Health Insurance for Now and Whatever Is **Next.**

2025
Member Handbook

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

AmeriHealth Caritas℠
Next

A product of AmeriHealth Caritas North Carolina, Inc.

www.amerihealthcaritasnext.com/nc

For more information, visit **www.amerihealthcaritasnext.com/nc**.

You can get this material and other plan information in large print at no cost to you. To get materials in large print, call Member Services at **1-833-613-2262 (TTY 711)**.

If English is not your first language, we can help. Call **1-833-613-2262 (TTY 711)**. You can ask us for the information in this material in your language. We have access to interpreter services and can help answer your questions in your language.

Welcome to AmeriHealth Caritas Next

Thank you for choosing us as your health insurance plan. We are excited to help you take charge of your health and to help you lead a healthier, more fulfilling life.

As our member, you have access to a lot of helpful services and resources. This Member Handbook will help you understand all of them.

Inside, you'll find important information about:

- How your plan works
- Payment information
- How to get care
- Information on your member ID

Member Services

1-833-613-2262
TTY 711
Monday through Friday, 8 a.m. to 6 p.m.

How to contact us

AmeriHealth Caritas Next
P.O. Box 7410
London, KY, 40742-7410

Member Services

1-833-613-2262
TTY 711
Monday through Friday, 8 a.m. to 6 p.m.

Fax: **1-844-201-6792**

Website

www.amerihealthcaritasnext.com/nc

Your AmeriHealth Caritas Next Quick-Reference Guide

You may do any of the following:

- Find a primary care provider (PCP), specialist, or health care service, including behavioral health services.
- Learn more about choosing or enrolling in a plan.
- Get this handbook in another format or language.
- Get help dealing with my stress or anxiety.
- Get answers to basic questions or concerns about my health, symptoms, or medicines.
- Understand a letter or notice I got in the mail from my health plan.
- File a complaint about my health plan.
- Get help with a recent change or denial of my health care services.
- Find my plan's health care Provider Directory or other general information about my plan.

Available contacts:

- My PCP. If I need help with choosing my PCP, I can call Member Services at **1-833-613-2262 (TTY 711)**.
- Member Services at **1-833-613-2262 (TTY 711)**.
- HOPE4NC at **1-855-587-3463** or text **"hope"** to **1-855-587-3463** if I am having a behavioral health crisis. If I am in danger or need immediate medical attention, I can call **911**.
- AmeriHealth Caritas Next through its website at **www.amerihealthcaritasnext.com/nc**.

Table of Contents

Welcome to AmeriHealth Caritas Next

This handbook will help you understand the health care services available to you. You can also call Member Services with questions at **1-833-613-2262 (TTY 711)** or visit our website at **www.amerihealthcaritasnext.com/nc**.

How to use this handbook

This handbook tells you how AmeriHealth Caritas Next works. It is your guide to health and wellness services.

Read pages 7 to 11 now. These pages have information that you need to start using your health benefits with AmeriHealth Caritas Next.

When any significant changes are made to this Member Handbook, AmeriHealth Caritas Next will let members know 30 days prior to the change taking effect.

When you have questions about your health plan, you can:

- Use this handbook.
- Ask your PCP.
- Call Member Services at **1-833-613-2262 (TTY 711)**.
- Visit our website at **www.amerihealthcaritasnext.com/nc**.

Member Services

Member Services has people to help you. You can call Member Services at **1-833-613-2262 (TTY 711)**.

- For help with nonemergency issues and questions, call Member Services 8 a.m. to 6 p.m., Monday through Friday.
- In case of a medical emergency, call **911**.
- **You can call Member Services to get help when you have a question.** You may call us to:
  - Choose or change your PCP.
  - Ask about benefits and services.
  - Get help with referrals.
  - Replace a lost member ID card.
  - Report the birth of a new baby.
  - Ask about any change that might affect you or your family's benefits.
- **If English is not your first language, we can help.** Just call us and we will find a way to talk with you in your own language.
- **For people with disabilities:** If you have trouble hearing or need assistance communicating, please call us. If you are reading this on behalf of someone who has a vision or hearing impairment, we can help. We can tell you if a health care provider's office is equipped with special communication devices. Also, we have services like:
  - TTY machine. Our TTY phone number is **711**.
  - Information in large print
  - Help in making or getting to appointments
  - Names and addresses of providers who specialize in your condition

If you use a wheelchair, we can tell you if a provider's office is wheelchair accessible and assist you in making or getting to appointments.

Special aids and services

If you have a hearing, vision, or speech disability, you have the right to receive information about your health plan, care, and services in a format that you can understand and access. AmeriHealth Caritas Next provides services at no cost to help people communicate with us. These services include:

- A TTY machine. Our TTY phone number is **711**.
- Qualified American Sign Language interpreters
- Closed captioning
- Written information in other formats (like large print, audio, and accessible electronic format)

These services are available at no cost to you. To ask for services, call Member Services at **1-833-613-2262 (TTY 711)**.

AmeriHealth Caritas Next complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, disability, gender, sex, creed, religious affiliation, ancestry, gender identity or expression, or sexual orientation. If you believe AmeriHealth Caritas Next has treated you unfairly, you can file a complaint. To file a complaint or to learn more, call Member Services at **1-833-613-2262 (TTY 711)**.

Sign up. Log in. Stay connected.

What is the member portal?

The member portal is a secure website that can help you stay connected with AmeriHealth Caritas Next. It has most of your recent health history. And it's easy to use. It gives you the power to be involved with your health.

Where do I find the member portal?

To find your portal, go to **www.amerihealthcaritasnext.com/nc**, and go to the member page. Click **member portal** from the menu. If you are a first-time user, you will need to sign up. To sign up, you will need your member ID number on your member ID card. Then you will need to choose a user ID and password. If you have already signed up, just log in.

Using your member portal can help you manage your health.

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

There are more benefits to using the member portal:

- Read a variety of health articles. This information can help you learn more about how to live a healthy life.
- Get your claims or billing history.
- Change your PCP at any time.
- Get benefit details.
- Get up to six months of your prescription history, find in-network pharmacies, and more.

Paying your monthly premium

Once you receive your invoice, you will be given a due date for payment.

Pay online

Make an online payment using a credit card, debit card, or bank withdrawal by logging in to **https://amerihealthcaritasnext.softheon.com/account/payments/locate-account**. Just follow the **pay online** instructions.

Pay by phone

Pay by automated phone. Call us at **1-866-591-8092** and use our automated payment system. It's available 24/7.

Pay by mail

Send a check or money order to the address listed on your billing invoice payment coupon.

Your coverage begins when your first premium payment is made. Your premium payment needs to be paid on or before the due date to keep your coverage.

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 amount. 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, as well as notify the subscriber of the termination if the premium hasn't been received within the grace period.

For those receiving a federal premium subsidy, we will still pay for all appropriate claims during the first month of the grace period but may pend claims for services received in the second and third months of the grace period. We will also notify the subscriber of the nonpayment of premiums, and 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. 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.

Be sure to mail your payment at least 10 calendar days prior to your premium payment due date. Be sure to:

- **Write your member ID number on the check or money order.**
- **Detach the payment coupon from the billing invoice and mail it to us with your payment.**

Mailing your payment to the correct address will help ensure your payments are processed on time.

AmeriHealth Caritas Next
P.O. Box 411117
Boston, MA 02241-1117

Welcome letter and packet

When you signed up to be a member, you received your welcome packet. The packet included:

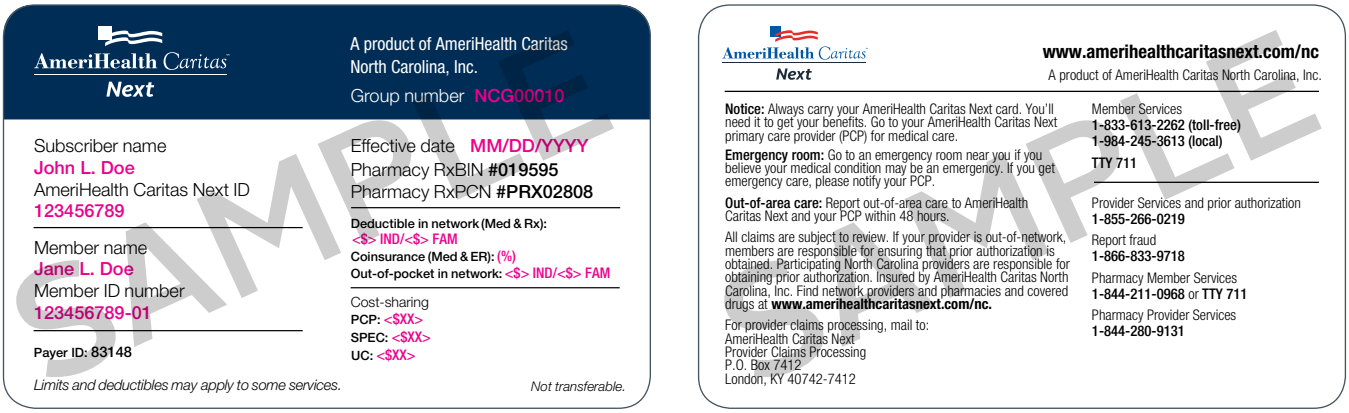
- **Letter welcoming you to the plan.**
- **Summary of Benefits and Coverage.** This is a summary of your plan's coverage. It discusses your covered benefits and any out-of-pocket costs, including copayments, coinsurance, and deductibles.
- **Member ID card.** You will be asked to present this card each time you get care or need to fill a prescription. Each member receives their own card.
  - Carry your AmeriHealth Caritas Next member ID card at all times.
  - If you lose your AmeriHealth Caritas Next ID card, call Member Services toll-free at **1-833-613-2262 (TTY 711)**.
- **Welcome brochure.** This is an explanation of your plan and the programs offered to help you stay healthy.
- **How to choose your PCP.** This material gives instructions on how to choose your PCP.

Benefits and exclusions can be found in the Evidence of Coverage or by viewing your Summary of Benefits and Coverage. These documents can be found by going to **www.amerihealthcaritasnext.com/nc**.

Once your membership is active, you may also sign up for our mobile app. In the app, you can access a copy of your member ID card at any time. Look for information about the mobile app in your member welcome packet or on our website.

You can also call Member Services at **1-833-613-2262** (**TTY 711**) to request a copy of the Evidence of Coverage or Summary of Benefits and Coverage.

Here is an example of what a member ID typically looks like:



Refer to your **Evidence of Coverage** to learn more about Dependent Member Coverage.

How to choose your primary care provider

Once you enroll, you and your covered dependents must choose a PCP. If you do not select one, we will pick one for you. You can also change your PCP if they are 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 a serious condition or disease, you may be able to select a specialist to serve as your PCP, subject to our health plan's approval. You can choose a network pediatrician as the PCP for any covered dependents under age 18.

Your PCP is a medical doctor, nurse practitioner, physician assistant, or another type of provider who will:

- Care for your health.
- Coordinate your needs.

When deciding on a PCP, you may want to find a PCP who(m):

- You have seen before.
- Understands your health history.
- Is taking new patients.
- Can serve you in your language.
- Is easy to get to.

Each family member enrolled in AmeriHealth Caritas Next can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Call Member Services at **1-833-613-2262 (TTY 711)** to get help with choosing a PCP who is right for you and your family.

You can find the list of all the doctors, clinics, hospitals, labs, and others who partner with AmeriHealth Caritas Next, in our Provider Directory. You can visit our website at **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** to look at the Provider Directory online. You can also call Member Services at **1-833-613-2262 (TTY 711)** to get a copy of the Provider Directory.

You can choose an OB/GYN to serve as your PCP. You do not need a PCP referral to see a plan OB/GYN doctor or another provider who offers reproductive health care services. You can get routine checkups, follow-up care if needed, and regular care during pregnancy.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. To learn more or to ask to choose a specialist as your PCP, call Member Services at **1-833-613-2262 (TTY 711)**. We will work with you to help coordinate the care you need that is appropriate to your condition or diagnosis.

If your provider leaves our network

If your provider leaves AmeriHealth Caritas Next, we will tell you within 15 days from when we know about this. If the provider who leaves AmeriHealth Caritas Next is your PCP, we will tell you within seven days of their departure and help you select a new PCP.

- If your provider leaves our network, we will help you find a new one.
- Even if your provider leaves our network, you may be able to stay with your provider for a while longer in certain situations.

If you have any questions, please visit our website **www.amerihealthcaritasnext.com/nc** or call Member Services at **1-833-613-2262 (TTY 711)**.

How to change your PCP

You can find your PCP's name and contact information on your member ID card. To learn more about changing your PCP, call Member Services at **1-833-613-2262 (TTY 711)**.

When to see your PCP

"Regular health care" means exams, regular checkups, shots, or other treatments to keep you well. It also includes giving you advice when you need it and referring you to the hospital or specialists when needed. You and your PCP work together to keep you well or to see that you get the care you need.

Call your PCP when you have a medical question or concern. If you call after hours or on weekends, leave a message. Let them know where or how you can be reached.

Your PCP will help take care of most of your health care needs, but you must have an appointment to see your PCP. If you cannot keep an appointment, call to let your PCP know.

Making your first regular health care appointment. As soon as you choose a PCP, if it is a new provider, call to make a first appointment. There are several things you can do to help your PCP get to know you and your health care needs.

How to prepare for your first visit with a new provider:

- Request a transfer of medical records from your current provider to your new PCP.
- Make a list of health concerns you have now. You should also be prepared to discuss your general health, past major illnesses, and surgeries.
- Make a list of questions you want to ask your PCP.
- Bring medicines and supplements you are taking to your first appointment.

It's best to visit your PCP within three months of joining the plan.

If you need care before your first appointment, call your PCP's office to explain your concern. Your PCP may give you an earlier appointment to address that particular health concern. If you are not able to get a sooner appointment, our urgent care clinics are available for any urgent health concerns. You should still keep the first appointment to talk about your medical history and ask questions.

Seeing a specialist

If you need specialized care that your PCP cannot offer, you can see any in-network specialist you choose without a referral. A specialist is a doctor who is trained and practices in a specific area of medicine (for example, a cardiologist or a surgeon). If you see an in-network specialist, it will be covered at the specialist cost share.

There are some treatments and services that your specialist must ask AmeriHealth Caritas Next to approve before you can get them. Your specialist will tell you what those services are.

If you have trouble getting the specialist care you think you need, contact Member Services at **1-833-613-2262 (TTY 711)**.

If AmeriHealth Caritas Next does not have a specialist or other provider in our provider network who can give you the care you need, we will refer you to a specialist or other provider outside our plan. This is called an **out-of-network referral**. Your PCP or another network provider must ask AmeriHealth Caritas Next for approval before you can get an out-of-network referral. You can talk to your PCP about this or call AmeriHealth Caritas Next Member Services at **1-833-613-2262 (TTY 711)** to discuss your needs and to get more details.

Sometimes we may not approve an out-of-network referral for a specific treatment. This may happen if you ask for care that is similar to what you can get from an AmeriHealth Caritas Next provider. If you do not agree with our decision, you can appeal our decision. See page 32 to find out how.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. To learn more or ask to choose a specialist as your PCP, call Member Services at **1-833-613-2262 (TTY 711)**. We will work with you to help coordinate the care you need.

Out-of-network providers

If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This specialist will be an **out-of-network provider**. To learn more about getting services from an out-of-network provider, talk to your PCP or call Member Services at **1-833-613-2262 (TTY 711)**.

Emergencies

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

Some examples of an emergency are:

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

Some examples of **nonemergencies** are colds, upset stomach, or minor cuts and bruises. Nonemergencies may also be family issues or a breakup. If you have a medical nonemergency, call your PCP.

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

You do not need approval from your plan or your PCP before getting emergency care. You are also not required to use our hospitals or doctors.

Remember: If you need to speak to your PCP after hours or on weekends, please call their after-hours line and leave a message. Let them know how you can be reached. Your PCP will get back to you as soon as possible.

Leaving a message in the after-hours mailbox does not take the place of your doctor. Always follow up with your doctor directly if you have questions about your health care.

If you are out of the area when you have an emergency, **go to the nearest ER.**

Remember: Use the ER only if you have an emergency. If you have questions, call AmeriHealth Caritas Next Member Services at **1-833-613-2262 (TTY 711)** or your PCP.

Urgent care

You may have an injury or an illness that is not an emergency but still needs prompt care and attention.

This could be:

- A child with an earache who wakes up in the middle of the night and won't stop crying
- The flu
- A cut that needs stitches
- A sprained ankle
- A bad splinter you cannot remove

Whether you are at home or away, you can go to an urgent care clinic to get care the same day or make an appointment for the next day. If you would like help with making an appointment:

- Call your PCP any time, day or night.
- If you are unable to reach your PCP, call Member Services at **1-833-613-2262 (TTY 711)**. Tell the person who answers what is happening. They will tell you what to do.

Care outside North Carolina and the United States

In some cases, such as urgent or emergent care, AmeriHealth Caritas Next pays for health care services you get from a provider located in another state. This coverage is subject to the terms and conditions in your Evidence of Coverage. Your PCP and AmeriHealth Caritas Next can give you more information about which providers and services are covered outside North Carolina by your health plan and how you can get care if needed.

If you need medically necessary emergency care while traveling **anywhere within the United States and its territories,** AmeriHealth Caritas Next will pay for your care.

Treatment outside of the United States is not covered unless you have a medical emergency while traveling.

If you have any questions about getting care outside North Carolina or the United States, talk with your PCP or call Member Services **1-833-613-2262 (TTY 711)**.

Hospital services

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

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

New technology for medical procedures

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

Prescription drug benefits

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

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

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

Formulary

The list of prescription drugs covered under this plan is called a formulary. The formulary applies only to drugs you get at retail, mail-order, and specialty pharmacies. Along with the covered drugs, the formulary also allows you to review any limitations or restrictions such as prior authorization, step therapy, quantity limits, and age limits. The formulary does not apply to drugs you get if you are in the hospital. For our latest pharmacy benefit and formulary information, please visit **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** or call us at **1-844-211-0968 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m.**

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

The formulary covers brand (preferred and nonpreferred), specialty and generic drugs and will determine what your out-of-pocket costs will be under our plan based on the drug tier. Please refer to your Summary of Benefits and Coverage for more information on copays and deductibles.

Covered prescription drugs and supplies

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

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

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

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

- Oral and injectable drug therapies used in the treatment of covered infertility services only when you have been approved for covered infertility treatment.
- Compounded medications: If at least one active ingredient requires a prescription by law and is approved by the U.S. Food and Drug Administration (FDA). Compounding kits that are not FDA approved and include prescription ingredients that are readily

available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call the Member Services team. Some compounded medications may be subject to prior authorization.

- We will also cover certain off-label uses of cancer drugs in accordance with state law. To qualify for off-label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following compendia: (1) National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium; (2) The Thompson Micromedex DrugDex; (3) American Hospital Formulary Service; (4) Lexi-Drugs; or (5) any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Included in the formulary are:

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

Narrow therapeutic index (NTI) drugs

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

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

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

Preventive medications

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

These include certain medications in the following categories:

- Bowel preparations — for members from ages 45 to 75
- Oral fluoride supplementation — for members from ages 6 months to 5 years
- Moderate-intensity statins — for members from ages 40 to 75 years
- Folic acid 400 to 800 micrograms (mcg) — for members of childbearing age
- Aspirin 81 milligrams (mg) — to prevent or delay the onset of preeclampsia
- Tobacco cessation
  - Nicotine gum
  - Nicotine lozenge
  - Nicotine patch
  - Bupropion hydrochloride (smoking deterrent) tablet, extended-release 12-hour, 150 mg
  - Varenicline tartrate
- HIV pre-exposure prophylaxis (PrEP)
  - Descovy (emtricitabine/tenofovir alafenamide 200 mg-25 mg), oral tablet
  - Emtricitabine/tenofovir disoproxil fumarate (DF) 200 mg-300 mg, oral tablet

- Breast cancer primary prevention
  - Anastrozole, oral tablet 1 mg
  - Exemestane, oral tablet 25 mg
  - Letrozole, oral tablet 2.5 mg
  - Raloxifene HCL, oral tablet 60 mg
  - Tamoxifen citrate, oral tablet 10 mg and 20 mg
- Vaccines recommended by Advisory Committee on Immunization Practices (ACIP)
- Contraception: As a requirement of the Women's Prevention Services provision of the ACA, contraceptives are covered at 100% for generic products when prescribed by a participating network provider.

  Contraceptive categories include*:
  - Oral contraceptives
  - Injectable contraceptives
  - Barrier methods (by prescription [Rx])
  - Intrauterine devices**, subdermal rods**, and vaginal rings (Rx)
  - Transdermal patches (Rx)
  - Emergency contraception (Rx or over-the-counter [OTC])
  - Condoms (OTC)
  - Female condoms (OTC)
  - Vaginal pH modulators (Rx)
  - Vaginal sponges (OTC)
  - Spermicides (OTC)

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

Note: A prescription is required for all listed medications, including over-the-counter (OTC) medications.

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

Exclusions

What is not covered:

- Any drug products used exclusively for cosmetic purposes
- Experimental drugs, which are those that cannot be marketed lawfully without the approval of the FDA and for which such approval has not been granted at the time of their use or proposed use, or for which such approval has been withdrawn
- Prescription drugs that are not approved by the FDA
- Drugs on the FDA Drug Efficacy Study Implementation (DESI) list
- Immunization agents or vaccines not listed on the formulary. Some immunizations may be covered under the medical benefit.
- Medical supplies*
- Mifepristone 200mg (Mifeprex 200mg)*
- Prescription and over-the-counter homeopathic medications
- Drugs that by law do not require a prescription (OTC) unless listed on the formulary as covered
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, fluoride for children, and supplements for the treatment of mitochondrial disease)
- Topical and oral fluorides for adults
- Medications for the treatment of idiopathic short stature
- Prescriptions filled at pharmacies other than network-designated pharmacies, except for emergency care or other permissible reasons. An override will be required to allow the pharmacy to process the claim.

- Prescriptions filled through an internet pharmacy that is not a verified internet pharmacy practice site certified by the National Association of Boards of Pharmacy
- Prescription medications when the same active ingredient, or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication, has become available over the counter. In these cases, the specific medication may not be covered, and the entire class of prescription medications also may not be covered.
- Prescription medications when copackaged with nonprescription products
- Medications packaged for institutional use will be excluded from the pharmacy benefit coverage unless otherwise noted on the formulary.
- Drugs used for erectile dysfunction or sexual dysfunction
- Drugs used for weight loss
- Bulk chemicals
- Repackaged products

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

For our latest pharmacy benefit and formulary information, please visit **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** or call us at **1-844-211-0968 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m.**

Formulary changes

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

Formulary tier explanation

Tier 1 — Generics

Tier 2 — Preferred Brand

Tier 3 — Nonpreferred Brand

Tier 4 — Specialty

Please see your Schedule of Benefits for your copay and coinsurance cost-share responsibility.

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

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

Prior authorizations (PA)

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

Step therapy (ST)

Step therapy is a type of prior authorization program

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

Quantity limits (QL)

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

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

Age limits (AL)

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

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

Generic drugs

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

New-to-market drugs

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

Non-formulary drugs

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

Noncovered drugs with over-the-counter alternatives

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

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

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

Prior authorization and exception requests

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

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

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

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

and

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

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

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

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

Your provider can request for both formulary drug prior authorizations (PA, ST, QL, and AL) and non-formulary exceptions in the following ways:

- Electronically: Directly to AmeriHealth Caritas Next's PBM, at **https://ppa.performrx.com/PublicUser/OnlineForm/OnlineFDBSingleForm.aspx?cucu_id=Y65L6nti7Fh2jJt8A7Rsjw%3d%3d**.
- Standard requests by fax: **1-855-756-9901**
- Expedited (fast)* requests by fax: **1-866-533-5497**
- By mail: **200 Stevens Drive, CC: 236**
  Philadelphia, PA 19113
- By phone: **1-844-211-0968 (TTY 711)**

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

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

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

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

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

You can ask for an appeal yourself. You may also ask a friend, a family member, your provider, or a lawyer to help you. You can call AmeriHealth Caritas Next at **1-833-613-2262 (TTY 711**) if you need help with your appeal request. It's easy to ask us for an appeal by using one of the options below:

- Mail: Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 180 days from the date of our written notice denying your claim or your request for service.
- Fax: Fill out, sign, and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax number listed on the form.
- By phone: Call **1-855-375-8811 (TTY 1-866-209-6421**) and ask for an appeal.

For more information on appeals, please see the section on Appeals on page 32.

Non-formulary exception request denial rights

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

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

- Web: **External Review Request Form** can be found at: **https://secure1.ncdoi.com/ consumer/ext_review_entry.jsp**.

  FAQs and more info about external review can be found at **https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review**.

- Mail: **North Carolina Department of Insurance**
  Health Insurance Smart NC
  1201 Mail Service Center
  Raleigh, NC 27699-1201
- Phone: **1-855-408-1212**
- Fax: **1-919-807-6865**

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

Specialty drug program

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

Filling prescriptions at the pharmacy

Retail pharmacy — You can fill up to a 30-day supply.

Mail-order pharmacy — You can fill a 31- to 90-day supply.

Specialty pharmacy — You can fill up to a 30-day supply.

Mail-order pharmacy

We use Alliance Rx Walgreens Pharmacy as our mail-order pharmacy. You must register and have your prescriptions sent to Alliance Rx Walgreens Pharmacy.

Alliance Rx Walgreens Pharmacy
P.O. Box 29061
Phoenix, AZ 85038-9061

Alliance Rx Walgreens Pharmacy Customer Care Center
Phone: **1-800-345-1985**
Fax: **1-480-752-8250**
https://www.alliancerxwp.com/

COVID-19

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

For details on the latest formulary information on COVID-19 vaccines, please visit **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** or call us at **1-833-613-2262 (TTY 711)**.

School supply

AmeriHealth Caritas Next allows school supplies for the following medications:

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

For our latest pharmacy benefit and formulary information, please visit **https://www.amerihealthcaritasnext.com/nc/members/find-a-provider-or-pharmacy.aspx** or call us at **1-833-613-2262** (**TTY 711**).

Behavioral health benefits

AmeriHealth Caritas Next's affordable health care plans provide access to whole-person care, including behavioral health care.

Behavioral health care includes mental health (your emotional, psychological, and social well-being) and substance (alcohol and drugs) use disorder treatment and rehabilitation services. All AmeriHealth Caritas Next members have access to services to help with mental health issues, like depression or anxiety, or to help with alcohol or other substance use disorders.

Members experiencing a mental health crisis can call or text the local North Carolina Department of Health and Human Services Behavioral Health Crisis line:

HOPE4NC: **1-855-587-3463** or text "hope" to **1-855-587-3463**.

If you are in danger or need immediate medical attention, call **911**.

Additionally, if you are having thoughts of harming yourself, call the National Suicide and Crisis Lifeline at **988**.

Behavioral health services

(Mental health and substance use disorder services)

These services may require preauthorization.

Call Member Services at **1-833-613-2262** (**TTY 711**) to learn which services require preauthorization, or if you have any questions about behavioral health benefits.

Mental and behavioral health services

Mental/behavioral health outpatient office visits	Mental/behavioral health outpatient nonoffice services
Mental health or substance dependence assessment	Outpatient rehabilitation services in individual or group settings
Diagnostic testing/assessment	Day treatment programs
Psychological testing	Outpatient opioid treatment

Mental and behavioral health services, *continued*

Ambulatory detoxification

Mental/behavioral health inpatient services facility fees

Mental/behavioral health inpatient services physician or surgeon fees

Emergency care

Psychiatric inpatient hospitalization

Partial hospitalization

Short-term partial hospitalization

Mobile crisis management

Electroconvulsive therapy

Chemical dependency/substance use disorder services

Chemical dependency/substance use disorder outpatient office visits

Diagnostic assessment

Chemical dependency/substance use disorder outpatient nonoffice services

Medication-assisted treatment (MAT)

Nonhospital medical detoxification

Medication management when provided in conjunction with a consultation

Chemical dependency/substance use disorder inpatient services facility fees

Chemical dependency/substance use disorder inpatient services physician or surgeon fees

Detoxification and related medical services when required for the diagnosis and treatment of addiction to alcohol and/or drugs

If you have any questions about behavioral health services or if you believe you need access to more intensive behavioral health services that your plan may not provide, like psychiatric residential treatment facilities or assertive community treatment, talk with your primary care provider or call Member Services at **1-833-613-2262 (TTY 711)**.

Bright Start® program

AmeriHealth Caritas Next wants to support you in having the healthiest pregnancy possible. We will help you:

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

Utilization Management

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

Prior authorizations

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

Your provider will need to get services authorized through AmeriHealth Caritas Next, even if an authorization previously existed. If you have questions about **prior authorizations**, please call Member Services at **1-833-613-2262 (TTY 711)**.

Prior authorization process

To ask for a **prior authorization**, you or your provider can contact AmeriHealth Caritas Next by calling Member Services at **1-833-613-2262 (TTY 711)**. Providers can also submit requests online through the provider portal.

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

1. AmeriHealth Caritas Next will work with your provider to collect information to help show us that the service is medically necessary.
2. AmeriHealth Caritas Next nurses, doctors, and behavioral health clinicians review the information. They use policies and guidelines approved by the North Carolina Department of Health and Human Services to see if the service is medically necessary.
3. If the request is approved, we will let you and your health care provider know it was approved.
4. If the request is not approved, a letter giving the reason for the decision will be sent to you and your health care provider.

You can appeal any decision AmeriHealth Caritas Next makes. If you receive a denial and would like to appeal it, talk to your provider. Your provider will work with AmeriHealth Caritas Next to determine if there were any problems with the information that was submitted.

You can contact the Commissioner at:

North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Toll-free phone:
1-855-408-1212

You may also contact Health Insurance Smart NC for help at:

Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Toll-free phone:
1-855-408-1212

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. This decision is called an **adverse benefit determination**. You will receive a letter from AmeriHealth Caritas Next notifying you of any adverse benefit determination. You have 180 days from the date on your letter to ask for an appeal. When members do not agree with our decisions on an appeal, they can contact the NCDOI at:

Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Toll-free phone: **1-855-408-1212**

Health Insurance Smart NC is available to provide assistance on AmeriHealth Caritas Next's internal appeals and grievance issues. You may be eligible to request an expedited external review from NCDOI. Expedited external review is available if you have a medical condition where the time frame for completion of an expedited appeal with us would reasonably be expected to seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

When you ask for an appeal, AmeriHealth Caritas Next has 30 days to give you an answer. You can ask questions and give any updates (including new medical documents from your providers) that you think will help us approve your request. You may do that in person, in writing, or by phone.

You can ask for an appeal yourself. You may also ask a friend, a family member, your provider, or a lawyer to help you. You can call AmeriHealth Caritas Next at **1-833-613-2262 (TTY 711)** if you need help with your appeal request. It's easy to ask us for an appeal by using one of the options below:

- **Mail:** Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 120 days after the date on the denial letter.
- **Fax:** Fill out, sign, and fax the Appeal Request Form in the denial letter you receive about our decision. You will find the fax number listed on the form.
- **By phone:** Call **1-833-613-2262 (TTY 711)** and ask for an appeal.

When you appeal, you and any person you have chosen to help you can see the health records and criteria AmeriHealth Caritas Next used to make the decision. If you choose to have someone help you, you must give them written permission by signing a Personal Representative Request Form, which can be obtained by calling Member Services at **1-833-613-2262 (TTY 711).**

Expedited (faster) appeals

You or your provider can ask for a faster review of your appeal when a delay will cause serious harm to your health or to your ability to regain your good health. This faster review is called an **expedited appeal**.

Your provider can ask for an expedited appeal by calling Member Services at **1-833-613-2262 (TTY 711)**.

You can ask for an expedited appeal by phone, by mail, or by fax. There are instructions on your Appeal Request Form that will tell you how to ask for an expedited appeal.

Provider requests for expedited appeals

If your provider asks us for an expedited appeal, we will give a decision no later than 72 hours after we get the request for an expedited appeal. We will call you and your provider as soon as there is a decision. We will send you and your provider a written notice of our decision no later than four days after receiving all necessary information to process your appeal.

Member requests for expedited appeals

AmeriHealth Caritas Next will review all member requests for expedited (faster) appeals. If a member's request for an expedited appeal is denied, we will call you during our business hours promptly following our decision. We also will tell the member and the provider in writing if the member's request for an expedited appeal is denied. We will tell you the reason for the decision. AmeriHealth Caritas Next will mail you a written notice within two calendar days.

If you do not agree with our decision to deny an expedited appeal request, you may file a grievance with us. (See page 39 for more information on grievances.)

When we deny a member's request for an expedited appeal, there is no need to make another appeal request. The appeal will be decided within 30 days of your request. In all cases, we will review appeals as fast as a member's medical condition requires.

Timelines for standard appeals

If we have all the information we need, you will have a decision in writing within 30 days from the day we get your appeal request. We will mail you a letter to tell you about our decision. If we need more information to decide about your appeal, we will:

- Write to you and tell you what information is needed.
- Explain why the delay is in your best interest.
- Decide no later than 14 days from the day we asked for more information.

If you need more time to gather records and updates from your provider, just ask. You or a helper you name may ask us to delay your case until you are ready. Ask for an extension by calling Member Services at **1-833-613-2262 (TTY 711)** or writing to:

AmeriHealth Caritas Next
P.O. Box 7417
London, KY, 40742-7417

Decisions on appeals

When we decide your appeal, we will send you a letter. This letter is called a **Notice of Decision**.

The Commissioner of Insurance in North Carolina is available to help. You can contact the Commissioner at:

North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Toll-free phone: **1-855-408-1212**

You may also contact Health Insurance Smart NC for help at:

Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Toll-free phone: **1-855-408-1212**

Independent external review

North Carolina law provides for review of noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. We will notify you in writing of your right to request an external review each time you:

- Receive a noncertification decision.
- Receive an appeal decision upholding a noncertification decision.

In order for your request to be eligible for external review, the NCDOI must determine the following:

- That your request is about a medical necessity determination that resulted in a noncertification decision;
- That you had coverage with us in effect when the noncertification decision was issued;
- That the service for which the noncertification was issued appears to be a covered health service under your policy; and
- That you have exhausted our internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, you will be considered to have exhausted the internal review process if you have:

- Completed our appeal and received a written determination from us, or
- Received notification that we have agreed to waive the requirement to exhaust the internal second-level grievance process.

If your request for a standard external review is related to a retrospective noncertification (a noncertification which 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 received a written final determination.

If you wish to request a standard external review, you (or your representative) must make this request to NCDOI within 120 days of receiving our written notice of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with 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.

Within 10 business days of receipt of your request for a standard external review, the NCDOI will notify you and your provider of whether your request is complete and whether it is accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 days of the date of our written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include:

- The name and contact information for the IRO assigned to your case;
- A copy of the information about your case that we have provided to the NCDOI;
- Notice that we will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
- Notification that you may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within seven days after receipt of the notice of acceptance.

If you choose to provide any additional information to the IRO, you must also provide that same information to us at the same time using the same means of communication (e.g., you must fax the information to us if you faxed it to the IRO).

Please note that you may also provide this additional information to the NCDOI within the seven-day deadline rather than sending it directly to the IRO and to us. The NCDOI will forward this information to the IRO and us within two business days of receiving your additional information.

The IRO will send you written notice of its determination within 45 days of the date the NCDOI received your standard external review request. If the IRO's decision is to reverse the noncertification, we will reverse the noncertification decision within three business days of receiving notice of the IRO's decision and provide coverage for the requested service or supply that was the subject of the noncertification decision. If you are no longer covered by us at the time we receive notice of the IRO's decision to reverse the noncertification, we will only provide coverage for those services or supplies

you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a noncertification decision may be available if you have a 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. If you meet this requirement, you may make a written or verbal request to the NCDOI for an expedited review after you:

- Receive a noncertification decision from us AND file a request for an expedited appeal, or
- Receive an appeal decision upholding a noncertification decision.

You may also make a request for an expedited external review if you receive an adverse appeal decision concerning a noncertification of an admission, availability of care, continued stay, or emergency care but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within two days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may:

- Accept the case for standard external review if our internal review process was already completed.
- Require the completion of our internal review process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective noncertifications.

The IRO will communicate its decision to you within three days of the date the NCDOI received your request for an expedited external review. If the IRO's decision is to reverse the noncertification, we will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If you are no longer covered by us at the time we receive notice of the IRO's decision to reverse the noncertification, we will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified 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 noncertification decision for which you have already received an external review decision.

For further information about external review or to request an external review, contact the NCDOI at:

Via internet: **https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied**

By mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201

Fax: **1-919-807-6865**

In person:
NC Department of Insurance
3200 Beechleaf Court
Raleigh, NC 27604

Phone: **1-855-408-1212** (toll-free)

Health Insurance Smart NC for external review information and request form

The Health Insurance Smart NC Program is also available to provide assistance to consumers who wish to file an appeal or grievance with their health plan.

If you believe you are eligible for and request an expedited appeal, you may be eligible to request an expedited external review from NCDOI. Expedited external review is available if you have a medical condition where the time frame for completion of an expedited appeal with us would reasonably be expected to seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

Grievances

If you have problems with your health plan, you can file a grievance.

We hope our health plan serves you well. If you are unhappy with or have a complaint about the plan or your health care service, you may talk with your PCP. You may also call Member Services at **1-833-613-2262** (**TTY 711)** or write to:

AmeriHealth Caritas Next
Attention: Appeals and Grievances
P.O. Box 7379
London, KY 40742
Fax: 1-844-201-6798

A grievance and a complaint are the same thing. Contacting us with a grievance means that you are unhappy with your health plan, provider, or your health services. Most problems like this can be solved right away. Whether we solve your problem right away or need to do some work, we will record your call, your problem, and our solution. We will inform you in writing that we have received your grievance. We will also send you a written notice when we have finished working on your grievance.

You can ask a family member, a friend, your provider, or a legal representative to help you with your complaint. If you need our help because of a hearing or vision impairment, if you need translation services, or if you need help filling out any forms, we can help you. You can contact us by phone or in writing:

- **By phone:** Call Member Services at **1-833-613-2262 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m.** After business hours, you may leave a message and we will contact you during the next business day.
- **By mail:** You can write to us with your complaint to:

  AmeriHealth Caritas Next
  Attention: Appeals and Grievances
  P.O. Box 7379
  London, KY 40742
  Fax: 1-844-201-6798

Resolving your grievance

We will let you know in writing within three days of receiving it that we got your grievance. If your grievance is regarding the quality of clinical care provided to you by your network provider, we will let you know in writing within 10 business days that we got your grievance. The acknowledgement letter will advise that your grievance is being referred to the Quality Assurance Committee for review and consideration or for any appropriate action against your provider.

We will review your complaint and tell you in writing within 30 days from receiving your complaint how we resolved it.

These issues will be handled according to our Evidence of Coverage. You can find them online at **www.amerihealthcaritasnext.com/nc**.

The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department at 1201 Mail Service Center, Raleigh, NC 27699, or by phone at **1-800-546-5664**.

Second-level grievance review

If you are dissatisfied with our response to the first-level grievance, you or your provider acting on your behalf may submit additional information, including written comments, records, or documents, along with a letter requesting a second-level review of your grievance to the address below:

Member Grievances
P.O. Box 7415
London, KY 40742-7415

You may also submit these documents via fax to **1-833-887-2262**.

Grievances regarding the quality of clinical care provided by your network provider are not eligible for a second-level grievance review.

Within 10 days of receiving your request for a second-level review, we will provide you with information on the grievance process and your rights. We will also send you the name, address, and phone number of the grievance review coordinator when they have been determined. For the second-level review, you (or your representative) have the right to present your case to the review panel, and you may submit additional material before or during the review meeting. You have the right to ask questions of any member of the review panel, as well as the right to be represented or assisted by a person of your choosing, including a family member, employer representative, or attorney.

Your grievance will be reviewed by the review panel. The review panel will schedule a review meeting within 45 days after receiving your request for a second-level review. We will notify you of the date of the review meeting, in writing, at least 15 days before the meeting takes place. Your right to a full review will not be conditioned on attendance of the review meeting.

We will make our decision and notify you and your provider in writing within seven business days of the review meeting. This notification will include the professional qualifications and licensure of the review panel members, a statement of the review panel's understanding of your grievance, and the review panel's recommendation and rationale along with a description of the evidence that was considered.

Expedited grievance review

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, please call Member Services immediately to file an expedited grievance. We will notify you orally of the determination within 72 hours after receipt of the expedited review request. We will then send written confirmation to you within three business days.

You may request expedited review of the first- or second-level grievance. You may request an expedited review of the second-level grievance review regardless of whether any initial review was expedited. Expedited reviews will meet all requirements of non-expedited reviews as described in our grievance procedures and in accordance with NCGS 58-50-62(f), (g), and (h) with changes to the time table.

When you are eligible for an expedited second-level review, we will conduct the review proceeding and communicate the decision within four days after receiving all necessary information. The review meeting may take place by way of a phone conference call or through the exchange of written information.

Fraud, waste, and abuse

How do I report provider fraud, waste, or abuse?

Fraud is an intentional deception or misrepresentation by a person or an entity, with the knowledge that the deception could result in some unauthorized benefit to himself/herself or to some other person. Examples of provider fraud include a provider knowingly billing for services, equipment, or medicines you did not get, or intentionally billing for a different service than the service you received. Billing for the same service more than once, or changing the date of the service, are also examples of possible provider fraud. To report provider fraud, you can call the AmeriHealth Caritas Next Fraud and Abuse Hotline at **1-866-833-9718 (TTY 711)**.

You may also report this information to the DHS Fraud and Abuse Reporting Hotline at **1-844-DHSTIPS** (**1-844-347-8477**).

You may report insurance fraud using any of the following methods:

- Report insurance fraud online at **https://www.ncdoi.gov/fraud-control/report-insurance-fraud**.
- Phone: **919-807-6840** or toll-free **888-680-7684** (NC Only)
- Fax: **919-715-1156**
- Mail:
  Criminal Investigations Division
  NC Department of Insurance
  1201 Mail Service Center, Raleigh, NC 27699-1201

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 you.

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

Out-of-network provider claims

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 the time required 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 and in no event, except in the absence of legal capacity of the member, later than one year from the time submittal of the claim is otherwise required.

Notice of claim

Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to AmeriHealth Caritas Next or our agent. Notice should include the name of the insured and the policy number. To give notice of a claim, please call us at the phone number listed on your member ID card to obtain a claim form. You must sign the claim form before we will issue payment to a provider or reimburse you for covered health services received under this policy. You must complete a claim form for services rendered by an out-of-network provider and submit it, together with an itemized bill and proof of payment, to AmeriHealth Caritas Next, 200 Stevens Drive, Philadelphia, PA 1911.

Reimbursement

Reimbursement will be made only for covered health services received in accordance with the provisions of your Evidence of Coverage. In the event you are required 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.

Time of payment of claims

Claim payments for benefits payable under this policy will be processed immediately upon receipt of a proper proof of loss. After receiving a claim form, we will either make a request for additional information or make a coverage decision within 30 calendar days.

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 or covered by any note or written order may be deducted from the claim payment.

Continuity or transition of care

In order to receive these services, you must obtain prior authorization and medically necessary review from the health benefit plan.

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 or honor an existing prior authorization. If the member is pregnant and in their second or third trimester, pregnancy-related services will be covered through 60 calendar days postpartum.

If a network provider stops participating in our network, they become an out-of-network

provider. If you are in active treatment for a serious condition or illness, you may continue receiving care from that out-of-network provider through your continuity or transition of care coverage. This coverage will end when treatment for the condition is completed or you change providers to a network provider, whichever comes first. This coverage is provided for a maximum of 90 days. Pregnant members in their second or third trimester of pregnancy who have started prenatal care with a provider who stops participating in our network can continue receiving pregnancy-related services including postpartum care through 60 calendar days after the birth. This continuity of care allowance does not apply to providers whose participation as network providers has been terminated for cause by the plan.

If your provider determines you to be terminally ill at the time they stop participating in our network or at the time of enrollment under our plan, and the provider was treating your terminal illness before the date of the provider's termination or your new enrollment in our plan, the transitional period shall extend for the remainder of your life for care directly related to the treatment of your terminal illness or its medical manifestations.

Care Management

AmeriHealth Caritas Next has programs to help keep you healthy. Our programs help members who have multiple health conditions; these members can be eligible for complex care management. People with other conditions, such as pregnancy and mental health, can benefit from our health programs as well.

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

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

- The member's Care Manager
- Member Services at **1-833-613-2262 (TTY 711**)

Or by visiting **www.amerihealthcaritasnext.com/nc**.

Member rights and responsibilities

Your rights

As a member of AmeriHealth Caritas Next, you have the right to:

- Receive information about the health plan, its benefits, services included or excluded from coverage policies, and network providers' and members' rights and responsibilities; written and web-based information that is provided to you must be readable and easily understood.
- Be treated with respect and be recognized for your dignity and right to privacy.
- Participate in decision-making with providers regarding your health care; this right includes candid discussions of appropriate or medically necessary treatment options for your condition, regardless of cost or benefits coverage.
- Voice grievances or appeals about the health plan or care provided and receive a timely response. You have a right to be notified of the disposition of appeals or grievances and the right to further appeal, as appropriate.
- Make recommendations regarding our member rights and responsibilities policies by contacting Member Services in writing.
- Choose providers, within the limits of the provider network, including the right to refuse care from specific providers.
- Have confidential treatment of personally identifiable health or medical information. You also have the right to access your medical record in accordance with applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, sex, gender, national origin, or source of payment.
- Formulate advance directives. The plan will provide information concerning advance directives to members and providers and will support members through our medical record-keeping policies.
- Obtain a current directory of network providers upon request. The directory includes addresses, phone numbers, and a listing of providers who speak languages other than English.
- File a complaint or appeal about the health plan or care provided with the applicable regulatory agency and receive an answer to those complaints within a reasonable period of time.
- Appeal a decision to deny or limit coverage through an independent organization. You also have the right to know that your provider cannot be penalized for filing a complaint or appeal on your behalf.
- Obtain assistance and referrals to providers who are experienced in treating your disabilities if you have a chronic disability.
- Have candid discussions of appropriate or medically necessary treatment options for your condition, regardless of cost or benefits coverage, in terms that you understand, including an explanation of your medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If you are unable to easily understand this information, you have the right to have

an explanation provided to your designated representative and documented in your medical record. The plan does not direct providers to restrict information regarding treatment options.

- Have services available and accessible when medically necessary, including availability of care 24 hours a day, seven days a week, for urgent and emergency conditions.
- Call 911 in a potentially life-threatening situation without prior approval from the plan, and to have the plan pay per contract for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Continue receiving services from a provider who has been terminated from the plan's network (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the provider is terminated for reasons that would endanger you, public health, or safety, or which relate to a breach of contract or fraud.
- Have the rights afforded to members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- Receive prompt notification of terminations or changes in benefits, services, or the provider network.
- Have a choice of specialists among network providers following an authorization or referral as applicable, subject to their availability to accept new patients.

Your responsibilities

As a member of AmeriHealth Caritas Next, you have the responsibility to:

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

Notice of Nondiscrimination

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation. AmeriHealth Caritas Next provides free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats. If you need these services, contact the Member Services number on the back of your card. If you believe that AmeriHealth Caritas Next has failed to provide these services or discriminated in another way, you can file a grievance with AmeriHealth Caritas Next Attention: Appeals and Grievances, P.O. Box 7379, London, KY 40742 or fax: **1-844-201-6798**.

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

OTH-NonDiscrimination(2025)-NC

We speak your language

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

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

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

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

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

Nous fournissons gratuitement des services linguistiques et des informations à ceux dont la langue principale n'est pas l'anglais. Pour communiquer avec un interprète, appelez l'équipe service aux adhérents au numéro indiqué au dos de votre carte.

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

Peb muab kev pab cuam txhais lus pub dawb thiab cov ntaub ntawv rau cov neeg uas hom lus ib txwm hais tsis yog lus Askiv. Txhawm rau txuas lus nrog ib tus kws pab txhais lus, hu rau tus npawb xov tooj Pab Cuam Tswv Cuab nyob sab tom qab ntawm koj daim npav.

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

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

અમે એવા લોકોને નિ:શુલ્ક ભાષા સેવાઓ અને માહિતી પ્રદાન કરીએ છીએ જેમની પ્રાથમિક ભાષા અંગ્રેજી નથી. દુભાષિયા સાથે વાત કરવા માટે, તમારા કાર્ડની પાછળ આપેલ સભ્ય સેવા નંબર પર કૉલ કરો.

We speak your language

យើងផ្តល់ជូនសេវាកម្មភាសា និងព័ត៌មានដោយឥតគិតថ្លៃទៅដល់អ្នកដែលមានភាសាទីមួយមិនមែនជាភាសាអង់គ្លេស ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ សូមហៅទៅលេខទូរស័ព្ទរបស់សេវាកម្មសមាជិកនៅខាងខ្នងនៃប័ណ្ណរបស់អ្នក ។

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

हम उन लोगों को मुफ्त भाषा सेवाएं और जानकारी प्रदान करते हैं जिनकी प्राथमिक भाषा अंग्रेजी नहीं है। दुभाषिए से बात करने के लिए, अपने कार्ड के पीछे सदस्य सेवाओं के नंबर पर कॉल करें।

ພວກເຮົາໃຫ້ບໍລິການພາສາຟຣີແລະຂໍ້ມູນຂ່າວສານສໍາລັບຜູ້ທີ່ພາສາຂອງທ່ານບໍ່ແມ່ນພາສາອັງກິດ. ເພື່ອໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາເບີບໍລິການສະມາຊິກຢູ່ດ້ານຫຼັງບັດຂອງທ່ານ.

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

AmeriHealth Caritas℠

Next

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www.amerihealthcaritasnext.com/nc

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