

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

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

Nou bay sèvis ak enfòmasyon gratis pou ede w nan lang pa w si se pa anglè ki lang prensipal ou. Pou pale avèk yon entèprèt, rele nimewo ekip sèvis pou manm yo ki nan do kat ou a.

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

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

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

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

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

Prestamos informações e serviços linguísticos gratuitos a pessoas cujo idioma principal não é o inglês. Para falar com um intérprete, ligue para o número de atendimento ao beneficiário indicado no verso do seu cartão.

ພວກເຮົາໃຫ້ບໍລິການພາສາຟຣີແລະຂໍ້ມູນຂ່າວສານສໍາລັບຜູ້ທີ່ພາສາຂອງທ່ານບໍ່ແມ່ນພາສາອັງກິດ. ເພື່ອໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາເບີບໍລິການສະມາຊິກຢູ່ດ້ານຫຼັງບັດຂອງທ່ານ.

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

ACLA-PY27-NDN-V1

We speak your language

ہم زبان کی خدمات اور معلومات ان لوگوں کو مفت فراہم کرتے ہیں جن کی بنیادی زبان انگریزی نہیں ہے۔ کسی مترجم سے بات کرنے کے لیے ممبر سروسز کے نمبر پر کال کریں جو آپ کے کارڈ کی پچھلی طرف درج ہے۔

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

ما برای افرادی که زبان اصلی‌شان انگلیسی نیست، خدمات زبانی و اطلاعات رایگان فراهم می‌کنیم. برای صحبت با مترجم، با شماره خدمات اعضا در پشت کارت خود تماس بگیرید.

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