2023 EVIDENCE OF COVERAGE

AmeriHealth Caritas Florida, Inc.

Individual Member Health Maintenance Organization (HMO) Policy

This is your contract with AmeriHealth Caritas Florida, Inc. Please read it carefully. The effective date of this policy is January 1st, 2023, unless a different effective date is confirmed during your application and enrollment process.

Important cancellation information: Please read the provision entitled "Eligibility and Termination" found on page 20 of this policy.

This policy contains a deductible provision.

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

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

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

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

Renewal

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

If you have any questions about this document, how to obtain alternate formats of this document, or how to use your health plan, please feel free to contact our Member Services team at 1-833-999-3567, 8 a.m. – 8 p.m., 5 days a week.

AmeriHealth Caritas Florida, Inc.

Loretta Lenko, President - Exchange

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Definitions of Important Words Used in This Document

- **Accidental injury —** Injury or injuries for which **benefits** are provided. These refer to **accidental** bodily injuries sustained by the insured person that are the direct cause independently of disease, bodily infirmity, or other cause of the loss and occur while the insurance is in force. Exceptions to this **policy** are:
  - Injuries for which **benefits** are provided under:
    - Any workers' compensation, employers' liability, or similar law;
    - Florida Automobile Reparations Reform Act (motor vehicle no-fault plan or similar law); or
    - Injuries occurring while the insured person is engaged for wage or profit in any activity pertaining to any trade, business, employment, or occupation.
- **Adverse benefit determination —** A coverage determination by the **health benefit plan** that:
  - An admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, does not meet the **health benefit plan's** requirements for **medical necessity**, appropriateness, health care setting, level of care, or effectiveness, or the prudent layperson standard for coverage of **emergency services** due to an **emergency medical condition** per Florida law, and coverage for the requested service is therefore denied, reduced, or ended;
  - The **health benefit plan** will not provide or make payment based on a determination of the member's eligibility to participate in a plan; or
  - Coverage has been rescinded (whether or not the rescission has an adverse effect on any particular benefit at that time).
- **Allowed amount** — The amount we pay a **provider** for a **covered health service** provided to a **member.** It is the lesser of the **provider's** charge or our maximum payment amount. If you need to pay a **coinsurance,** it is a percentage of the **allowed amount.**
- **AmeriHealth Caritas Next Telemedicine —** The preferred vendor who we have contracted with to provide **telemedicine services** to our **members**. Our preferred vendor contracts with **providers** to render **telemedicine services** to our **members**.
- **Appeal** —A disagreement with our **adverse benefit determination** to deny a request for coverage of **health care services** or prescription drugs, or payment for services or drugs you already received. You may also make an **appeal** if you disagree with our determination to stop services 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. These include, but are not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

- **Autism spectrum disorder (ASD)** — As defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM*) or the most recent edition of the *International Statistical Classification of Diseases and Related Health Problems (ICD).*
- **Behavioral health** — The diagnosis, evaluation, and treatment of a mental or behavioral disease, disorder, or condition listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, as revised, or any other diagnostic coding system. This applies whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin.
- **Benefit period** — One calendar year or one **plan year**, applied per the terms of the **member's** plan. However, when a **member** is initially enrolled, the **benefit period** will be the date of enrollment through the end of the then-current calendar year.
- **Benefits** — Your right to payment for **covered health services** available under this **policy**.
- **Bone marrow transplant (BMT)** — Human blood precursor cells given to a patient to restore normal hematological and immunological functions after ablative or nonablative therapy with curative or life-prolonging intent. Human blood precursor cells may be taken from the patient in an autologous transplant. They may also be taken from a medically acceptable related or unrelated donor. They may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "**bone marrow transplant**" includes both the transplantation and the chemotherapy.
- **Brand name drug** — A prescription drug that is made and sold by the pharmaceutical company that originally researched and developed the drug. **Brand name drugs** have the same active-ingredient formula as the generic version of the drug. However, **generic drugs** are made and sold by other drug manufacturers. These drugs are generally not available until after the patent on the **brand name drug** has expired.
- **Center of Excellence** – A **Center of Excellence** is a team, shared facility, or entity that provides leadership, best practices, research, support, and/or training for a focus area. AmeriHealth Caritas Next evaluates transplant programs throughout the U.S. AmeriHealth Caritas Next only includes transplant programs that meet our strict Centers of Excellence criteria in our **network**. We annually re-evaluate programs to ensure the **network** maintains its standards of care.
- **Clinical review criteria** – The written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an **insurer** to determine **medically necessary** services and supplies. They are based on sound clinical evidence that is periodically evaluated to ensure ongoing efficacy.

- **Coinsurance** — A percentage of the **allowed amount** you need to pay for **covered health services** and prescription drugs**.** A **copayment** is not a **coinsurance**. **Copayment** is defined elsewhere in this document.
- **Commissioner** — The Florida Insurance Commissioner, who leads the Florida Office of Insurance Regulation.
- **Complication of pregnancy** — Medical conditions whose diagnoses are separate from pregnancy. They may be caused or made more serious by pregnancy. They may also put the mother's life or health in jeopardy or make a live birth less viable. Examples include:
  - Abruption of placenta
  - Acute nephritis
  - **Emergency** cesarean section, if provided in the course of treatment for a **complication of pregnancy**
  - Kidney infection
  - Placenta previa
  - Poor fetal growth
  - Preeclampsia or eclampsia
- **Complaint** — Any expression of dissatisfaction by a **subscriber**, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to a state agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a grievance as defined by Florida state law.
- **Convalescent nursing home** or **extended care facility** — A **convalescent nursing home** or **extended care facility** (skilled nursing facility) operated pursuant to law. The facility is approved for payment of **Medicare** benefits or be qualified to receive such approval, if so requested. The facility primarily provides room and board accommodations and skilled nursing care under the supervision of a duly licensed **physician**. It provides continuous 24-hour nursing service by or under the supervision of a registered graduate professional **nurse** (RN). The facility maintains daily medical records for each patient.

  Convalescent nursing home or **extended care facility** does not mean any home or facility used:
  - Primarily for rest
  - For the care of the elderly or drug addicts or alcoholics
  - For the care and treatment of mental diseases or disorders

- For custodial or educational care

- **Copayment (or copay)** — A specific dollar amount you may need to pay as your share of the **allowed amount** for a **covered health service** or prescription drug you received. A **copayment** is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug. A **copayment** is a not a **coinsurance**. **Coinsurance** is defined elsewhere in this document.
- **Cost-sharing** — Amounts that a **covered person** must pay when services or drugs are received. **Cost-sharing** includes any combination of these types of payments:
  - Any **coinsurance** amount, a percentage of the total amount paid, for a service or drug that a health plan requires when a specific service or drug is received.
  - Any **deductible** amount a health plan may impose before services or drugs are covered.
  - Any fixed **copayment** amount that a health plan requires when a specific service or drug is received.
- **Covered health service** — **Health care services** that are payable under this **Evidence of Coverage**. They must be **medically necessary** and ordered or performed by a **provider** who is legally authorized or licensed and appropriately credentialed to order or perform the service. **Covered health services** include things such as a medical service or supply, doctor's visit, hospital visit, or prescription drug. For prescription drugs, **covered health services** mean drugs or supplies to treat medical conditions, such as disposable needles and syringes when dispensed with insulin.
- **Covered person, member,** or **you** – A policyholder, **subscriber**, enrollee, or other individual covered by this **health benefit plan**.
- **Deductible** — The amount you must pay for health care or prescriptions each year before your health plan begins to pay.
- **Dependent** — The **subscriber**'s spouse, domestic partner, or child who resides within the United States.
- **Dependent Child** — A natural-born child, an adopted child, or a child placed for adoption or **foster care** who is younger than 18 years of age on the date of the adoption or **placement for adoption** or **foster care**. The limiting age for **dependent child** coverage is 30 years of age unless the child has a mental, physical, or developmental disability.

  If your **dependent child** does not have a mental, physical, or developmental disability they must:
  - If under the age of 26
    - Be dependent upon the policyholder for support.
    - Reside in the policyholder's household or be a full-time or part-time student.

- If over age 26 up to age 30
  - Be unmarried.
  - Not have a **dependent child** of their own.
  - Be a Florida resident or a full-time or part-time student.
  - Not have coverage as a **subscriber**, insured, enrollee, or **covered person** under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to beenfits under Title XVIII of the Social Security Act.

- **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:
  - Walkers
  - Wheelchairs
  - Crutches
  - Powered mattress systems
  - Diabetes supplies
  - IV infusion pumps
  - Speech-generating devices
  - Oxygen equipment
  - Nebulizers
  - Hospital beds ordered by a **provider** for use in the home
- **Effective date** — The date a **member** becomes eligible under this **policy** for **covered health services**.
- **Emergency** or **emergency medical condition** – An **emergency medical condition** is when you, or any other prudent layperson with an average knowledge of health and medicine, reasonably believe you have acute symptoms of enough severity (including severe pain) such that the absence of immediate medical attention could mean:
  - Placing your health (or, for a pregnant person, the health of the person or their unborn child) in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

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

- **Emergency services** and **emergency care** – Medical screening, examination, and evaluation by a **physician**, or, to the extent allowed by applicable law, by other appropriate personnel under the supervision of a **physician**, to determine if an **emergency medical condition** exists. If it does, the appropriate personnel will also determine the needed care, treatment, or surgery for a covered service by a **physician** to relieve or remove the **emergency medical condition**. The determination includes consideration of available hospital services.
- **Evidence of Coverage (EOC) and coverage information** — This document, your enrollment form, and any other attachments, **Schedule of Benefits, riders**, or other optional coverage selected, that explain your coverage. It explains your rights, what we must do, and what you must do as a **member** of our health plan.
- **Experimental** or **Investigational** — Services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply that meets one or more of the following criteria as determined by AmeriHealth Caritas Next:
    - A drug or device that cannot be lawfully marketed without the approval of the U. S. Food and Drug Administration and has not been granted such approval on the date the service is provided.
    - The service is subject to oversight by an Institutional Review Board.
    - No reliable evidence demonstrates that the service is effective in clinical diagnosis, evaluation, management, or treatment of the condition.
    - The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.
    - Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

  Note: Reliable evidence includes but is not limited to reports and articles published in authoritative peer-reviewed medical and scientific literature and assessments and coverage recommendations published by AmeriHealth Caritas Next for Clinical Effectiveness.
- **Final internal adverse benefit determination (final determination)** – An **adverse benefit determination** that has been upheld by us and completes our internal **appeal** process.
- **Formulary** — A list of medications we cover. Products that are on the **formulary** generally cost less than products that are not on the **formulary**.
- **Foster care** — Continuing provision of the essentials of daily living on a 24-hour basis for children who are:
    - **Dependent**

- Neglected
- Abused
- Abandoned
- Destitute
- Orphaned
- Undisciplined
- Delinquent

Foster care may also be provided to other children who, due to similar problems of behavior or family conditions, are living apart from their parents, relatives, or guardians in a family foster home or residential child care facility. The essentials of daily living include, but are not limited to:

- Shelter
- Meals
- Clothing
- Education
- Recreation
- Individual attention and supervision

- **Foster child** — A minor for whom a guardian has been appointed by the Clerk of Superior Court of any county in the state. This can also be a minor for whom a court of competent jurisdiction has ordered a guardian the primary or sole custody.
- **Generic drug** — A recognized drug approved by the Food and Drug Administration (FDA) as having the same active ingredients as a **brand name drug**. Generally, a **generic drug** works the same as a **brand name drug** and costs less.
- **Grievance** — A written complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:
  (a) Availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
  (b) Claims payment, handling, or reimbursement for health care services; or
  (c) Matters pertaining to the contractual relationship between a subscriber and an organization.
  A grievance does not include a written complaint submitted by or on behalf of a subscriber eligible for a grievance and appeals procedure provided by an organization pursuant to contract with the Federal Government under Title XVIII of the Social Security Act.
- **Habilitative services** — **Health care services** that help you keep, learn, or improve skills and

functioning for daily living. These services may include physical and occupational therapy, speech and language therapy, and other services for people with disabilities in inpatient or outpatient settings.

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

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

  Health benefit plan does not include any of the following kinds of insurance:

  - Accident
  - Adult and **dependent** dental coverage
  - Adult vision coverage
  - Coverage issued as a supplement to liability insurance
  - Credit
  - Disability income
  - **Hospital** income or indemnity
  - Insurance under which **benefits** are payable with or without regard to fault and that is statutorily required to be contained in any liability **policy** or equivalent self-insurance
  - Long-term or nursing home care
  - Medical payments under automobile or homeowners
  - **Medicare** supplement
  - Specified disease
  - Workers' compensation
- **Health care provider** or **provider** — Any person who is licensed, registered, or certified under the laws of a state to provide **health care services** in the ordinary care of business, practice, or profession or in an approved education or training program. This can also mean a **pharmacy** or a health care facility as defined in the laws of Florida to operate as a health care facility.

- **Health care services** — Services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- **Home health aide** — A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or prescribed exercising). **Home health aides** do not have a nursing license or provide therapy.
- **Home health care** — **Health care services** provided to the **member** in the home for treatment of an illness or injury by an organization licensed and approved by the state to provide these services.
- **Hospice** — A program for **members** who have six months or less to live that addresses the physical, psychological, social, and spiritual needs of the **member** and their immediate family.
- **Hospital** — A facility licensed as a **hospital** and operated pursuant to law to provide for the care and treatment of sick and injured persons on a resident or inpatient basis. It includes facilities for diagnosis and surgery under the supervision of a staff of one or more duly licensed **physicians** and provide 24-hour nursing services by registered **nurses**. **Hospital** may be defined in relation to its status, facilities, and available services. It may also be defined to reflect its accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Hospital Association.

  Hospital does not mean:

  - Health resort
  - Spa
  - Infirmary at a school or camp
  - Any military or veteran's hospital, soldier's home, or any hospital contracted for or operated by a national government or agency for the treatment of **members** or ex-members of the armed forces
  - Convalescent home, convalescent, rest, or nursing facility
  - Facility for the elderly or those with drug or alcohol addictions
  - Facility primarily offering custodial, educational, or rehabilitory care
  - Facility primarily offering care for mental and nervous disorders
- **Inpatient rehabilitation facility** — A facility that provides inpatient rehabilitation health services, as authorized by law.
- **Insurer** — An entity that writes a **health benefit plan** and is any of the following:
  - An insurance company

- A service corporation
- A health maintenance organization
- A multiple employer welfare arrangement

- **Managed care plan —** A **health benefit plan** in which an **insurer** either requires a **covered person** to use or creates incentives, including financial incentives, for a **covered person** to use **providers** that are under contract with or managed, owned, or employed by the **insurer**.
- **Medical advice, diagnosis, care, or treatment —** Advice, diagnosis, care, or treatment recommended by, or received from, an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law. Medical care or condition means amounts paid for any of the following:
  - The diagnosis, cure, easing, or prevention of disease or to affect any structure or function of the body
  - Transportation primarily for and essential to medical care
  - Insurance covering medical care
- **Medically necessary** or **medical necessity —** The **covered health services** or supplies that are:
  - Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease. They are not experimental, investigational, or for cosmetic purposes, except as allowed under Florida law.
  - Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms
  - Within generally accepted standards of medical care in the community
  - Not only for the convenience of the insured, the insured's family, or the **provider**

  For **medically necessary** services, nothing in this subsection precludes an **insurer** from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.
- **Medicare** — The federal health insurance program for:
  - People who are 65 or older
  - Certain younger people with disabilities
  - People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)
- **Member** (**member** of our health plan, or "**health plan member**") — A person who is eligible to receive **covered health services** after their enrollment has been confirmed and any

necessary premiums have been paid. A **member** includes the **subscriber** and any **dependents**.

- **Mental** or **nervous disorder** — A mental or emotional disease or disorder of any kind. These include, but are not limited to, neurosis, psychoneurosis, psychopathy, and psychosis.
- **Network** or **in-network** — The doctors and other health care professionals, medical groups, **hospitals**, health care facilities, and **providers** who have agreed to provide **covered health services** to our **members**. They also have agreed to accept our payment and any cost-share the **member** pays as a full payment.
- **Network or in-network pharmacy** — A pharmacy that has an agreement with our **health benefit plan** to provide prescription drugs and other items to our **members**. They agree to accept our payment and any **member** cost-share as a full payment. In most cases, your prescriptions are covered only if they are filled at one of our **network pharmacies**.
- **Network/in-network provider** or **network/in-network facility** — **Providers** who have an agreement with our health plan to provide **covered health services** to our **members.** They have agreed to accept our payment and any **member** cost-share as a full payment. Our health plan pays **network providers** based on the agreements we have with them. **Network providers** may also be referred to as "**health plan providers**."
- **Nurse —** The term **nurse** is restricted to a type of **nurse**, such as:
  - Registered graduate professional **nurse** (RN)
  - Licensed practical **nurse** (LPN)
  - Licensed vocational **nurse** (LVN)

  The words **nurse**, trained **nurse,** or registered **nurse**, used generally, mean an individual who qualifies for these terms per applicable statutes or administrative rules of the licensing or registry board of Florida.
- **One period of confinement** — One or more separate or combined periods of confinement in a hospital for the same or related causes. Periods of confinement do not count as one if separated by an interval of more than six consecutive months between the end of one such period and the start of the next period. When two or more confinements for the same or related causes are separated by a six-month interval, the later confinement will be considered a new period of confinement. Any applicable benefit provisions will be restored.
- **Out-of-network pharmacy** — A pharmacy that does not have an agreement with our health plan to provide covered prescriptions and other items to our **members**. It has not agreed to accept our payment and any **member** cost-share as payment in full. Under this **Evidence of Coverage**, most drugs you get from **out-of-network pharmacies** are not covered by our health plan unless certain conditions apply.
- **Out-of-network provider** or **out-of-network facility** — A **provider** or facility that does not

have an agreement with us to coordinate or provide **covered health services** to **members** of our health plan. They have also not agreed to accept our payment and any **member** cost-share as a full payment. **Out-of-network providers** are not employed, owned, or operated by our health plan.

- **Out-of-pocket costs** — See the definition for **cost-sharing** above. A **member's cost-sharing** requirement to pay for a portion of services or drugs received or any **deductible** amount is also called the **member's** out-of-pocket cost requirement.
- **Out-of-pocket maximum** amount — The most you pay out-of-pocket during the **benefit period** for **in-network covered health services**. It includes **deductibles** and any **cost-sharing** amounts you have paid. Amounts you pay for your **premiums** do not count toward the **out-of-pocket maximum** amount.
- **Partial disability** — An individual with an inability to perform some part or all of the major, important, or essential duties of their employment or occupation. This can also refer to a percentage of time worked, a specified number of hours, or compensation.
- **Partial hospitalization** — Services received from a free-standing or hospital-based program that provides services at least 20 hours per week, and continuous treatment for at least three hours, but no more than 12 hours per 24 hours.
- **Participating provider** — A **provider** who has an agreement with an **insurer** or an **insurer's** contractor or subcontractor to provide **health care services** to **covered persons.** In return, the **provider** receives direct or indirect payment from the **insurer.** This payment does not include **coinsurances**, **copayments**, or **deductibles**. This **provider** also agrees to accept the payment and any **member cost-sharing** as a full payment.
- **Pharmacy coverage** — **Policy** that covers prescription drugs must offer medication synchronization at least once per **plan year**. This allows a **member** to align the refill dates for prescription drugs covered by the **policy**.
- **Physician** or **medical doctor** — A duly licensed **physician** who provides medical care and treatment when they are within the scope of the **providers**' licensed authority, pursuant toSection 627.419, Florida Statutes (F.S.). **Physicians** must be licensed under Chapters 458, 459, 460, and 461. The words **physician** or **medical doctor** also refer to dentists who perform surgical procedures when the words are used in any:
    - Health insurance **policy**
    - **Health care services** plan
    - Other contract providing for the payment of surgical procedures specified in the **policy** or contract or are performed in an accredited **hospital** in consultation with a licensed **physician** and are within the scope of a doctor's professional license
- **Placement for adoption** or **being placed for adoption** — The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has

been placed in anticipation of the child's adoption.

- **Plan year** — This is typically a calendar year. However, if your initial **effective date** is other than January 1, your initial **plan year** will be less than 12 months. It will then start on the **effective date** and run through December 31 of the same year.
- **Policy** — The document that describes the agreements between the **health benefit plan** and the **member**. Your **policy** includes this document, the **Schedule of Benefits**, your application, and any amendments or **riders**. Sometimes your **policy** is called a contract.
- **Premium** — The periodic payment to AmeriHealth Caritas Florida or a health care plan for health and/or prescription drug coverage.
- **Primary care provider** — The doctor or other **provider** you see first for most health problems. This provider can be a physician in family medicine, general medicine, internal medicine, or pediatric medicine; advanced practice nurse; certified nurse practitioner; or physician's assistant. They make sure you get the care you need for your best health. They may also talk with other **health care providers** about your care and refer you to them.
- **Prior authorization** — Approval in advance to get services or certain drugs that may or may not be on our **formulary**. Some **in-network** medical services are covered only if your **in-network provider** gets **prior authorization** from our health plan.
- **Prosthetics** and **orthotics** — Medical devices ordered by your **health care provider**. Covered items include, but are not limited to:
  - Arm, back, and neck braces
  - Artificial limbs
  - Artificial eyes
  - Prostheses following mastectomy
  - Devices to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy
- **Provider** — A general term we use for doctors, other health care professionals, **hospitals**, and health care facilities licensed or certified under the state law of Florida.
- **Quantity limits** — A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Drugs may be limited by the amount we cover per prescription or for a defined time frame.
- **Rehabilitation services** — These services include chiropractic, physical therapy, speech and language therapy, and occupational therapy. Services may be provided on an inpatient or outpatient basis and subject to limitations described in the **Schedule of Benefits**.
- **Rider** — An amendment to this **Evidence of Coverage** that may modify the covered **benefits**.

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

- **Second opinion** — A clinical evaluation by a **provider** other than the **provider** originally recommending a service. This is to assess the clinical necessity and appropriateness of the proposed service. See more information under **Member Rights and Responsibilities**.

- **Service area** — The geographic area approved by the Agency for Health Care Administration within which:

    - An **insurer** is authorized to offer a health insurance **policy.**
    - A health maintenance organization is authorized to provide or arrange for comprehensive **health care services.**

  Visit our website to see our coverage map of counties in our **service area**: www.amerihealthcaritasnext/fl. You may also contact our Member Services team at 1-833-999-3567, 8 a.m. – 8 p.m., 5 days a week, for additional information.

- **Sexual dysfunction** — Any of a group of sexual disorders that cause inhibition either of sexual desire or the psychophysiological changes that are usually part of sexual response. Included are female sexual arousal disorder, male erectile disorder, and hypoactive sexual desire disorder.

- **Sickness** — Illness or disease of an insured person that first manifests after the **effective date** of insurance and while the insurance is in force. This definition excludes **sickness** or disease for which benefits are provided under any workers' compensation, occupational disease, employers' liability, or similar law.

- **Skilled nursing facility (SNF) care** — Skilled nursing care and **rehabilitation services** provided continuously and daily in a **skilled nursing facility**. Examples of **SNF** care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

- **Special enrollment period** -— An opportunity to enroll in a health plan outside of the annual open enrollment period based on specific qualifying events, such as birth, adoption, divorce, or marriage.

- **Stabilize** — To provide medical care appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, per Health Care Financing Administration (HCFA) interpretative guidelines, policies, and regulations for responsibilities of **hospitals** in **emergency** cases. These are as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42

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

- **Step therapy** — A pharmacy management tool that requires you to first try another drug to treat your medical condition before we will cover the drug your **provider** may have initially prescribed.
- **Subscriber** — The **covered person** who is properly enrolled under this **policy** and on whose behalf this **policy** is issued. It does not include **dependents**.
- **Telemecidine services** — Includes evaluation, management, and consultation services for **behavioral health** and nonemergency medical issues with a **provider** via an interactive audio or video telecommunications system.
- **Total disability** — A term meaning that for the first 12 months of a disability, an individual is totally disabled from engaging in any employment or occupation for which the individual is or may become qualified by reason of education, training, or experience. During this period, the individual must not be engaged in any employment or occupation for wage or profit. The term **totally disabled** requires that the insured be receiving regular care and attendance by a **physician** or a **member** of the insured's family.
- **Urgent care services** — Services 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 you can't reach an **in-network provider**.
- **Utilization review** — A set of formal techniques to monitor the use or evaluate the clinical necessity, appropriateness, efficacy or efficiency of **health care services**, procedures, **providers**, or facilities. These techniques may include:
    - Ambulatory review — **Utilization review** of outpatient services.
    - Case management — A coordinated set of activities for individual patient management of serious, complicated, protracted, or other health conditions.
    - Certification — A determination by an **insurer** or its designated **Utilization Review Organization (URO)** that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the **insurer's** requirements for **medically necessary** services and supplies, appropriateness, health care setting, level of care, and effectiveness.
    - Concurrent review — **Utilization review** during a patient's **hospital** stay or treatment.
    - Discharge planning — The formal process for determining, before discharge from a **provider** facility, the coordination and management of the care that a patient receives after discharge from a **provider** facility.
    - Prospective review — **Utilization review** before an admission or a course of treatment

including any required preauthorization or precertification.

- Retrospective review — **Utilization review** of **medically necessary** services and supplies after services have been provided to a patient. It includes the review of claims for **emergency services** to determine whether the prudent layperson standard has been met per Florida law.
    - Retrospective review does not include a review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

- **Utilization review organization (URO) —** An entity that conducts **utilization review** under a **managed care plan,** but not man **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:

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

Eligible dependents

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

- Your spouse or domestic partner, as recognized under the applicable marriage or civil union laws of Florida, who resides within the **service area**
- Your natural-born child or a legally adopted child
- Stepchildren
- Children awarded coverage pursuant to an administrative or court order
- Foster children
- A newborn child of a covered family **member** who is not the insured's spouse. Coverage for the newborn child will terminate 18 months after the newborn's birth.

The limiting age for **dependent child** coverage is 30 years of age. 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 30 if all of the following are true:

- The child is and remains incapable of self-sustaining employment by reason of intellectual disability or physical handicap.
- The child depends on you for most or all of their support.

For the child to stay eligible, you must provide our health plan and the Federal Health Insurance Exchange written proof that the child is mentally, physically, or developmentally disabled, depends on you for most of their support, and is incapable of earning a living. You have 31 days from the date the child reaches age 30 to do this. We may periodically ask you to confirm that your child's condition has not changed. We will not ask for this confirmation more than one time a year.

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

When coverage begins

If you are newly enrolled in our health plan and have paid your first month's **premium**, your

coverage will begin on the date listed as the **effective date** on your member ID card. No health services received before the **effective date** are covered.

If you were previously a **member** of the health plan in the past 12 months, your **premium** payments must be up to date for the past **plan year** before we can renew this **policy**. If there is any balance due for the prior **plan year**, any payment you make toward a new or renewing **policy** will be applied to that outstanding balance before it is applied to the new **policy premium**. You must make the first month's **premium** payment for coverage to begin.

Enrollment periods

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

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

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

Enrolling dependents

Dependents who experience a qualifying event as defined by state and federal law can be enrolled into our health plan outside of the open enrollment period during a **special enrollment period**. A **dependent** who becomes aware of a qualifying event may enroll during the 60 calendar days before or after the **effective date** of the event, but coverage will not begin earlier than the day of the qualifying event. If a **dependent** is not enrolled when they first become eligible, the **dependent** must wait until the next open enrollment period to enroll unless they enroll under the **special enrollment period**. This requirement is waived when a parent is required to enroll a child due to an administrative or a court order. Eligibility for your **dependent child** will last until the end of the calendar year that the child turns 30.

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

A newborn **dependent child** of the **subscriber** is automatically covered for the first 30 days of life

from the moment of birth. Coverage includes services due to injury or sickness, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, and routine care furnished any infant from the moment of birth. Coverage for the newborn dependent child beyond the 31st day will require an additional **premium**. If you want to continue enrollment of the newborn beyond the 31st day, you must notify us or the marketplace to enroll your newborn within 60 days from the date of birth. In addition, you will be required to pay any additional premiums within 90 days from the date of birth. If you do not provide enrollment notification and premiums timely, your newborn child's coverage will end on the 31st day from the date of birth. If the newborn is born to a covered family **member** who is not the insured's spouse, coverage for the newborn child ends 18 months after the newborn's birth. If the **dependent** is a newly adopted child or **foster child**, the **effective date** of coverage is the date of the adoption or the moment of **placement for adoption**, or the moment of placement for **foster care**. In the case of a newborn adopted child, coverage shall begin from the moment of birth. An eligible adopted child must be enrolled within 60 days from the legal date of the adoption. A **foster child** must be enrolled within 60 days from the date of placement in the foster home. If the **premium** changes because of adding the **foster child** or adopted child to your coverage, then you will need to pay the full **premium** amount within 90 days of the legal adoption date or placement of the **foster child**.

Changes in eligibility

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

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

We will extend coverage for a child enrolled in a postsecondary educational institution during a **medically necessary** leave of absence. If there are changes to your marital status, on the entry of a valid decree of divorce between the **subscriber** and the insured spouse, the divorced spouse is entitled to have issued to them an individual **policy** of accident and health insurance. This can be issued without evidence of insurability, on application made to the **insurer** within 60 days following the entry of the decree, and on payment of the appropriate **premium**.

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**. Your **end of coverage** will also end coverage for any **dependents** who may be enrolled in our health plan with you under this **policy**. If your coverage ends, we will send you written notice 45 days before ending your coverage. If your **policy** ends as a result of an age limit and a **premium** is accepted and the date the coverage would end falls within the period for which the premium is accepted, your coverage will continue until the end of the period for which the premium was paid.

Reasons for ending coverage may include any of the following:

- You give us written notice asking us to cancel this **policy** for you and/or your **dependents**. If you have already paid any **premiums** in advance for any months after the date of termination, we will refund or credit that amount within 30 days of the request for termination. For retroactive terminations, we will not refund or credit any **premium** when claims have been submitted for dates of service after the requested date of termination.
- Loss of eligibility if you are no longer living in the **service area** served by our plan.
- Loss of eligibility for you or your **dependents** due to becoming eligible for **Medicare** at age 65 or as a result of a disability before the age of 65.
- For an enrolled **dependent child**, the end of the calendar year in which they turn 30, unless the child has a mental, physical, or developmental disability.
- For non-dependents covered under a child-only **policy**, the end of the calendar year in which they turn 21.
- The death of the **subscriber**, although **dependents** may continue coverage under a new **policy**.
- Loss of eligibility of an enrolled spouse **dependent** due to legal separation or termination of marriage by divorce or annulment or similar actions.
    - Loss of eligibility begins on the date a final decree of divorce, annulment or dissolution of marriage is entered between the **dependent** spouse and **subscriber** or the date a termination of domestic partnership between the **subscriber** and domestic partner is entered.
- If **premiums** are not paid when they are due. In this case we will give you 15 days' advance written notice of pending termination before ending coverage.
- Discontinuation of this plan. In this case we will give you 90 days' advance written notice before ending coverage and will provide you with the option to purchase a different health insurance plan offered by AmeriHealth Caritas Next in the individual market. In exercising the option to discontinue coverage of this type and in offering the option of coverage described, AmeriHealth Caritas Next will act uniformly without regard to any health status-related factor of its enrolled individuals or individuals who may become eligible for

coverage.

- Discontinuation of all of our plans in the Florida Exchange. In this case we will give you 180 days' advance written notice before ending coverage.
- You have committed an act of fraud, including improper use of your member ID card or made an intentional misrepresentation of material fact under the terms of coverage.
- We may end your **policy** if your or your **dependents'** behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that continuing your membership with us seriously impairs our ability to furnish services to you or your **dependents**. Before termination we will make a reasonable effort to resolve the problem with you or your **dependents**. This will include the use of our **grievance** procedures, described elsewhere in this document. We will consider extenuating circumstances and will ascertain, to the extent possible, that the behavior is not related to the use of medical services or mental illness. We will document the problems, efforts, and any medical conditions.

Extension of benefits

The termination of this **policy** by AmeriHealth Caritas Next will be without prejudice to any continuous loss that began while your **policy** was in force. If your **policy** is ended for any of the above reasons, AmeriHealth Caritas Next will not provide you with coverage after the termination date of your **policy**. The provisions described below allow for an extension of limited benefits after your **policy** has ended.

- If you or any of your **dependents** become pregnant while you are covered under this **policy** before the termination date, AmeriHealth Caritas Next will provide the **covered person** an extension of limited coverage for pregnancy services listed in this **policy** after the termination date. This extension of coverage will end the day the child is born.
- If you or any of your **dependents** are determined to be totally disabled as a result of an accident or illness while you are covered under this **policy** and before your termination date, AmeriHealth Caritas Next will provide an extension of benefits for the disabled individual only. This extension of benefits is limited to **covered health services** that are determined to be **medically necessary** by your **network provider** to treat the disabling condition. This extension of benefits will terminate at the end of a 12-month period beginning on the termination date of your **policy**. See the definition of **total disability** of this **policy** for further information on requirements to be deemed **totally disabled**.
- If you or your **dependents** are receiving covered dental services while you are covered under this **policy** before the termination date, AmeriHealth Caritas Next will provide a limited extension of benefit for covered dental treatment for 90 days following the date of termination. This limited extension of benefits ends when you or your **dependents** become covered under another insurance **policy**. The extension ends regardless of the time frame elapsed from the termination date. To receive this limited extension of **benefits,** your or

your **dependents'** treatment and dental procedures must be recommended in writing by a **network provider**. Services are subject to all provisions within this **policy**. We will not provide coverage for routine examinations, prophylaxis, X-rays, sealants, or orthodontic services.

Conversion on ending of eligibility expense incurred

If a covered person ceases to be covered due to no longer being eligible (and before becoming eligible for **Medicare** or Medicaid), they are entitled to have issued, without evidence of insurability, a **policy**. They are entitled to this **policy** once they apply and if they pay their **premium** within 31 days. The coverage will be equal to or, at the option of the insured, less than the amount of insurance that ended due to termination.

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 Florida 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 15 days after the next **premium** due date (three months for those receiving a federal **premium** subsidy Advance Premium Tax Credit) to pay your next **premium**. Coverage will remain in force during the grace period. If we do not receive full payment of your **premium** within the grace period, your coverage will end as of the last day of the last month for which a **premium** has been paid. We will notify the **subscriber** of the nonpayment of **premium** and pending termination. We will also notify the **subscriber** of the termination if the **premium** has not been received within the grace period.

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

Reinstatement of coverage

If the renewal premium is not paid before the grace period ends, the **policy** will lapse. Late acceptance of the premium by AmeriHealth Caritas Next, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this **policy**. If AmeriHealth Caritas Next or its agent needs an application, you 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 AmeriHealth Caritas Next has previously written the insured of its disapproval. The reinstated **policy** will cover only loss that results from an 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 AmeriHealth Caritas Next and the **insurer** will remain the same. These rights are subject to any provisions noted on or attached to the reinstated **policy**. Any premiums AmeriHealth Caritas Next 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** coverage ends under this **policy** or you exhaust continuation of coverage. Please keep this **certificate of creditable coverage** in a safe place. You can also request a **certificate of creditable coverage** while you are still covered under this **policy** and for up to 24 months after the end of your coverage. To do so, call Member Services at the number listed on your member ID card.

How To Use Your Health Plan

Your **health benefit plan** operates as health maintenance organization (HMO), and **emergency** inpatient, outpatient, and **physician** services shall be available to you 24 hours a day, seven days a week. These services will be available either through our own **network** facilities or through arrangements with other **providers.** Our plan uses **network providers** to provide **covered health services** to you. This means we will not pay for services you might receive from **out-of-network providers** unless one of the following applies:

- You have an **emergency medical condition**.
- We authorize services from an **out-of-network provider** because the **medically necessary** services you need are not available from a **network provider**.

If we authorize **out-of-network** services your cost share responsibility will be at your **in-network** cost share unless otherwise stated in your **Schedule of Benefits**. You can find a **network provider** online through our **provider** directory at https://amerihealthcaritasnext.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACNEXT_I&brandCode=ACNEXT&alphaPrefix=&bcbsaProductId=&productCode=FLEXv. You can also call our Member Services number on your member ID card or provided at the end of this document in **How To Contact Us**. **Network providers** are not employees 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, ophthalmologist, podiatrist, dermatologist, licensed clinical social worker, certified substance abuse counselor, dentist, chiropractor, psychologist, pharmacist, advanced practice **nurse**, registered **nurse** anesthetist, or **physician** assistant, these services are included in your **benefits** and eligible for reimbursement. You can see any **in-network** specialist you choose without a referral, including covered services with a chiropractor, podiatrist, or dermatologist.

You can see any **in-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**, **copayments**, and **coinsurance** as outlined in your **Schedule of Benefits**. You will also be required to pay for any non-covered health services. **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 emergency medical condition or we authorize services from **an out-of-network provider** because the medically necessary services you need are not available from a

network provider. If we authorize **out-of-network** services your cost share responsibility will be at your **in-network** cost share.

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.

Choosing a primary care provider (PCP)

Once you enroll, you and any covered **dependents** in this plan must choose a **PCP**. If you do not select one, we will pick one for you. You can also change your **PCP** if the **PCP** is no longer a **network provider**. Your **PCP** will oversee your care and coordinate services from other **network providers** when needed. In certain instances, if you have been diagnosed with a serious or chronic degenerative, disabling, or life-threatening condition or disease, you may select a specialist, such as an OB/GYN or doctor of osteopathy, to serve as your **PCP,** subject to our health plan's approval. Female members are able to 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 an **in-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, whichever is of shorter duration. If the **member** is pregnant and in their second or third trimester, **pregnancy**-related services will be covered through 60 calendar days postpartum.

If an **in-network provider** stops participating in our **network** they become an **out-of-network provider**. If you are in active treatment for a serious condition or illness when this occurs, you may continue receiving care from that **out-of-network provider** until treatment for the condition is completed or you change **providers** to a **network provider**, whichever comes first. We will notify you when your **in-network provider** becomes an **out-of-network provider**. The out-of-network provider who is treating you is prohibited from billing you more than your in-network cost-share for up to 90 days after you are notified.

For these services to be covered, you must obtain **prior authorization** from the **health benefit plan**. Pregnant **members** in their second or third trimester of **pregnancy** and who have started prenatal care with a **provider** who stops participating in our **network** can continue receiving prenatal care through the date of the birth of the baby and 60 days of postpartum care. This continuity of care allowance does not apply to **providers** who have been terminated for cause as **network providers** by the plan.

If you are determined to be terminally ill when your **provider** stops participating in our **network**, or at the time you enroll in our plan, and your **provider** was treating your terminal illness before the date of the **provider's** termination or your new enrollment in our plan, you can continue to receive care from that **provider**. However, this is only true for services that directly relate to the treatment of your illness or its medical manifestations.

Medical necessity

Covered **benefits** and services under our plan must be **medically necessary**. We use clinical criteria, scientific evidence, professional practice standards, and expert opinion in making decisions about **medical necessity**. The cost of services and supplies that 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 **prior authorization** is denied and the **provider** still provides you with these services, the **provider** cannot bill you for these denied services unless you agreed 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 **prior authorization** has been received before receiving services. If you do not, the service may not be covered under this plan. **Prior authorization** can be retracted after **emergency services** are provided if you or your **provider** materially misrepresented your condition. Coverage will also depend on any limitations or exclusions for this plan, payment of **premium**, eligibility at the time of service, and any **deductible** or **cost-sharing** amounts. If you do not obtain **prior authorization** 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 **prior authorization** requirements.

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

Physical health services requiring prior authorization

- All **out-of-network** services excluding **emergency services**
- All services that may be considered experimental and/or investigational

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

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

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

Physical health services that do not require prior authorization

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

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

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

Behavioral health services requiring prior authorization

- All **out-of-network** services except **emergency care**
- Ambulatory detoxification
- Electroconvulsive therapy (ECT)
- Mobile crisis management
- Nonhospital medical detoxification
- Intensive outpatient treatment for opioid substance use treatment

- **Partial hospitalization**
- Professional treatment services in facility-based crisis programs (following the initial seven days/112 units)
- Psychiatric inpatient hospitalization
- Psychological testing

Behavioral health services that do not require prior authorization

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

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 **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 1-833-983-3577 Utilization Management clinical staff are available on call after normal business hours, weekends, and holidays by calling 1-833-435-8600. A toll-free fax line is available to receive

inbound communications from **providers** 24 hours a day, seven days a week, at 1-833-329-3577. 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 make review decisions after all of the necessary information about the requested service has been received. Within the following time frames, we will communicate our review determination, whether adverse or not, to 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.
- Urgent care prospective requests are decided and communicated as soon as possible, taking into account medical needs, but will not exceed 72 hours from the date of receipt.
    - A prospective request is considered urgent if it is determined that a delay in the decision could reasonably appear to seriously jeopardize the life or health of the **member** or jeopardize the **member's** ability to regain maximum function; or, in the opinion of a **physician** with knowledge of the **member's** medical condition, would subject the **member** to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- Nonurgent care prospective requests are decided and communicated within 15 calendar days from the date of receipt.
- Retrospective requests are decided and communicated within 30 calendar days from the date of receipt.

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

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

- 48 hours for urgent care prospective requests

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

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

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

  In making a decision, we will take any urgent medical needs into account. As long we receive the request at least 24 hours before the expiration of the prescribed period of time or number of treatments, we will notify the **member** of the benefit determination within 24 hours of receiving the request for concurrent requests and within 72 hours for prospective requests. This is true whether the benefit determination is adverse or not. Notification of any **adverse benefit determination** for a request to extend the course of treatment shall be made in accordance with this plan.

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

To obtain **prior authorization** or verify requirements for inpatient or outpatient services, including which other types of facility admissions need **prior authorization**, you or your **provider** can call us

at 1-833-999-3567.

Cost-sharing requirements

In addition to the monthly **premium**, the amount you will have to pay for **covered health services** may include a **deductible**, **coinsurance**, and **copayments**. Our contract with **network providers** for **covered 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**.

- A **copayment** or **copay** is your share of the cost for **covered health services** or prescription drugs that you pay as a set dollar amount.
- **Coinsurance** is your share of the cost for **covered health services** or prescription drugs that you pay, usually shown as a percentage of the **allowed amount** for a **covered health service**.
- The **out-of-pocket maximum** amount is the most you will pay out of pocket during the year for **covered health services**. This does not include any amounts you pay for **premiums**.
- Your **deductible** is the amount you will have to pay each year for **covered health services** before the health plan begins to pay. Any **coinsurance** or **copayment** amounts will not apply to your **deductible** but will count toward your **out-of-pocket maximum** amount.

Covered Health Services

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

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

The **Schedule of Benefits** and other **policy** documents are available on request by contacting our Member Services team at 1-833-999-3567, 8 a.m. – 8 p.m., 5 days a week. You may also access **policy** documents online at www.amerihealthcaritasnext.com/fl.

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

Abortion services

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

Accident-related dental services

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

Allergy testing and treatment

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

Ambulance services

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

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

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

or facility

- To a more cost-effective acute care facility
- Cost of transporting a newborn to and from the nearest available facility that is appropriately staffed and equipped to treat the newborn's condition, when the transportation is certified by the attending **physician** as necessary to protect the newborn's health and safety. Coverage for transportation may not exceed the usual and customary charges, up to $1,000.

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

Autism spectrum disorders (ASDs)

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

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

Biofeedback

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

Bone mass measurement services

We will cover services for bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last bone mass measurement was performed. We may provide coverage for follow-up bone mass measurement more frequently than every 23 months if **medically necessary**. Bone mass measurement services

will only be covered for individuals meeting certain clinical criteria, if for a primary diagnosis other than prevention or wellness. They will need **prior authorization**.

Chemotherapy services

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

Chiropractic Care

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

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

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

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

Complications of pregnancy

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

Child health supervision services

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

- Periodic examinations which include a history, a physical examination, a developmental

assessment, and anticipatory guidance

- Appropriate immunizations
- Laboratory tests

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

Congenital cleft lip and palate care and treatment

We will cover, for covered persons younger than 18 years of age, **medically necessary** care and treatment including, but not limited to:

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

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

Dental services

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

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

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

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

Diabetes services and supplies

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

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

Diagnostic services — outpatient

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

Dialysis services — outpatient

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

Durable medical equipment (DME) and devices

We cover **medically necessary DME** ordered or provided by a **physician**. **DME** may require a **prior authorization**, and we reserve the right to approve rental instead of purchase of the **DME**. Examples of **DME** include, but are not limited to, crutches, orthotics (including for positional plagiocephaly), prosthetics, and wheelchairs. We will provide coverage for prescription and nonprescription enteral formulas for home use when prescribed by a **network provider** for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the

neonatal period. Care for inherited diseases of amino acids and organic acids is covered for a **covered person** up to age 25 and shall include food products modified to be low protein.

Emergency services

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

Family planning services

Family planning services covered under this plan include counseling and education about family planning; injectable contraceptive medication administered by a **physician**; intrauterine devices, including insertion and removal; and surgical sterilization (vasectomy, tubal ligation). 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 the abortion is necessary to save the life or health of the member, or as a result of incest or rape
- Fetal reduction surgery
- Reversal of sterilization or vasectomies
- Services related to surrogate parenting

Habilitative services

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

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

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

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

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

Healthy rewards program

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

Home health care

We will cover certain services received in the home from a certified/licensed home health agency when ordered by a **physician**. Examples of these services include skilled care, physical/ occupational/speech and language/respiratory therapy, social work services, and home infusion. Services must only be provided on a part-time, intermittent basis and cannot be solely for helping with activities of daily living. Part-time home health care services days are limited to less than eight hours per day and cannot exceed 40 hours per week. For intermittent home health care services, days are limited to two hours per visit, per day. Please refer to your **Schedule of Benefits** for more information on your home health care benefit and limitations that may apply.

Hospice care

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

Hospital services

This plan covers inpatient **hospital services** and **physician** and surgical services for the treatment

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

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

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

Mastectomy and breast cancer reconstruction

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

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

Inpatient discharge decisions following mastectomy procedures will be made by the attending **physician** in consultation with the patient. Length of post-mastectomy inpatient stays are based on the unique characteristics of each patient, taking into consideration their health and medical history. 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 call the Member Services number on the back of your AmeriHealth Caritas Next member ID card.

Mental health and substance use services

Inpatient **behavioral health** services and substance use services are covered when received in an inpatient or intermediate care setting. Care may be provided in a general or psychiatric **hospital**, a residential treatment center, or an alternate facility. Substance use services include

detoxification and related medical services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation.

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

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

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

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

AmeriHealth Caritas Next complies with the federal 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.

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

Osteoporosis services

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

Other practitioners/provider office visits

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

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

We will cover facility charges for **covered health services** delivered in an outpatient setting for treatment of an illness or injury, including, when applicable, surgical services and associated

services and supplies for this care, including anesthesia, subject to **prior authorization**. Covered services performed in an ambulatory surgery center will be covered if such service would have been covered under the **policy** as an eligible inpatient service.

Outpatient surgery physician/surgical services

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

Pediatric vision services

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

Physician services for sickness and injury

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

Pregnancy services

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

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

Prescription drugs

We use a **pharmacy benefits** management (PBM) organization to help manage your prescription

drug benefit, including specialty medications. You will need to fill your prescription medications from a **network pharmacy** to for it to be covered under your prescription drug benefit. Prescriptions can be filled at either a retail **network pharmacy** or through our mail-order **network pharmacy**. As with obtaining any service under our plan, you will need to show your member ID card when you fill or obtain your prescription medications.

The list of prescription drugs covered under this plan is also called a **formulary**. The **formulary** covers both brand (preferred and non-preferred) and generic medications and will determine what your **out-of-pocket costs** will be for medications under our plan. The **formulary** is occasionally subject to change, but we will provide written notice to you before any changes take effect and will work with you and your prescriber to switch to another covered medication if you are on a long-term prescription. The **formulary** listing is available on request by contacting Member Services at 1-833-999-3567, 8 a.m. – 8 p.m., 5 days a week. A searchable **formulary** is available at https://www.amerihealthcaritasnext.com/fl/view-plans/searchable-drug-list.aspxlist.aspx. You can enter a medication name to see if it is covered on the **formulary**, what drug benefit tier it is on, and if there are any limitations such as **Prior Authorization**, **Step Therapy**, **Quantity Limits** or Age Limits. There is also a printable **formulary** document at www.amerihealthcaritas.com/fl. It shows all of the medications on the **formulary**, their drug benefit tiers and any limitations.

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

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

Your pharmacy **formulary** is a closed **formulary**. This means products not listed on the **formulary**

are treated as non-formulary and will not be covered by your **health benefit plan**. It is possible that there is a prescription drug you are currently taking, or one that you and your prescribing **provider** think you should be taking, that is not on the **formulary** list. Drugs not on the **formulary,** including drugs that have not been reviewed for inclusion in the **formulary**, can still be requested. Our PBM's coverage determination and **prior authorization** process allows the opportunity for non-formulary exceptions.

To make a request for coverage of a non-formulary drug, you, your authorized representative, or prescribing **provider** may call us at 1-833-982-7977. Or you may fill out the online submission form at https://ppa.performrx.com/PublicUser/OnlineForm/OnlineFDBSingleForm.aspx?cucu_id=Y65L6nti7Fh2jJt8A7Rsjw%3d%3d. Requests can also be sent via fax to 1-833-479-3329 or by mail to PerformRx/AmeriHealth Caritas Next PO Box 516 Essignton, PA 19029. If submitting a request by mail or by fax we recommend you view the online submission form or contact us by phone to ensure all applicable and necessary information is included in your request.

Once the request is received, our PBM will review the request for **medical necessity** and appropriateness. For a standard exception review, we will make our decision no later than 72 hours of the date we received the request and any additional required information. You can request an expedited (fast) exception if you, your authorized representative, or prescribing **provider** believe that your health could be seriously harmed by waiting up to 72 hours for a decision. You can indicate your urgent circumstance on your request by asking for an expedited review. We will give you a decision on expedited requests no later than 24 hours after we receive the request and any additional required information.

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

Preventive health care

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

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

- Abdominal aortic aneurysm screening for men ages 65 – 75 who have ever

smoked.

- Annual mammogram, Pap test, colonoscopy, and colorectal cancer screenings.
- Cervical cancer screening — examination and laboratory tests for early detection and screening including annual Pap smear, liquid-based cytology, and human papillomavirus detection; this will follow the American Cancer Society guidelines.
- Colorectal cancer screening — annual examinations and laboratory tests for colorectal cancer are covered for any **member** who is age 50 or older, or is younger than age 50 but is at high risk for colorectal cancer.
- Mammograms — We cover the following mammogram services per **benefit period**.
    - Baseline mammogram for any woman who is 35 or older, but younger than 40.
    - Mammogram every two years for any woman who is 40 or older, but younger than 50, or more frequently based on the patient's **physician's** recommendation.
    - A mammogram every year for any woman who is 50 or older.
    - One or more mammograms a year, based on a **physician's** recommendation for any woman who is at risk for breast cancer because she has:
        - A personal or family history of breast cancer,
        - A history of biopsy-proven benign breast disease,
        - A mother, sister, or daughter who has or has had breast cancer, or
        - Not given birth before the age of 30.

  For coverage other than that mandated in the above, we will cover a mammogram, with or without a **physician** prescription, performed in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health for breast cancer screening. Coverage is subject to the **deductible** and cost-share provisions applicable to outpatient visits, and all terms and conditions applicable to other **benefits**.
- Nutritional counseling
- Ovarian cancer screening — for female **members** age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a

rectovaginal pelvic examination, is covered.

- Preventive care and screenings for infants, children, and adolescents according to guidelines supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screenings for women according to guidelines supported by HRSA
- Prostate cancer examinations, screenings, and laboratory work for diagnostic purposes per the most recent published guidelines of the American Cancer Society
- Routine immunizations for children, adolescents, and adults who have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

The complete list of federally required preventive services can be found at the federal Health Insurance Marketplace website at:

https://www.healthcare.gov/coverage/preventive-care-benefits/

Primary care office visits

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

Radiation therapy — outpatient

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

Rehabilitation services

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

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

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

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

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

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

Skilled nursing facility services

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

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

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

Specialist visits

Office visits for specialty care services are covered.

Telemedicine services

Telemedicine services through **AmeriHealth Caritas Next Telemedicine** are covered at $0 cost share if you receive services via telemedicine through an **in-network provider** that currently offers the service via telemedicine. Certain specialty services including pediatrics are not eligible for **AmeriHealth Caritas Next Telemedicine**. **Telemedicine services** from any other professional **provider** are covered, subject to the same **cost-sharing** and **out-of-network** limitations as the same **health care services** when delivered to a **member** in-person. You can check with your **provider** to see if **telemedicine services** are available.

Temporomandibular joint (TMJ) disorder

Covered health services under this **policy** include **medically necessary** services for the treatment of a disorder of the TMJ or any bone or joint of the face or head resulting from an accident, trauma, congenital or developmental defect, illness, or pathology. Diagnosis and treatment of

TMJ disorder must be recognized by the medical or dental profession as effective and appropriate for TMJ disorder. Payment for splints for the treatment of TMJ dysfunction is limited to one splint in a six-month period unless a more frequent replacement is determined by us to be **medically necessary**.

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

Transplant services

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

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

Urgent care services

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

Exclusions and Limitations

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

This plan does not cover the following:

- Any care which extends beyond traditional medical management or **medically necessary** inpatient confinements for conditions such as learning disabilities, behavioral problems, or intellectual disabilities. Examples of care which extends beyond medical management include, but are not limited to, the following:
  - Educational services such as remedial education including tutorial services or academic skills training.
  - Neuropsychological testing including educational testing such as I.Q. tests, mental ability, and aptitude tests unless these tests are for an evaluation related to medical treatment.
  - Services to treat learning disabilities, behavioral problems, or intellectual disabilities.
- Any charges incurred due to failure to keep a scheduled appointment or charges for lack of completion of a claim form.
- Any **covered health service**, supply, or device that would otherwise be at no cost in the absence of coverage by this **policy**.
- Any **experimental** or **investigational** treatments or unproven services (except when **bone marrow transplant** procedures are recommended by a referring **physician**).
- Any items or services related to personal hygiene or convenience whether or not they are specifically recommended by a **network provider** or **out-of-network provider,** such as air conditions, humidifiers, physical fitness equipment, stair glides, elevators/lifts or barrier free home modifications.
- Any medical and/or recreational use of cannabis or marijuana.
- Any prescription or over-the-counter drugs not on the **formulary** unless an exception is granted.
- Any prescription vitamins, except vitamins prescribed during **pregnancy**, and fluoride vitamins, or as indicated as covered in the **formulary**.
- Any services that are not identified as a **covered health service** under this **policy.** You will be responsible for payment in full for any services that are not **covered health services**.
- Care given by a family member or person living with you.

- Diabetes prevention programs offered by **out-of-network providers**.
- Expenses, fees, taxes, or surcharges imposed by a **provider** or facility that are actually the responsibility of the **provider** or facility.
- Expenses for appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (for example, dynamic orthotic cranioplasty or molding helmets); except when the appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and expenses for devices necessary to exercise, train, or participate in sports.
- For certain contraceptive services including, contraceptive devices, implants and injections and all related services, contraceptive prescription drugs, except when provided for purposes other than birth control, as required by law.
- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this policy or for correction of a birth defect in a child. For inpatient admissions which are primarily for physical medicine or for diagnostic studies.
- For outpatient **habilitative** and rehabilitative services for which there is no reasonable expectation to keep, learn, or improve skills and functioning.
- For routine or periodic physical examinations, except as otherwise set forth in this document; the completion of forms or the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for employment, school, camp, travel or sports, except as mandated by Florida law.
- For services required as a result of a court order or other tribunal unless determined to be **medically necessary** by your **network physician** or coverage is required by federal or Delaware state law**.**
- For the reversal of sterilization or vasectomies.
- For treatment of **sexual dysfunction** not related to organic disease or injury.
- **Hearing Aids** (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of maintenance and repair, except where required by Florida Law.
- Home health - Services rendered by an adult congregate living facility, adult foster home, adult day care center, or a nursing facility.
- Prescription drugs and services to decrease weight loss including weight reduction programs.
- Services provided by a naturopathic **physician**.

- The following are not covered for at-home treatment or care under this **policy's home health care** benefit:
  - Care not prescribed in the approved treatment plan.
  - Chemotherapy and radiation therapy.
  - Chronic condition care.
  - Dietary care.
  - Disposable supplies.
  - **Durable medical equipment.**
  - Homemaker services such as housekeeping, food and meal preparation, and cooking.
  - Imaging services.
  - Inhalation therapy.
  - Laboratory tests.
  - Prescription drugs except home infusion services.
  - Volunteer care.
- The following are not covered under this **policy's hospice** benefit:
  - Care not prescribed in the approved treatment plan.
  - Financial, legal, or estate planning.
  - Homemaker services such as housekeeping, food and meal preparation, and cooking.
  - 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:

- Abortions, except in the case of rape, incest, or danger to the mother.
- Any charges incurred due to failure to keep a scheduled appointment or charges for lack of completion of a claim form.
- Any examinations, tests, screenings or any other services required by:
    - For employment or government-related diagnostic testing, laboratory procedures, screenings, or examinations;
    - A university, school, or college in order to enter school property or a particular location regardless of reason; or
    - A governmental body for public surveillance purposes.
- **Covered health benefits** that are provided to **members** of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the **member** has a legal obligation to pay.
- For any illness or bodily injury which occurs in the course of employment if **benefits** or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the **member** files a claim for said **benefits** or compensation.
- For any loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
- For **behavioral health** and **substance use disorder** services related to:
    - Court-ordered services required for parole or probation.
    - Marital and relationship counseling.
    - Testing for aptitude or intelligence.
    - Testing for evaluation and diagnosis of learning abilities.
- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this **policy** or for correction of a birth defect in a child.
- For fetal reduction surgery.
- For nontraditional alternative or complementary medicine not consistent with conventional medicine. These include, but are not limited to, acupuncture; hydrotherapy; hypnotism; and alternative treatment modalities including, but not limited to, boot camp, equine therapy, wilderness therapy, and similar programs.

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

Grievances and Appeals

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

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

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

If you need help with filing a **grievance** or **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 1-833-999-3567, 8 a.m. – 8 p.m., 5 days a week.

Grievances

You, your authorized representative, or your **provider** can file a **grievance** with us at any time. You can do so in writing or over the phone; however, it will not be considered a formal **grievance** unless submitted in writing. **Grievances** must be submitted within one year after the date of occurrence of the action that initiated the **grievance**. The **grievance** process is voluntary.

A **grievance** can be provided to us at any time by you or your authorized representative by calling Member Services at the toll-free phone number 1-833-999-3567 or in writing at:

Member Grievances

PO BOX 7450

London, KY 40742-7420

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

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

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

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

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

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

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

Expedited grievance

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

PO BOX 7450

London, KY 40742-7420

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

Standard appeals

You or your authorized representative can file an **appeal** of an **adverse benefit determination** verbally by calling Member Services at 1-833-999-3567 or in writing to Member Appeals, AmeriHealth Caritas Next, P.O. Box 7101, London, KY 40742-7101. An **appeal** must be filed within 180 days from the date of our written notice denying 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**. Unless you are requesting an expedited **appeal**, a verbal **appeal** must be followed up with a written and signed **appeal**. When you make a verbal **appeal**, we will let you know how to file a signed written **appeal**. We will also help you with filing the written **appeal** if you need it.

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

Once we have received your written **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 1-833-999-3567, 8 a.m. – 8 p.m., 5 days a week. 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 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 1-833-999-3567 (TTY 711). Note: You cannot request an extension of services after the original authorization has ended. For more details, please contact Member Services.

Expedited appeals

An expedited **appeal** can be requested by you or your authorized representative either verbally or in writing. You can file a request for an expedited **appeal** with our Member Services department

by phone at 1-833-999-3567 or in writing at Member Appeals, AmeriHealth Caritas Next, P.O. Box 7101, London, KY 40742-7101. An expedited **appeal** will be made available when a non-expedited **appeal** would reasonably appear to seriously jeopardize the life or health of a **covered person** or jeopardize the **covered person's** ability to regain maximum function or, in the opinion of a **physician** with knowledge of 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. When we have made a decision on your **appeal**, we will try to notify you verbally of our decision within 72 hours of receiving the expedited **appeal** request. If we deny the request for the **appeal** to be processed in an expedited manner, we will handle the request as a standard **appeal** and will send written notice to you or your authorized representative that we have denied your request for an expedited **appeal**. You have the right to submit a **grievance** if the expedited **appeal** request is handled as a standard **appeal**.

We will, in consultation with a **medical doctor**, provide expedited review and communicate the decision verbally to covered **members** and their **providers** as soon as possible, but not later than 72 hours after receiving the information justifying expedited review. We will communicate our decision in writing within 2 business days after verbal notification was provided. If the expedited review is a concurrent review determination, we will remain liable for the coverage of **health care services** until the **covered person** has been notified of the determination. Retrospective **adverse benefit determinations** are not eligible for expedited review.

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

Florida law makes available to you an independent external review of **adverse benefit determination** decisions made by AmeriHealth Caritas Next. The external review will be performed by a third party independent 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 benefit determination** decision.
- Receive an **appeal** decision upholding an **adverse benefit determination** decision — also known as a **final determination.**

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

If you have any questions or concerns regarding the independent external review process, please contact Member Services at 1-833-999-3567 (TTY 711).

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

200 East Gaines Street

Tallahassee, FL 32399

Phone: 1-850-413-3140

Fax: 1-803-737-6231

https://www.myfloridacfo.com/division/consumers/ or https://floir.com/home

Exhaustion of internal appeals

A request for external review may not be made until the **covered person** has exhausted our internal appeal process. 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.

Eligibility for independent external review

For your request to be eligible for external review:

- Your coverage with us must be in effect when the **adverse benefit determination** decision was issued;
- The service for which the **adverse benefit determination** was issued appears to be a covered service under your **policy**; and
- You have exhausted our internal review process, as described below, unless you submit an expedited external review request at the same time as an expedited internal appeal with

us.

- Your request must be a consideration of whether AmeriHealth Caritas Next is complying with the surprise billing and **cost-sharing** protections under the Public Health Service Act or be a determination that resulted in an **adverse benefit determination** decision for reasons of:
    - **Medical necessity**, appropriateness, health care setting, level of care or effectiveness of health services, or the treatment that you are requesting is experimental or investigational; or
    - A rescission in coverage.

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

Standard external review requests

Your request for standard external review must be submitted in writing to AmeriHealth Caritas Next within four months of receiving our notice of **final determination** that the services in question are not approved. You can submit this request to us at PO BOX 7422, London, KY 40742-7422 or fax the request to 1-833-435-3290.

Expedited external review requests

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

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

Expedited external review requests must be submitted within four months from the date on your **final determination** notice. You can submit your request either verbally by contacting Member Services at 1-833-999-3567 (TTY 711) or in writing at the following address PO BOX 7422, London, KY 40742-7422 or fax the request to 1-833-435-3290.

IRO external review eligibility determination

Within five business days of receipt of your request for a standard external review, and as expeditiously as reasonably possible for expedited external review requests, we will complete a review of your request to determine if you meet the eligibility requirements 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 within one business day of our review decision. If a request is made for an expedited external review, we will make a determination of whether 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 contact the Florida Office of Insurance Regulation (FLOIR) for further help.

IRO assignment

If your request for external review is accepted, we will assign an IRO on a rotating basis. We are required to submit all documents and any information considered in making the **adverse benefit determination** or **final determination** to the IRO within five business days of receipt of 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 benefit determination** or **final determination**. If this occurs, the IRO will immediately contact us and you or your authorized representative.

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

IRO review and decision

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

If the IRO's decision is to reverse the **adverse benefit determination**, we will reverse the **adverse benefit determination** decision by approving the covered benefit or supply that was the subject of the **adverse benefit determination** within five business days of receiving notice of the IRO's

decision for standard external review requests and as expeditious as reasonably possible for expedited external review requests. If you are no longer covered by us at the time we receive notice of the IRO's decision to reverse the **adverse benefit determination**, we will only provide coverage for those services or supplies 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 benefit 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 **in-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.

Out-of-network provider claims

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

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.

Notice of claim

Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to AmeriHealth Caritas Next 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**. You must complete a claim form for

services rendered by an **out-of-network provider** and submit it, together with an itemized bill and proof of payment, to AmeriHealth Caritas Next, 200 Stevens Drive, Philadelphia, PA 19113.

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.

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 the AmeriHealth Caritas Next is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in 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 of payment of claims

After receiving a claim form or written proof of loss, we will pay monthly all **benefits** then due. **Benefits** for any other loss covered by this **policy** will be paid as soon as the **insurer** receives proper written proof.

Payment of claims

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

Unpaid premium

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

Member Rights and Responsibilities

Member rights

A **member** has the right to:

- Receive information about the health plan, its **benefits**, services included or excluded from coverage policies, and **network providers'** and **members'** rights and responsibilities. Written and web-based information 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; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.
- Formulate advance directives. The plan will provide information concerning advance directives to **members** and **providers** and will support **members** through our medical record-keeping policies.
- Obtain a current directory of **network providers**, on request. The directory includes addresses, phone numbers, and a listing of **providers** who speak languages other than

English.

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

requirements for specialist services. If you choose to see a **physician** who is **out-of-network** you will be responsible for a 40% **coinsurance** for all services rendered. Any tests ordered by the **out-of-network physician** must be performed at one of our **in-network** facilities or the costs for said tests will not be covered. If it is determined by AmeriHealth Caritas Next and its **network providers** that you have unreasonably overused this **second opinion** privilege your **out-of-network second opinion**s will be limited to three referrals per year. If you are denied reimbursement for **second opinion** services you may file a **grievance** with AmeriHealth Caritas Next. See the **Grievance** and **Appeals** section of this **policy** for additional details on how to file your **grievance**. Treatment not authorized by AmeriHealth Caritas Next will not be covered and you will be responsible for the full cost of any services rendered.

Member responsibilities

A **member** has the responsibility to:

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

General Provisions

Entire policy

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

Modifications

This contract may not be modified, amended, or changed, except in writing and signed by an officer of AmeriHealth Caritas Florida, Inc. or the person designated by an officer of AmeriHealth Caritas Florida, 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.

Time limit on certain defenses

After two 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 two-year period.

Non-waiver

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

Conformity with state laws

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

Nondiscrimination

AmeriHealth Caritas Florida, Inc. does not discriminate based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth,

lactation, and related medical conditions); cognitive, sensory, or mental disability; 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.

Continuation of benefit limitations

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

Protected health information (PHI)

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

We protect all oral, written, and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. Our Notice of Privacy Practices describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https://www.amerihealthcaritasnext.com/fl/about/contact.aspx or call our Member Services team at 1-833-999-3567.

Our relationship with providers

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

Legal actions

No 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.

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.

Misstatement of age

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

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 occupation.

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.

Fibrocystic condition
AmeriHealth Caritas Next will not deny the issuance or nonrenewal, or cancel, your **policy**, solely because you have been diagnosed with having a fibrocystic condition.

Human immunodeficiency virus (HIV) infection
AmeriHealth Caritas Next will not exclude or limit coverage for HIV infections.

Nonduplication of coverage
AmeriHealth Caritas will not duplicate **benefits** which are payable through any workers' compensation, occupational disease, employers' liability or similar law, or payable pursuant to the Florida 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**, Florida Automobile Reparations Reform Act (motor vehicle no-fault plan or similar law), and similar benefit programs.

Coordination of benefits
This **policy** does not coordinate **benefits** with any other policies. That means that this **policy** pays **benefits** regardless of other coverage you might have.

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 to secure such

rights, as permitted by law. The **member** shall do nothing to prejudice the rights given the plan by this paragraph without its consent. These provisions shall not apply where subrogation is specifically prohibited by law.

HOW TO CONTACT US

Method	Member Services — contact information
Call:	1-833-999-3567 Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m. Monday to Friday
TTY	711 Calls to this number are free.
Fax:	1-833-329-3567
Write:	Mailing address: 200 Stevens Drive Philadelphia, PA 19113
Website:	https://www.amerihealthcaritasnext.com/fl/about/contact.aspx

Language assistance and alternate formats:

Assistance is available at no cost to help **members** communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English
- Written information in alternative formats such as large print
- Help with reading our website

To ask for help with these services, please call the Member Services number on your member ID card.

Spanish (US):

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese (S):

注意：**如果您**讲中文，我们可以为您提供免费的语言协助服务。请拨打您ID **卡上的会**员服务电话号码。

Vietnamese:

LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số Dịch vụ Hội viên trên thẻ ID của quý vị.

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 있는 회원 서비스 번호로 전화하십시오.

French (FR):

REMARQUE : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le numéro des services aux membres, qui figure sur votre carte d'identification.

Arabic:

تنبيه: إذا كنت تتحدث اللغة العربية، فيمكنك االستعانة بخدمات المساعدة اللغوية بدون مقابل. اتصل برقم خدمات أألعضاء المدون على

بطاقة التعريف الخاصة بك.

Hmong:

UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus nab npawb xov tooj nyob ntawm koj daim npav ID.

Russian:

ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните в Службу работы с клиентами по телефону, указанному в Вашей идентификационной карте.

Tagalog:

PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo para sa wika. Tawagan ang numero ng Mga Serbisyo sa Miyembro na nasa inyong ID kard.

Japanese:

注記：日本語をお話しになる方は、無料の言語アシスタンスサービスをご利用いただけます。IDカード に記載のメンバーサービス電話番号までお電話ください。

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter der auf Ihrer ID-Karte aufgeführten Telefonnummer für Mitgliederdienstleistungen an.

Gujarti:

ધ્યાન આપો: જો તમે અંગ્ેજી સિવયા્ની અન્ કોઇ ભયાષયા બોલો છો, તો તમયારયા મયાટે ભયાષયા િહયા્ િેવયાઓ સનઃશલ પર કોલ કરો. ક ઉપલબ્ધ છે. તમયારયા આઇડી કયાડ્ પર રહલ યા િદસ્ની િેવયાઓનયાં નબર

Hindi:

ध्यान दें: ्दद आप अंग्रेजी करे अलयावया कोई अन् भयाषया बोलतरे हैं, तो आपकरे ललए मुफ़्त में भयाषया सहयात्तया सरेवयाएं उपलब्ध हैं। आपकरे आईडी कयाड्ड पर ददए गए सदस् सरेवया नंबर पर कॉल करें।

Laotian:

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອ່ ນ , ການບໍລິການຊ່ວຍເຫຼືອ ດ້ານພາສາທ່ ິບ ນອກຈາກພາສາອງກດ

Mon-Khmer:

ចាប់អារម្មណ៍ ៖ បបសិនបបើបោកអ្នកនិយាយភាសាប្បេង បបរៅពីភាសាអង់ប្លេស បោះបសវា ជំនួយភាសាបោយឥត្ិតថ្លេ ីមានសបមាប់បោកអ្នក។ សូមទូរស័ព្ទបៅបេខបសវាបបបមើ សមាជិកដែេមានបៅបេើកាតសមាគា េ់ របស់បោកអ្នក។

Persian Farsi:

برای این منظور . در صورتی کە بە زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی بە طور رایگان برای شما وجود دارد:توجە
با شماره خدمات اعضای موجود روی کارت شناسایی خود تماس بگیرید

4813-6644-7606, v. 5

AmeriHealth Caritas Florida, Inc.
11631 Kew Gardens Avenue, Suite 200
Palm Beach Gardens, FL 33410

AMENDMENT TO THE EVIDENCE OF COVERAGE

This amendment applies to the Evidence of Coverage with the form number listed below.

ACFL Ind FL PY23 - EOC – 202208 v7

These changes become effective January 1, 2024.

A. The page headers are amended to change the plan year from 2023to 2024, to read as follows:

   2024 Evidence of Coverage for AmeriHealth Caritas Florida, Inc.

B. The cover page is amended to change the plan year from 2023 to 2024, to read as follows:

   2024 EVIDENCE OF COVERAGE

C. The "Definitions of Important Words Used in This Document" section is revised to change the definition "**AmeriHealth Caritas Next Telemedicine**" to "**AmeriHealth Caritas Next Virtual Care 24/7**." The term "**telemedicine services**" is changed to "**virtual care services**." The definition is to read as follows:

   - **AmeriHealth Caritas Next Virtual Care 24/7 —** The preferred vendor with whom we have contracted to provide **virtual care services** to our **members**. Our preferred vendor contracts with **providers** to render **virtual care services** to our **members**.

D. The "Definitions of Important Words Used in this Document" section is revised to add a definition for "**Serious and complex condition or illness**," to read as follows:

   - **Serious and complex condition or illness —** an acute condition or chronic illness that requires specialized treatment over a period of time to avoid injury, or impairment that results in, or is likely to result in, any of the following:
     - Death or permanent harm;
     - Significant decline in physical, mental, or psychosocial functioning that is not solely due to the normal progression of a disease or aging process;
     - Loss of limb, or disfigurement;
     - Avoidable pain that is excruciating, and more than transient; or
     - Other serious harm that creates life-threatening complications/conditions.

E. The "Definitions of Important Words Used in This Document" section is revised to change the definition of "**Telemedicine services**" to "**Virtual care services**" and is placed in alphabetical order by its new name after "**Utilization review organization (URO)**". The revised definition is to read as follows:

- **Virtual care services** — Includes evaluation, management, and consultation services with a professional **provider** for **behavioral health** and nonemergency medical issues via an interactive audio or video telecommunications system.

F. The "Eligibility and Termination" section, "Payment of premiums" subsection is revised to change the grace period for non-federal premium subsidy also known as an Advance Premium Tax Credit, members from 15 days to 31 days, to read as follows:

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 also known as an Advance Premium Tax Credit) to pay your next **premium**. Coverage will remain in force during the grace period. If we do not receive full payment of your **premium** within the grace period, your coverage will end as of the last day of the last month for which a **premium** has been paid. We will notify the **subscriber** of the nonpayment of **premium** and pending termination. We will also notify the **subscriber** of the termination if the **premium** has not been received within the grace period.

G. The section entitled "How To Use Your Health Plan" is revised to add additional language to the following paragraph, to read as follows:

AmeriHealth Caritas Next plans comply with the provisions of the No Surprises Act of the 2021 Consolidated Appropriations Act and any associated rules or regulations that the Centers for Medicare and Medicaid Services (CMS) or other regulatory authorities may issue. The **member** will not be penalized and will not incur out-of-network benefit levels unless participating **providers** able to meet the **member's** health needs are reasonably available without unreasonable delay or the **member** agrees to sign over their rights. The **member** will not be charged for balance bills for out-of-network care (emergency services or care by a non-participating **provider** at an **in-network facility**) without the informed consent of the **member** or **prior authorization**. If the **member** receives incorrect information from AmeriHealth Caritas Next about a **provider's network** status, they will only be responsible for the in-network cost share. If a **provider** or health care facility leaves our **network** and you are in active treatment or terminally ill, AmeriHealth Caritas Next will continue to cover **covered health services** at the **member's** in-network cost share for up to 6 months. Please refer to the "Continuity/transition of care" section of this **policy** for additional information.

H. The "How to Use Your Health Plan" section is revised to bold the defined term "**serious and complex condition or illness**," add a 6-month coverage period for continuity/transition of care from an in-network provider who stops participating in our network, and add additional coverage details regarding your continuity/transition of care benefit. The section is to read as follows:

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

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

This coverage is provided through completion of treatment, until you select another **network facility** or **network provider** as your treating physician, or until the next open enrollment period offered by AmeriHealth Caritas Next, whichever is longer. This coverage is provided for a maximum of 6 months. We will notify you if your **in-network provider** or **in-network facility** becomes an **out-of-network provider** or **out-of-network facility**. The **out-of-network provider** or **out-of-network facility** who is treating you is prohibited from billing you more than your in-network cost-share for up to 90 days after you are notified.

For these services to be covered, you must obtain **prior authorization** from the **health benefit plan**. Pregnant **members** in any trimester of **pregnancy** who have started prenatal care with a **provider** or facility who stops participating in our **network** can continue receiving pregnancy-related services from the date of the birth until completion of postpartum care. This continuity of care allowance 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 until the next open enrollment period offered by AmeriHealth Caritas Next, whichever is longer. This coverage is provided for a maximum of 6 months if your **in-network provider** or facility becomes an **out-of-network provider** or **out-of-network facility** or 90 days if you are a new enrollee.

I. The "How to Use Your Health Plan," "Prior authorization," "Behavioral health services requiring prior authorization" subsection is revised as follows:
    - "Professional treatment services in facility-based crisis programs" is replaced with "Crisis intervention services."
    - "Intensive outpatient treatment for opioid substance use treatment" is changed to "Intensive outpatient treatment."
    - Reordered in alphabetical order.

The subsection is to read as follows:

Behavioral health services requiring prior authorization

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

J. The "Covered Health Services" section, "Telemedicine services" subsection, is revised as follows:
   - "**Telemedicine services**" is changed to "**Virtual care services**."
   - "**telemedicine services**" is changed to "**virtual care services**."
   - "**AmeriHealth Caritas Next Telemedicine**" is changed to "**AmeriHealth Caritas Next Virtual Care 24/7**."
   - "$0 cost share" is changed to "no cost."
   - The paragraph is modified for benefit clarity.
   - Reordered in this section by its new name to appear just after "Urgent care services."

   This subsection is to read as follows:

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

K. A new section entitled "Additional Covered Health Services and Programs" is added to the Evidence of Coverage, following "Covered Health Services." The Healthy Rewards program is moved from the "Covered Health Services" to the "Additional Covered Health Services and Programs" section of the Evidence of Coverage. The Healthy Rewards program is modified to remove duplicative information from the first paragraph of this new section and to add additional information regarding the program. The added section is to read as follows:

Additional Covered Health Services and Programs

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

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

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

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

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

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

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AMENDMENT TO THE EVIDENCE OF COVERAGE

This amendment applies to the Evidence of Coverage and Evidence of Coverage Amendment with the form numbers listed below:

ACFL Ind FL PY23 - EOC – 202208 v7
ACFL Ind FL PY24 – EOC Amendment – 202307 v2

These changes become effective January 1, 2025.

A. The page headers are amended to change the plan year from 2024 to 2025, to read as follows:

2025 Evidence of Coverage for AmeriHealth Caritas Florida, Inc.

B. The cover page is amended to change the plan year from 2024 to 2025, to read as follows:

2025 EVIDENCE OF COVERAGE

C. The "Definitions of Important Words Used in this Document" section is revised to add the definition of "Approved clinical trials." The added definition is to read as follows:

- **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 qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
        - Any of the following if the conditions for departments are met:
            - The Department of Veterans Affairs.
            - The Department of Defense.

- The Department of Energy.

Conditions for Departments: The conditions described below, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

- To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and
- Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- 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.

D. The "Definitions of Important Words Used in this Document" section is revised to add the definition of "Routine patient care costs for approved clinical trials." The added definition is to read as follows:

- **Routine patient care costs for approved clinical trials** — All items or **covered health services** that are otherwise generally available to a **covered person** that are provided in a **clinical trial** except the following:
  - The **investigational** items or service itself.
  - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patients.
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

E. The "How to Use Your Health Plan" section, "Prior authorization" subsection has been revised to:

- Require prior authorization on prosthetics and custom orthotics that cost over $750.
- Require prior authorization for biomarker testing, home sleep studies, and removal of lesions.

The revised subsection reads as follows:

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 **prior authorization** is denied and the **provider** still provides you with these services, the **provider** cannot bill you for these denied services unless you agreed 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 **prior authorization** 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

prior authorization 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 **prior authorization** requirements.

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

Physical health services requiring prior authorization

…
- Biomarker testing

...
- **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

…
- Home sleep studies

…
- Removal of lesions

F. The "How to Use Your Health Plan" section, "Prior authorization," "Behavioral health services that do not require authorization" subsection is revised to:

- Change "Psychiatric and substance use disorder outpatient and medication management services," to "Outpatient psychiatric, substance use disorder, and medication management services not otherwise specified as needing prior authorization. For specific services, please have your provider refer to the Prior Authorization Lookup Tool on the PA section of our plan website."

The revised subsection reads as follows:

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

G. The "Covered Health Services" section has been revised to add a benefit for biomarker testing, to read as follows:

Biomarker testing

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

H. The "Covered Health Services" section has been revised to add a benefit for blood products to read as follows:

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.

I. The "Covered Health Services" section has been revised to add coverage of routine patient care costs for clinical trials, to read as follows:

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**.

J. The "COVERED HEALTH SERVICES" section, "Prescription drugs" subsection has been revised to clarify the resolution time frames for non-formulary exception requests and non-formulary exception external review requests through an Independent Review Organization (IRO).

The revised subsection reads as follows:

Prescription drugs

We use a Pharmacy Benefit Manager (PBM) to help manage your prescription drug benefit, including specialty medications. You will need to fill your prescription medications from a **network pharmacy** to for it to be covered under your prescription drug benefit. Prescriptions can be filled at either a retail **network pharmacy** or through our mail-order **network pharmacy**. As with obtaining any service under our plan, you will need to show your member ID card when you fill or obtain your prescription medications.

The list of prescription drugs covered under this plan is also called a **formulary**. The **formulary** covers both brand (preferred and non-preferred) and generic medications and will determine what your **out-of-pocket costs** will be for medications under our plan. The **formulary** is occasionally subject to change, but we will provide written notice to you before any changes take effect and will work with you and your prescriber to switch to another covered medication if you are on a long-term prescription. The **formulary** listing is available on request by contacting Member Services at [1-833-999-3567], [8 a.m. – 8 p.m.], [5] days a week. A searchable **formulary** is available at [https://www.amerihealthcaritasnext.com/fl/view-plans/2024/searchable-drug-list.aspx l]. You can

enter a medication name to see if it is covered on the **formulary**, what drug benefit tier it is on, and if there are any limitations such as **Prior Authorization**, **Step Therapy**, **Quantity Limits** or Age Limits. There is also a printable **formulary** document at [https://www.amerihealthcaritasnext.com/fl/members/2024/find-a-provider-or-pharmacy.aspx]. It shows all of the medications on the **formulary**, their drug benefit tiers, and any limitations.

We will cover prescription drugs used in the treatment of diabetes, conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis. We will cover certain off-label uses of cancer drugs per Florida law. Your **health benefit plan** does not exclude coverage of any prescription drugs prescribed for the treatment of cancer solely on the basis that the drug is not approved by the Food and Drug Administration (FDA) for a particular indication. To qualify for off-label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following four compendia (summaries of drug information that are compiled by experts who have reviewed clinical data on drugs): (1) National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium; (2) The Thomson Micromedex DrugDex®; (3) American Hospital Formulary Service and Lexi-Drugs ; or (4) any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Your **health benefit plan** also covers the **medically necessary** services associated with the administration of these drugs. Notwithstanding this section, if the **cost-sharing** requirements for intravenous or injected cancer treatment medications under the **policy** or contract are less than $50 per month, then the **cost-sharing** requirements for orally administered cancer treatment medications may be up to $50 per month.

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

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

To make a request for coverage of a non-formulary drug, you, your authorized representative, or prescribing **provider** may call us at [1-833-981-7967] for **members** or [1-833-982-7977] for **providers**, or you may fill out the online submission form at

[https://ppa.performrx.com/PublicUser/OnlineForm/OnlineFDBSingleForm.aspx?cucu_id=Y65L6nti7Fh2jJt8A7Rsjw%3d%3d]. You can also ask your **provider** to fax a request to [1-844-470-2507] for standard review, or [1-844-470-2510] for expedited (fast) review, or by mail to [PerformRx/AmeriHealth Caritas Next P.O. Box 516 Essington, PA 19029]. If submitting a request by mail or by fax we recommend you view the online submission form or contact us by phone to ensure all applicable and necessary information is included in your request.

Once the non-formulary exception request is received, our PBM will review the request for **medical necessity** and appropriateness. For a standard non-formulary exception review, we will make our decision no later than 72 hours of the date we received the request. You can request an expedited (fast) non-formulary exception 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 urgent circumstance on your request by asking for an expedited review. We will give you a decision on expedited requests no later than 24 hours after we receive the request.

If the non-formulary request is denied and you feel we have denied the request incorrectly, you may challenge the decision through the internal **appeal** process of AmeriHealth Caritas Next. You also have the right to pursue either a standard or, if warranted and appropriate, an expedited external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO).

You may exercise your right to external review with an Independent Review Organization (IRO) upon initial denial or following a decision to uphold the initial denial pursuant to the internal **appeal** process of AmeriHealth Caritas Next. If a decision is made to uphold the initial denial, your denial notice will explain your right to external review and provide instructions on how to make this request. An external review request can be made by you, your authorized representative, or your prescribing **provider**.

An expedited external review may be warranted 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 a standard external review, we will provide coverage for the non-formulary drug 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 drug for the duration of the exigency.

K. The “Covered Health Services” section has been revised to add a benefit for routine foot care, to read as follows:

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.

L. The "Covered Health Services" section has been revised to add a benefit for skin cancer screenings, to read as follows:

Skin cancer screenings

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

M. The "Exclusions and Limitations" section is revised to remove the following exclusion for contraceptive services as contraceptives are covered under your health benefit plan:

- For certain contraceptive services including, contraceptive devices, implants and injections and all related services, contraceptive prescription drugs, except when provided for purposes other than birth control, as required by law.

N. The "Exclusions and Limitations" section is revised to:
- Add exclusions for certain disorders, doula services, incontinence supplies, refractive laser eye surgery, and certain types of glasses and lenses.

The revised section reads as follows:

Exclusions and Limitations

Covered health services must be administered by a **network provider** unless you receive **prior authorization** for **out-of-network** services. In order for a benefit to be paid, the **covered health 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 that extends beyond traditional medical management or **medically necessary** inpatient confinements for conditions such as learning disabilities, behavioral problems, personality disorders, factitious disorders, sleep disorders, or intellectual disabilities. Examples of care that extend beyond medical management include, but are not limited to, the following:
    - Educational services such as remedial education including tutorial services or academic skills training
    - Neuropsychological testing including educational testing such as I.Q., 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

…

- Birthing support services provided by a doula

…

- Incontinence supplies

…

- Refractive laser eye surgery such as laser-assisted in situ keratomileusis (LASIK)
- Safety glasses, athletic glasses, and sunglasses; non-standard lenses such as photocolor or scratch-resistant lenses

O. The “Exclusions and Limitations” section is revised to add an exclusion for immunizations for foreign travel, to read as follows:

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

…

- For immunization or exam services required for foreign travel or employment purposes