Healthy DC Plan
Enrollee Agreement and Evidence of Coverage

AmeriHealth Caritas District of Columbia (DC)
1201 Maine Ave. SW
10th Floor, Ste. 1000
844-214-2470

INDIVIDUAL ENROLLMENT AGREEMENT
FOR A HEALTHY DC PLAN

This Individual Enrollment Agreement, including any attachments, notices, amendments and riders is issued to the Enrollee, and contains the principal provisions affecting the Enrollee and other provisions that explain the duties of AmeriHealth Caritas DC and those of the Enrollee. The Agreement, in its entirety, is the complete contract between AmeriHealth Caritas DC and the Enrollee.

The Enrollee accepts and agrees to the Agreement by selecting AmeriHealth Caritas DC's Healthy DC Plan. AmeriHealth Caritas DC agrees to the Agreement when it is issued to the Enrollee. The Enrollee's selection of AmeriHealth Caritas DC's Healthy DC Plan, triggering payment for the plan from the Healthy DC Plan Trust Fund and AmeriHealth Caritas DC's issuance make the Agreement's terms and provisions binding on AmeriHealth Caritas DC and the Enrollee.

AmeriHealth Caritas DC may, under certain circumstances, terminate the Agreement. See Section 3 of the Agreement for additional information.

NOTE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, AmeriHealth Caritas DC may deny insurance benefits if false information materially related to a claim was provided by the applicant.

AmeriHealth Caritas DC recommends that the Enrollee familiarizes himself or herself with the AmeriHealth Caritas DC complaint and appeal procedure and make use of it before taking any other action.

THE ENROLLEE MAY CANCEL THIS AGREEMENT WITHIN TEN (10) DAYS
The Enrollee may cancel this Agreement by notifying AmeriHealth Caritas DC or the Healthy DC Plan in writing within ten (10) days of the date he or she received it. AmeriHealth Caritas DC will cancel the Enrollee's coverage at midnight on the day AmeriHealth Caritas DC or the Healthy DC Plan receives the cancellation notice. AmeriHealth Caritas DC will refund any Healthy DC Plan Trust Fund payments to the Healthy DC Plan Trust Fund for coverage beyond the cancellation date. If any Enrollee utilizes Covered Services during the ten (10) day period, the Enrollee must pay for those services.

Term: This Agreement will have an initial term from the Agreement Effective Date stated above until December 31st of that year. The Agreement will automatically be renewed from year to year on January 1st of each succeeding year unless terminated by AmeriHealth Caritas DC or the Enrollee or the Application Filer.

AmeriHealth Caritas District of Columbia (DC)

Karen M. Dale

Karen Dale, R.N., MSN
Market President

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SECTION 1
DEFINITIONS

The underlined terms when capitalized are defined as follows:

Adoption means the earlier of a judicial decree of adoption or, the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152).

Agreement means this agreement between AmeriHealth Caritas DC and the Enrollee and it includes the Individual Enrollment Agreement, Benefit Determinations and Appeals, Description of Covered Services, Schedule of Benefits, and any duly authorized notices, amendments, and riders.

Allowed Benefit means:

A. For a Contracting Provider, the Allowed Benefit for a Covered Service is the amount agreed upon between AmeriHealth Caritas DC and the Contracting Provider which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance amounts, for which the Enrollee is responsible.

B. For a Non-Contracting Provider, there is no Allowed Benefit, other than for Emergency Services.

C. For Emergency Services provided by a Non-Contracting Provider the Enrollee is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits. AmeriHealth Caritas DC will ensure that the provider does not bill the Enrollee directly for any amounts beyond any applicable Deductible, Copayment, or Coinsurance.

Annual Open Enrollment Period means the periods during each Calendar Year, as designated by the Healthy DC Plan or applicable law, during which a Qualified Individual may enroll or change coverage in a Healthy DC Plan.

Benefit Period means the Calendar Year during which coverage is provided for Covered Services.

Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Enrollee after the Enrollee's death to help the Immediate Family or Family Caregiver cope with the death of the Enrollee.

Brand Name Drug means a Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and may be used and protected by a trademark.

Calendar Year means January 1 through December 31 of each year.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process, and enhance the psychosocial and vocational status of eligible Enrollees.

Civil Union means a same-sex relationship similar to marriage that is recognized by law. The Enrollee's partner in a Civil Union is eligible for coverage to the same extent as an eligible Spouse.

Coinsurance means the percentage of the Allowed Benefit allocated between AmeriHealth Caritas DC and the Enrollee, whereby AmeriHealth Caritas DC and the Enrollee share in the payment for Covered Services.

Contracting Physician means a licensed doctor who has entered into a contract with AmeriHealth Caritas DC to provide Covered Services to Enrollees and has been designated by AmeriHealth Caritas DC as a Contracting Physician.

Contracting Provider means any physician, health care professional, health care facility, or pharmacy provider that has contracted with AmeriHealth Caritas DC, Inc. to render Covered Services to Enrollees.

Convenience Item means personal hygiene and convenience items, including, but not limited to; air conditioners, humidifiers, physical fitness equipment, elevators, hoyer/stair lifts, ramps, shower/bath benches, and items available without a prescription.

Copayment (Copay) means the fixed dollar amount that an Enrollee must pay for certain Covered Services.

Cosmetic means a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by AmeriHealth Caritas DC.

Covered Prescription Drug means a Prescription Drug included in the AmeriHealth Caritas DC Healthy DC Formulary.

Covered Service means Medically Necessary services or supplies provided in accordance with the terms of this Agreement.

Covered Specialty Drug means a Specialty Drug included in the AmeriHealth Caritas DC Healthy DC Formulary.

Custodial Care means care provided primarily to meet the personal needs of the patient. Custodial Care does not require skilled medical or paramedical personnel. Such care includes help in walking, bathing, or dressing. Custodial Care also includes preparing food or special diets, feeding, administering medicine, or any other care that does not require continuing services of medically trained personnel.

Decertification or Decertified means the termination by the Healthy DC Plan of the certification and offering of this Healthy DC Plan.

Deductible means the dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Services that must first be incurred by the Enrollee before AmeriHealth Caritas DC will make payments for Covered Services.

Dentist means an individual who is licensed to practice dentistry as defined by the respective jurisdiction where the practitioner provides care.

Diabetes Device means a legend device or non-legend device used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar. The term includes a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device, or insulin syringe.

Diabetic Supply or Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes, including but not limited to lancets, alcohol wipes, test strips (blood and urine), syringes and needles.

Domestic Partner means an unmarried same or opposite sex adult who resides with the Enrollee and has registered in a state or local domestic partner registry with an Enrollee.

Effective Date means the date on which the Enrollee's coverage becomes effective. Covered Services rendered on or after the Enrollee's Effective Date are eligible for coverage.

Emergency Medical Condition means:

A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman who is having contractions: there is inadequate time to affect a safe transfer to another hospital before delivery, or transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services means, with respect to an Emergency Medical Condition:

A. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;

B. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

C. Except as provided in item D. below, Covered Services that are furnished by a Non-Contracting Provider or non-contracting emergency facility after the individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in item 1. above are furnished.

D. The Covered Services described in item C. above are not included as emergency services if all of the following conditions are met:

1. The attending emergency physician or treating provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available contracting provider or facility located within a reasonable travel distance, taking into account the individual's medical condition;

2. The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 C.F.R § 149.420(c) through (g) with respect to such items and services, provided that the written notice additionally satisfies the following, as applicable;

   i. In the case of a contracting emergency facility and a non-contracting provider, the written notice must also include a list of any contracting providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a contracting provider.

ii. In the case of a non-contracting emergency facility, the written notice must include the good faith estimated amount that the individual may be charged for items or services furnished by the non-contracting emergency facility or by non-contracting providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the non-contracting emergency facility or non-contracting providers in conjunction with such items or services);

3. The individual (or an authorized representative of such individual) is in a condition to receive the information described in item b. above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law.

Enrollee means the Qualified Individual to whom this Agreement has been issued.

Experimental/Investigational means a service or supply in the developmental stage and in the process of human or animal testing excluding patient costs for clinical trials as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

A. The Technology* must have final approval from the appropriate government regulatory bodies;

B. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;

C. The Technology must improve the net health outcome;

D. The Technology must be as beneficial as any established alternatives; and

E. The improvement must be attainable outside the Investigational settings.

* "Technology" includes drugs, devices, processes, systems, or techniques.

FDA means the United States Food and Drug Administration.

Facility means

A. a hospital (as defined in section 1861(e) of the Social Security Act),

B. a hospital outpatient department,

C. a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act), or

D. an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act).

Family Caregiver means a relative by blood, marriage, or Adoption who lives with or is the primary Caregiver of the terminally ill Enrollee.

Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Enrollee for the purpose of learning to care for the Enrollee and to adjust to the impending death of the Enrollee.

Formulary means the list of Prescription Drugs issued by AmeriHealth Caritas DC and used by health care providers when writing, and Pharmacists, when filling, prescriptions for which coverage will be provided under this Agreement. AmeriHealth Caritas DC may change this list periodically without notice to Enrollees. A copy of the Formulary is available to the Enrollee upon request.

Generic Drug means any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

Habilitative Services means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Health Care or Home Health Care Services means the continued care and treatment of an Enrollee in the home by a licensed Home Health Agency if:

A. The institutionalization of the Enrollee in a hospital, related institution, or Skilled Nursing Facility would otherwise have been required if Home Health Care Services were not provided; and

B. The Plan of Treatment covering the Home Health Care Service is established and approved in writing by the health care provider and determined to be Medically Necessary by AmeriHealth Caritas DC.

Immediate Family means the Spouse, Domestic Partner, Civil Union partner, legal partner, parents, siblings, grandparents, and children of the terminally ill Enrollee.

Infusion Services means treatment provided by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion Services also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. Infusion Services includes all medications administered intravenously and/or parenterally.

Insurer means AmeriHealth Caritas DC.

Low Vision means a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in Low Vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for Enrollees with Low Vision.

Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.

Mastectomy means the surgical removal of all or part of the breast.

Medical Director means a board-certified physician who is appointed by AmeriHealth Caritas DC. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary or Medical Necessity means health care services or supplies that a health care provider, exercising clinical judgment, renders to or recommends for a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease, or its symptoms. These health care services or supplies are:

A. In accordance with generally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;

C. Not primarily for the convenience of a patient or health care provider; and

D. Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of the patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.

The fact that a health care provider may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Agreement.

Medical Nutrition Therapy provided by a licensed dietitian-nutritionist involves the assessment of the Enrollee's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. The licensed dietitian-nutritionist, working in a coordinated, multidisciplinary team effort with the Primary Care Physician, takes into account an Enrollee's condition, food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Medication-Assisted Treatment (MAT) means Prescription Drugs used to treat Substance Use Disorders (Alcohol Use Disorder and opioid use disorder).

Minimum Essential Coverage has the meaning given in the Affordable Care Act, 26 U.S.C. §5000A(f).

Non-Contracting Physician means a licensed doctor who is not contracted with AmeriHealth Caritas DC to provide Covered Services to Enrollees.

Non-Contracting Provider means any health care provider that has not contracted with AmeriHealth Caritas DC to provide Covered Services to Enrollees.

Opioid Reversal Agents means Prescription Drugs used to reverse an opioid overdose.

Out-of-Pocket Maximum means the maximum amount the Enrollee will have to pay for his/her share of benefits in any Benefit Period. The Out-of-Pocket Maximum does not include premiums, the cost of services that are not Covered Services, or any amounts paid to providers in excess of the Allowed Benefit. Once the Enrollee meets the Out-of-Pocket Maximum, the Enrollee will no longer be required to pay Copayments, Coinsurance or Deductible for the remainder of the Benefit Period.

Over-the-Counter means any item or supply, as determined by AmeriHealth Caritas DC, available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception items for men, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and related over-the-counter medications, solutions, items or supplies.

Pharmacist means an individual licensed to practice pharmacy regardless of the location where the activities of practice are performed.

Pharmacy means an establishment in which prescription or nonprescription drugs or devices are compounded, dispensed, or distributed.

Prescription Drug means:

A. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription";

B. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by AmeriHealth Caritas DC;

C. A covered Over-the-Counter medication or supply; or

D. Any Diabetic Supply.

E. Prescription Drugs do not include:

1 Compounded bulk powders that contain ingredients that:

a) Do not have FDA approval for the route of administration being compounded, or

b) Have no clinical evidence demonstrating safety and efficacy, or

c) Do not require a prescription to be dispensed.

2. Compounded drugs that are available as a similar commercially available Prescription Drug unless:

a) There is no commercially available bioequivalent Prescription Drug; or

b) The commercially available bioequivalent Prescription Drug has caused or is likely to cause the Enrollee to have an adverse reaction.

Prescription Guidelines means the limited list of Prescription Drugs issued by AmeriHealth Caritas DC for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from AmeriHealth Caritas DC and the quantity limits that AmeriHealth Caritas DC has placed on certain drugs. A copy of the Prescription Guidelines is available to the Enrollee upon request.

Preventive Drug means a Prescription Drug or Over-the-Counter medication, or supply dispensed under a written prescription by a health care provider that is included on the AmeriHealth Caritas DC Preventive Drug List.

Preventive Drug List means the list issued by AmeriHealth Caritas DC of Prescription Drugs or Over-the-Counter medications or supplies dispensed under a written prescription by a health care provider that have been identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration. AmeriHealth Caritas DC may change this list periodically and without notice to Enrollees. A copy of the Preventive Drug List is available to the Enrollee upon request.

Primary Care Physician (PCP) means a Contracting Provider selected by an Enrollee to provide and manage the Enrollee's health care. PCP means health care practitioners in the following disciplines:

A. General internal medicine;

B. Family practice medicine;

C. General pediatric medicine; or

D. Geriatric medicine.

Services rendered by Specialists in the disciplines above will be treated as PCP visits for Enrollee payment purposes.

Professional Nutritional Counseling means individualized advice and guidance given to an Enrollee at nutritional risk due to nutritional history, current dietary intake, medication use, or chronic illness or condition, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a licensed dietitian-nutritionist, physician, physician assistant, or nurse practitioner.

Qualified Home Health Agency means a licensed program which is approved for participation as a home health agency under Medicare or certified as a home health agency by the Joint Commission on Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency.

Qualified Hospice Care Program means a coordinated, interdisciplinary program provided by a hospital, Qualified Home Health Agency, or other health care facility licensed or certified by the state in which it operates as a hospice program and is designed to meet the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement period. Benefits are available to:

A. Individuals who have no reasonable prospect of cure as estimated by a physician; and

B. The immediate families or Family Caregivers of those individuals.

Qualified Individual means an individual who has been determined by the Healthy DC Plan to be eligible to enroll.

Rescind or Rescission means a termination, cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. Coverage is not Rescinded, and a cancellation or discontinuance of coverage is not a Rescission if:

A. The termination, cancellation or discontinuance of coverage has only a prospective effect; or

B. The termination, cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due.

Respite Care means temporary care provided to the terminally ill Enrollee to relieve the Caregiver/Family Caregiver from the daily care of the Enrollee.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) accredited or approved under Medicare or The Joint Commission and provides continuous Skilled Nursing Care and related services for Enrollees who require medical care, Skilled Nursing Care, or rehabilitation services. Inpatient skilled nursing is for patients who are medically fragile with limited endurance and require a licensed health care professional to provide skilled services in order to ensure the safety of the patient and to achieve the medically desired result. Inpatient skilled nursing services must be provided on a 24 hour basis, 7 days a week.

Sound Natural Teeth means teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition; absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (implants, fixed or removable bridges, dentures).

Special Enrollment Period means a period during which a Qualified Individual who experiences certain qualifying events may enroll in, or change enrollment in, a Healthy DC Plan outside of any Annual Open Enrollment Periods.

Specialist means a licensed health care provider who is certified or trained in a specified field of medicine.

Specialty Drugs means a prescription drug that is prescribed for a person with a physical, behavioral, or developmental condition that may have no known cure, is progressive, or can be debilitating or fatal if left untreated or undertreated, such as multiple sclerosis, hepatitis C, or rheumatoid arthritis; or A disease or condition that affects fewer than 200,000 persons in the United States or approximately one in 1,500 persons worldwide, such as cystic fibrosis, hemophilia, or multiple myeloma.

Spouse means a person of the same or opposite sex who is legally married to the Enrollee under the laws of the state or jurisdiction in which the marriage took place. A marriage legally entered into in another jurisdiction will be recognized as a marriage in the District of Columbia.

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the hospital emergency room. An Urgent Care facility is a freestanding facility that is not a physician's office, and which provides Urgent Care.

SECTION 2
ELIGIBILITY AND ENROLLMENT

1. Requirements for Coverage

   A. The Enrollee must be a Qualified Individual;

   B. An eligible Qualified Individual must timely enroll during enrollment opportunities as provided in Section 2.2.

2. Enrollment Opportunities and Effective Dates. Eligibility to enroll in and change Healthy DC Plan coverage is determined by the Healthy DC Plan.

3. Clerical or Administrative Error. If an individual is ineligible for coverage, the individual cannot become eligible just because AmeriHealth Caritas DC or the Healthy DC Plan made a clerical or administrative error in recording or reporting information. Likewise, if an Enrollee is eligible for coverage, the Enrollee will not lose coverage because AmeriHealth Caritas DC or the Exchange made an administrative or clerical error in recording or reporting information.

4. Cooperation and Submission of Information. The Enrollee agrees to cooperate with and assist AmeriHealth Caritas DC and/or the Healthy DC Plan, including providing AmeriHealth Caritas DC and the Healthy DC Plan with reasonable access to eligibility records upon request. At any time coverage is in effect, AmeriHealth Caritas DC reserves the right to request documentation substantiating eligibility and to provide any information it receives regarding an Enrollee's eligibility to the Healthy DC Plan.

SECTION 3
TERMINATION OF COVERAGE

1. Termination of Enrollment by the Enrollee.

   A. The Enrollee may terminate his or her enrollment under the Agreement at any time by notifying the Healthy DC Plan. AmeriHealth Caritas DC will be notified of the termination by the Healthy DC Plan.

   B. The date of a termination of coverage for an Enrollee when initiated by the Enrollee will be the date specified by the Healthy DC Plan.

2. Termination of Agreement by AmeriHealth Caritas DC or the Healthy DC Plan. AmeriHealth Caritas DC or the Healthy DC Plan may terminate the enrollment of an Enrollee at any time by written notice delivered or mailed to the last address as shown by the records of AmeriHealth Caritas DC or Healthy DC Plan under the following circumstances:

   A. Termination for Ineligibility.

      1. The Enrollee is no longer a Qualified Individual eligible to enroll in a Healthy DC Plan. If the Enrollee is no longer eligible for coverage under this Agreement, the Agreement will be terminated.

      2. The effective date of termination will be determined by the Healthy DC Plan.

      3. The Enrollee is responsible for notifying the Healthy DC Plan of any changes in the status of an Enrollee as a Qualified Individual. These changes include a death or divorce. If the Enrollee knows of an Enrollee's ineligibility for coverage and intentionally fails to notify the Healthy DC Plan, AmeriHealth Caritas DC may have the right to seek Rescission of the coverage of the Enrollee or the Agreement under Section 3.3 as of the initial date of the Enrollee's ineligibility. In such a case, AmeriHealth Caritas DC has the right to recover the full value of the services and benefits provided during the period of the Enrollee's ineligibility. AmeriHealth Caritas DC can recover these amounts from the Enrollee.

   B. Termination due to the Decertification of the Agreement as a Healthy DC Plan. If this Agreement is Decertified as a Healthy DC Plan, the date of termination of this Agreement shall be the date established by the Healthy DC Plan after written notice has been provided to the Enrollee and the Enrollee has been afforded an opportunity to enroll in other coverage.

   C. Accommodation for Persons with Disabilities. Notwithstanding the termination provisions above, AmeriHealth Caritas DC, when required by the Healthy DC Plan, shall make reasonable accommodation of these provisions for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals.

3. Rescission of Enrollment for Fraud or Misrepresentation. This Agreement, or the enrollment of Enrollee, may be Rescinded if:

   A. The Enrollee has performed an act, practice, or omission that constitutes fraud;

   B. The Enrollee has made an intentional misrepresentation of material fact; or

   C. An act, practice or omission that constitutes fraud includes, but is not limited to, fraudulent use of AmeriHealth Caritas DC's identification card by the Enrollee, the alteration or sale of prescriptions by the Enrollee, or an attempt by the Enrollee to enroll non-eligible persons.

D. AmeriHealth Caritas DC demonstrates, to the reasonable satisfaction of the Healthy DC Plan, if required by the Healthy DC Plan, that the rescission is appropriate.

AmeriHealth Caritas DC will provide thirty (30) days advance written notice of any Rescission. AmeriHealth Caritas DC shall have the burden of persuasion that its Rescission complies with applicable local law. The Rescission shall either (i) void the enrollment of the Enrollee as of the Enrollee's Effective Date (for fraudulent acts, practices, or omissions that occur at the time of enrollment); or (ii) in all other cases, void the enrollment of the Enrollee as of the first date the Enrollee performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of material fact. The Enrollee will be responsible for payment of any voided benefits paid by AmeriHealth Caritas DC.

4. Death of Enrollee. In case of the death of the Enrollee, this Agreement shall terminate on the date of the Enrollee's death.

5. Effect of Termination. No benefits will be provided for any services received on or after the date on which this Agreement terminates. This Section includes services received for an injury or illness that occurred before the date of termination.

6. Reinstatement. An Enrollee may apply for reinstatement of a terminated policy if the Enrollee believes the policy was terminated due to an error by AmeriHealth Caritas DC or the Healthy DC Plan. All reinstatement requests must be approved by the Healthy DC Plan and may be declined. Under no circumstances will AmeriHealth Caritas DC or the Healthy DC Plan automatically reinstate a terminated policy.

SECTION 4
COORDINATION OF BENEFITS (COB); SUBROGATION

1. Coordination of Benefits (COB).

A. Applicability.

1. This Coordination of Benefits (COB) provision applies to this AmeriHealth Caritas DC Plan when an Enrollee has health care coverage under more than one Plan.

2. If this COB provision applies, the Order of Benefit Determination Rules should be reviewed first. Those rules determine whether the benefits of this AmeriHealth Caritas DC Plan are determined before or after those of another Plan. The benefits of this AmeriHealth Caritas DC Plan:

a) Shall not be coordinated when, under the order of determination rules, this AmeriHealth Caritas DC Plan determines its benefits before another Plan;

b) May be coordinated when, under the order of determination rules, another Plan determines its benefits first.

B. Definitions. For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Agreement.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments that are covered in whole or in part by any of the Plans covering the Enrollee. This means any expense or portion of an expense not covered by any of the Plans is not an Allowable Expense. If this AmeriHealth Caritas DC Plan is advised by an Enrollee that all Plans covering the Enrollee are high-deductible health plans and the Enrollee intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

AmeriHealth Caritas DC Plan means this Agreement.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in a specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy issued on a group basis, including those of a nonprofit health service plan, those of a commercial, group, and blanket policy, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law and coverage under a governmental plan, except a governmental plan which, by law, provides benefits in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;

2. An intensive care policy, which does not provide benefits on an expense incurred basis;

3. Coverage regulated by a motor vehicle reparation law;

4. The first one-hundred dollars ($100) per day of a hospital indemnity contract; or

5. An elementary and/or secondary school insurance program sponsored by a school or school system.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this AmeriHealth Caritas DC Plan is a Primary Plan or Secondary Plan as to another Plan covering the Enrollee.

1. When this AmeriHealth Caritas DC Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

2. When this AmeriHealth Caritas DC Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be coordinated because of the other Plan's benefits.

3. When there are more than two Plans covering the Enrollee, this AmeriHealth Caritas DC Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease specified in the policy or for the treatment unique to a specific disease; or
(2) additional benefits for a disease specified in the policy or for treatment unique to a specified disease.

C. Order of Benefit Determination Rules.

1. General. When there is a basis for a claim under this AmeriHealth Caritas DC Plan and another Plan, this AmeriHealth Caritas DC Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless;

   a) The other Plan has rules coordinating benefits with those of this AmeriHealth Caritas DC Plan; and

   b) Both those rules and this AmeriHealth Caritas DC Plan's rules require this AmeriHealth Caritas DC Plan's benefits be determined before those of the other Plan.

2. Rules. This AmeriHealth Caritas DC Plan determines its order of benefits using the first of the following rules which applies:

   a) Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, enrollee or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except if the

person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) Secondary to the Plan covering the person as a dependent, and

(2) Primary to the Plan covering the person as other than a dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

b) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

c) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal, state or local law also is covered under another Plan, the following shall be the order of benefits determination:

(1) First, the benefits of a Plan covering the person as an employee, retiree, enrollee or subscriber (or as that person's dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

d) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

e) Medical and Dental Plan. When one of the plans is a medical plan and the other is a Dental Plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as the Primary Plan.

D. Effect on the Benefits of this AmeriHealth Caritas DC Plan.

1. When this Section Applies. This section applies when, in accordance with the prior section, order of benefits determination rules, this AmeriHealth Caritas DC Plan is a Secondary Plan as to one or more other Plans. In such an event, the benefits of this AmeriHealth Caritas DC Plan may be coordinated under this section. Any additional Plan or Plans are referred to as "the other Plans" immediately below.

2. Coordination in this AmeriHealth Caritas DC Plan's Benefits. When this AmeriHealth Caritas DC Plan is the Secondary Plan, the benefits under this AmeriHealth Caritas DC Plan *may* be coordinated so the total benefits would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this AmeriHealth Caritas DC Plan are coordinated, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of this AmeriHealth Caritas DC Plan.

E. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. AmeriHealth Caritas DC has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. AmeriHealth Caritas DC need not tell, or get the consent of, any person to do this. Each person claiming benefits under this AmeriHealth Caritas DC Plan must give this AmeriHealth Caritas DC Plan any facts it needs to pay the claim.

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

G. Right of Recovery. If the amount of the payments made by this AmeriHealth Caritas DC Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

5.2 Medicare Eligibility. This provision applies to Enrollees who are entitled to Part A and/or Part B of Medicare. An Enrollee will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the Agreement. Benefits covered by Medicare are subject to the provisions in this section.

A. Coverage Secondary to Medicare. Except where prohibited by law, the benefits under this AmeriHealth Caritas DC Plan are secondary to Medicare.

B. Medicare as Primary.

1. When benefits for Covered Services, Covered Dental Services or Covered Vision Services are paid by Medicare as primary, this AmeriHealth Caritas DC Plan will not duplicate those payments. AmeriHealth Caritas DC will coordinate and pay benefits based on Medicare's payment (or the payment Medicare would have paid). When AmeriHealth Caritas DC coordinates the benefits with Medicare, AmeriHealth Caritas DC's payments will be based on the Medicare

allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare), less any claim reduction or denial due to an Enrollee's failure to comply with Medicare's administrative requirements. AmeriHealth Caritas DC's right to coordinate is not contingent on any payment actually being made on the claim by Medicare. Enrollees enrolled in Medicare agree to, and shall, complete and submit to Medicare, AmeriHealth Caritas DC, and/or any health care providers all claims, consents, releases, assignments and other documents required to obtain or assure such claim payment by Medicare.

2. If a Medicare-eligible Enrollee has not enrolled in Medicare Part A and/or Part B, AmeriHealth Caritas DC will not "carve-out," coordinate, or reject a claim based on the amount Medicare would have paid had the Enrollee actually applied for, claimed, or received Medicare benefits.

5.3 Employer or Governmental Benefits. Coverage does not include the cost of services or payment for services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

2. Subrogation.

A. AmeriHealth Caritas DC has subrogation and reimbursement rights. Subrogation requires the Enrollee to turn over to AmeriHealth Caritas DC any rights the Enrollee may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to an Enrollee for an injury or illness. Subrogation applies to any illness or injury which is:

1. Caused by an act or omission of a third party; or

2. Covered under an Enrollee's uninsured or underinsured policy issued to or otherwise covering the Enrollee; or

3. Covered by No Fault Insurance.

a) No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose.

B. If the Enrollee receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Agreement, the payment will be treated as having been paid to the Enrollee as a recovery for the medical, hospital and other expenses for which AmeriHealth Caritas DC provided or will provide benefits. AmeriHealth Caritas DC may recover the amounts paid or will pay in benefits up to

the amount received from or on behalf of the third party or applicable first party coverage.

All recoveries the Enrollee or the Enrollee's representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated (for example as "pain and suffering"), must be used to reimburse AmeriHealth Caritas DC in full for benefits paid. AmeriHealth Caritas DC's share of any recovery extends only to the amount of benefits paid or payable to the Enrollee, the Enrollee's representatives, and/or health care providers on the Enrollee's behalf. For purposes of this provision, "Enrollee's representatives" include, if applicable, heirs, administrators, legal representatives, parents (if the Enrollee is a minor), successors, or assignees. This is AmeriHealth Caritas DC's right of recovery.

C. AmeriHealth Caritas DC's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. If required by law, AmeriHealth Caritas DC will reduce the amount owed by the Enrollee to AmeriHealth Caritas DC in accordance with applicable law.

D. AmeriHealth Caritas DC will have a lien on all funds the Enrollee recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. AmeriHealth Caritas DC may give notice of that lien to any party who may have contributed to the Enrollee's loss, or who may be liable for payment as a result of that loss.

E. AmeriHealth Caritas DC has the option to be subrogated to the Enrollee's rights to the extent of the benefits provided under this Agreement. This includes AmeriHealth Caritas DC right to bring suit or file claims against the third party in the Enrollee's name.

F. Enrollees agree to take action, furnish information and assistance, and execute such instruments that AmeriHealth Caritas DC may require while enforcing AmeriHealth Caritas DC rights under this Section. The Enrollee agrees to not take any action which prejudices AmeriHealth Caritas DC 's rights and interests under this provision.

SECTION 5
GENERAL PROVISIONS

1. Entire Agreement; Changes. The entire agreement between AmeriHealth Caritas DC and the Enrollee includes: (a) the Individual Enrollment Agreement; (b) Benefit Determinations, Grievances and Appeals attachment; (c) the Description of Covered Services attachment; (d) Schedule of Benefits attachment; and (e) any additional duly authorized notices, amendments and riders.

   No amendment or modification of any term or provision of this Agreement shall be valid until approved by an executive officer of AmeriHealth Caritas DC. Any duly authorized notice, amendment or rider will be issued by AmeriHealth Caritas DC to be attached to the Agreement. No agent has authority to change this Agreement or to waive any of its provisions. Any waiver of an Agreement term or provision shall only be given effect for its stated purpose and shall not constitute or imply any subsequent waiver.

   Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations and/or exclusions of this Agreement, or increase or void any coverage or reduce any benefits. Such oral statements cannot be used in the prosecution or defense of a claim.

2. Claims and Payment of Claims.

   A. Claim Forms. A claim form can be requested by calling Enrollee Services at 844-214-2470 (TTY 711). When we receive the notice of claim, we will direct you to where you can access a claim form on our website or send you a claim form by mail if you request it. You must sign the claim form before we will issue payment to a provider or reimburse you for covered 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 DC, P.O. Box 7341, London, KY, 40742.

   B. Proof of Loss. For Covered Services provided by Contracting Providers, Enrollees are not required to submit claims in order to obtain benefits.

      For Covered Services provided by Non-Contracting Providers, Enrollees must furnish written proof of loss, or have the provider submit proof of loss, to AmeriHealth Caritas DC within one (1) year after the date of the loss. The Enrollee is also responsible for providing information requested by AmeriHealth Caritas DC including, but not limited to, medical records.

      Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

      AmeriHealth Caritas DC will honor claims submitted for Covered Services by any agency of the federal, state, or local government that has the statutory authority to submit claims beyond the time limits established under this Agreement. These claims must be submitted to AmeriHealth Caritas DC before the filing deadline established by the applicable statute on claims forms that provide all of the information AmeriHealth Caritas DC deems necessary to process the claims. AmeriHealth Caritas DC provides forms for this purpose.

   C. Time of Payment of Claims. Except as provided in this paragraph, benefits payable will be paid immediately after receipt of written proof of loss.

   D. Claim Payments Made in Error. If AmeriHealth Caritas DC makes a claim payment to or on behalf of the Enrollee in error, the Enrollee is required to repay AmeriHealth Caritas

DC the amount paid in error. If the Enrollee has not repaid the full amount owed AmeriHealth Caritas DC and AmeriHealth Caritas DC makes a subsequent benefit payment, AmeriHealth Caritas DC may subtract the amount owed AmeriHealth Caritas DC from the subsequent payment.

E. Payment of Claims. Payments for Covered Services will be made by AmeriHealth Caritas DC directly to Contracting Providers. Direct payments will also be made by AmeriHealth Caritas DC to providers from the United States Department of Defense and the United States Department of Veteran Affairs. If an Enrollee receives Covered Services from Non-Contracting Providers, AmeriHealth Caritas DC reserves the right to pay either the Enrollee or the provider. If the Enrollee has paid the health care provider for services rendered, benefits will be payable to the Enrollee. Benefits will be paid to the Enrollee, if living, or to the Enrollee's beneficiary. If there is no living beneficiary, benefits are payable to the Enrollee's estate. AmeriHealth Caritas DC may pay up to $1,000 to any relative of the Enrollee who AmeriHealth Caritas DC finds is entitled to it. Any payment made in good faith will fully discharge AmeriHealth Caritas DC to the extent of the payment.

3. No Assignment. An Enrollee cannot assign any benefits or payments due under this Agreement to any person, corporation or other organization, except as specifically provided by this Agreement or required by applicable law.

4. Legal Actions. An Enrollee cannot bring any lawsuit against AmeriHealth Caritas DC to recover under this Agreement before the expiration of sixty (60) days after written proof of loss has been furnished, and not after three (3) years from the date written proof of loss is required to be submitted to AmeriHealth Caritas DC.

5. Events Outside of AmeriHealth Caritas DC's Control. If AmeriHealth Caritas DC, for any reason beyond the control of AmeriHealth Caritas DC, is unable to provide the coverage promised, AmeriHealth Caritas DC is liable for reimbursement of the expenses necessarily incurred by any Enrollee in procuring the services through other providers, to the extent prescribed by law.

6. Physical Examinations and Autopsy. AmeriHealth Caritas DC, at its own expense, has the right and opportunity to examine the Enrollee when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

7. Identification Card. Any cards issued to Enrollees are for identification only.

   A. Possession of an identification card confers no right to benefits.

   B. To be entitled to such benefits, the holder of the card must, in fact, be an Enrollee.

   C. Any person receiving benefits to which he or she is not then entitled will be liable for the actual cost of such benefits.

8. Enrollee Medical Records. It may be necessary to obtain Enrollee medical records and information from hospitals, Skilled Nursing Facilities, physicians or other practitioners who treat the Enrollee. When an Enrollee becomes covered, the Enrollee (and if the Enrollee is legally incapable of giving such consent, the representative of such Enrollee) automatically gives AmeriHealth Caritas DC permission to obtain and use such records and information, including medical records and information requested to assist AmeriHealth Caritas DC in determining benefits and eligibility of Enrollees.

9. Enrollee Privacy. AmeriHealth Caritas DC shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable financial, medical or health related data. In that regard, AmeriHealth Caritas DC will not provide to unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the Enrollee or as otherwise permitted by law. Personal

information, including email addresses and phone numbers, may be used and shared with other businesses who work with AmeriHealth Caritas DC to administer and/or provide benefits under this plan. Personal information, as described below, may also be used to notify enrollees about treatment options, health-related services, and/or coverage options. Enrollees may contact AmeriHealth Caritas DC to change the information used to communicate with them.

The more complete information health care providers have, the better they can meet the Enrollees' health care needs. Sharing information and data with the Enrollee's treating providers can lead to better coordinated care, help the Enrollee get timely care, limit duplicative services, and help the provider better identify patients who would benefit most from care management and other care coordination programs.

A. How we use medical information to enhance or coordinate the Enrollee's care. In order to administer the Enrollee's health benefits, AmeriHealth Caritas DC receives claims data and other information from the Enrollee's various providers of care regarding diagnoses, treatments, programs and services provided under your health plan. Individual treating providers, however, may not have access to information from the Enrollee's other providers. When AmeriHealth Caritas DC has such information, it may share it with the Enrollee's treating providers through secure, electronic means solely for purposes of enhancing or coordinating the Enrollee's care and to assist in clinical decision making.

B. The Enrollee may Opt-Out of information sharing by AmeriHealth Caritas DC for these care coordination purposes. The Enrollee has the right to opt-out of the sharing of this information by AmeriHealth Caritas DC with his/her treating provider for care coordination purposes at any time. To opt-out, the Enrollee must contact Enrollee Services at 844-214-2470 (TTY 711). If the Enrollee opts out, his/her treating providers will not have access to the data or information AmeriHealth Caritas DC has available to help enhance or coordinate his/her care.

10. AmeriHealth Caritas DC's Relationship to Providers. Health care providers, including Contracting Providers, are independent contractors or organizations and are related to AmeriHealth Caritas DC by contract only. Contracting Providers are not employees or agents of AmeriHealth Caritas DC and are not authorized to act on behalf of or obligate AmeriHealth Caritas DC with regard to interpretation of the terms of the Agreement, including eligibility of Enrollees for coverage or entitlement to benefits. Contracting Providers, maintain a provider-patient relationship with the Enrollee and are solely responsible for the professional services they provide. AmeriHealth Caritas DC is not responsible for any acts or omissions, including those involving malpractice or wrongful death of Contracting Providers, or any other individual, facility or institution which provides services to Enrollees or any employee, agent or representative of such providers.

11. Provider and Services Information. Listings of current Contracting Providers will be made available to Enrollees at the time of enrollment. Updated listings are available to Enrollees upon request. The listing of Contracting Providers is updated every 30 days on the AmeriHealth Caritas DC Healthy DC website at www.amerihealthcaritasdc.com/hdcp.

12. Administration of Agreement. AmeriHealth Caritas DC may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

13. Rules for Determining Dates and Times. The following rules will be used when determining dates and times:

A. All dates and times of day will be based on the dates and times applicable to the Washington, DC area, i.e., Eastern Standard Time or Eastern Daylight Savings Time, as applicable.

B. When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.

C. When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.

D. "Days" mean calendar days, including weekends, holidays, etc., unless otherwise noted.

E. "Year" refers to Calendar Year, unless a different benefit year basis is specifically stated.

14. Notices.

A. To the Enrollee. Notice to Enrollees will be sent via electronic mail, if the Enrollee has consented to receive such notices via electronic mail, or by first class mail to the most recent address or electronic address for the Enrollee in AmeriHealth Caritas DC's files. The notice will be effective on the date mailed, whether or not the Enrollee in fact receives the notice or there is a delay in receiving the notice.

B. To AmeriHealth Caritas DC. When notice is sent to AmeriHealth Caritas DC, it must be sent by first class mail to:

AmeriHealth Caritas DC
1201 Maine Avenue SW
10th Floor, Ste. 1000
Washington, DC 20024

1. Notice will be effective on the date of receipt by AmeriHealth Caritas DC, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service.

2. AmeriHealth Caritas DC may change the address at which notice is to be given by giving written notice thereof to the Enrollee.

15. Amendment Procedure. AmeriHealth Caritas DC will amend this Agreement to implement modifications made pursuant to Section 5.21 by mailing a notice of the amendment(s) to the Enrollee, via first class mail or electronically if the Enrollee has consented to receive such notices via electronic mail, before the date of the next annual open enrollment period.

If the material modification required by law is made at a time other than renewal, and if it affects the content of the summary of benefits and coverage, AmeriHealth Caritas DC will provide advance notice at least sixty (60) days before the effective date of the modification.

No agent or other person, except an officer of AmeriHealth Caritas DC, has the authority to waive any conditions or restrictions of the Agreement or to bind AmeriHealth Caritas DC by making any promise or representation or by giving or receiving any information. No change in the Agreement will be binding on AmeriHealth Caritas DC, unless evidenced by an amendment signed by an authorized representative of AmeriHealth Caritas DC.

16. Regulation of AmeriHealth Caritas DC. AmeriHealth Caritas DC is subject to regulation in the District of Columbia by the Department of Insurance, Securities and Banking pursuant to Title 31 of the District of Columbia Code and the District of Columbia Department of Health pursuant to Reorganization Plan No. 4 of 1996, as amended.

17. Records and Clerical Errors.

A. The Enrollee must furnish AmeriHealth Caritas DC with data and notifications required for coverage in the format approved by AmeriHealth Caritas DC.

B. Clerical errors in recording or reporting data will not alter this Agreement. Upon discovery, adjustments will be made to remedy the errors.

18. Applicable Law. This Agreement is entered into and is subject to the laws of the District of Columbia. All claims arising from this Agreement will be brought and maintained in the District of Columbia. The Enrollee consents to the jurisdiction of the District of Columbia for all actions arising from this Agreement.

19. Contestability of Agreement.

A. The Agreement may not be contested after it has been in force for two (2) years from the date of issue;

B. Absent fraud, each statement made by an Enrollee is considered to be a representation and not a warranty; and

C. A statement to effectuate coverage may not be used to avoid the coverage or reduce the benefits unless:

1. The statement is contained in a written instrument signed by the Enrollee, and

2. A copy of the statement is given to the Enrollee.

No statement contained within this provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage or upon other provisions in this Agreement.

20. Notice of Address Change. The Enrollee must notify AmeriHealth Caritas DC within fifteen (15) days of a change in residence or change in e-mail address, if the Enrollee has consented to receive notices via electronic mail, or as soon as reasonably possible.

21. Uniform Modification. AmeriHealth Caritas DC reserves the right to modify the Agreement at renewal if the modification is consistent with State law and is effective uniformly for all individuals with this product.

A. For purposes of this provision, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:

1. The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

2. The modification is directly related to the imposition or modification of the Federal or State requirement.

22. Agreement Solely Between the Enrollee and AmeriHealth Caritas DC. The Enrollee hereby expressly acknowledges the Enrollee's understanding that this Agreement constitutes a contract solely between the Enrollee and AmeriHealth Caritas DC; AmeriHealth Caritas DC is an independent corporation. The Enrollee further acknowledges and agrees it has not entered into this Agreement based upon representations by any person other than AmeriHealth Caritas DC; and no person, entity, or organization other than AmeriHealth Caritas DC shall be held accountable or liable to the Enrollee for any of AmeriHealth Caritas DC's obligations to the Enrollee. This paragraph shall not create any additional obligations whatsoever on the part of AmeriHealth Caritas DC other than those obligations created under other provisions of this Agreement.

23. Conformity to Law. Any provision in this Agreement that is in conflict with the requirements of any state or federal law that applies to this Agreement is automatically changed to satisfy the minimum requirements of such law.

24. Selection of a Primary Care Physician.

A. An Enrollee must select a Primary Care Physician and may select any Primary Care Physician from AmeriHealth Caritas DC's current list of Contracting Provider Primary Care Physicians. If the Primary Care Physician is not available, AmeriHealth Caritas DC will assist the Enrollee in making another selection.

B. An Enrollee may change his or her Primary Care Physician at any time by notifying AmeriHealth Caritas DC. If the Enrollee notifies AmeriHealth Caritas DC by the twentieth (20th) day of the month, AmeriHealth Caritas DC will make the change effective the first day of the next month. If the Enrollee notifies AmeriHealth Caritas DC after the twentieth (20th) day of the month, AmeriHealth Caritas DC will make the change effective the first day of the second month following the notice.

C. AmeriHealth Caritas DC may require an Enrollee to change to a different Primary Care Physician if:

1. The Enrollee's Primary Care Physician is no longer available as a Primary Care Physician; or

2. AmeriHealth Caritas DC determines that the furnishing of adequate medical care is jeopardized by a seriously impaired physician-patient relationship between the Enrollee and his or her Primary Care Physician due to any of the following:

a) The Enrollee engages in threatening or abusive behavior toward the physician, the physician's staff or other patients in the office; or

b) The Enrollee attempts to take unauthorized controlled substances from the physician's office or to obtain these substances through fraud, misrepresentation, and forgery or by altering the physician's prescription order.

D. If a change in Primary Care Physician is required, advance written notice will be given to the Enrollee. The change is effective upon written notice to the Enrollee. However, the Enrollee may request a review of the action under the Benefit Determinations and Appeals Procedure.

AmeriHealth Caritas DC will not furnish any further benefits or services for a particular condition if the Enrollee refuses to follow a prescribed course of treatment for that condition. If the Enrollee disagrees with a prescribed course of treatment, the Enrollee shall be permitted to receive a second opinion from another Contracting Provider. If the second physician disagrees with the prescribed course of treatment, AmeriHealth Caritas DC may not refuse to provide services or benefits for that particular condition, subject to this Agreement and AmeriHealth Caritas DC's utilization review protocols and policies.

SECTION 6
SERVICE AREA

AmeriHealth Caritas DC's Service Area is a clearly defined geographic area in which AmeriHealth Caritas DC has arranged for the provision of health care services to be generally available and readily accessible to Enrollees.

The Service Area is as follows: District of Columbia.

ATTACHMENT A
BENEFIT DETERMINATIONS, GRIEVANCES, AND APPEALS

1. Benefit Determinations – Medical and Behavioral Health Services. 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 benefit determination decisions, we use documented clinical review criteria based on sound clinical evidence that is periodically evaluated to ensure ongoing efficacy. We obtain all information needed to make medically necessary utilization review decisions, including pertinent clinical information. Retrospective review includes the review of claims for emergency services to determine whether the applicable prudent layperson legal standards have been met.

   We will:

   A. Routinely assess the effectiveness and efficiency of our utilization review program.

   B. 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.

   C. 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 enrollee. The department's clinical staff and medical directors are available and accessible to all providers and enrollees from 8:00 a.m. to 5:00 p.m., Monday through Friday, with the exception of company observed holidays by calling our toll-free number at 833-301-3377. Utilization Management clinical staff are available on call after normal business hours, weekend and holidays by calling 833-533-8686. A toll-free fax line is available to receive inbound communications from providers 24 hours a day 7 days a week at 844-332-9329. TTD/TTY and language assistance is also available at 711.

   D. 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.

   E. Provide written procedures for making utilization review decisions and notifying covered persons of those decisions.

   F. Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

   We will review service requests for medical necessity. Medically necessary or medical necessity refers to the covered health services or supplies that are:

A. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease. They are not for experimental, investigational, or for cosmetic purposes, except as allowed under DC or Federal law.

B. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

C. Within generally accepted standards of medical care in the community.

D. Not only for the convenience of the insured, the insured's family, or the provider.

E. 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.

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

A. Urgent concurrent requests are decided and communicated within 24 hours from the date of receipt.

B. 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.

    1. 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 enrollee or jeopardize the enrollee's ability to regain maximum function or in the opinion of a physician with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

C. From the date of receipt, non-urgent care prospective requests are decided and communicated within 5 business days if received electronically and within 7 calendar days if received from a non-electronic source.

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

Notification of utilization management decisions will be consistent with DC and Federal laws and regulations as well as 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:

A. 45 calendar days for retrospective requests.

B. 45 calendar days for non-urgent care prospective requests.

C. 48 hours for urgent care prospective requests.

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

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

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

B. Adverse Benefit Determination is a coverage determination by the health benefit plan that:

   1. An admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or the prudent layperson standard for coverage of emergency services due to an emergency medical condition per DC and Federal law, and coverage for the requested service is therefore denied, reduced, or ended; or

   2. The health benefit plan will not provide or make payment based on a determination of the enrollee's eligibility to participate in a plan; or

   3. Coverage has been rescinded (whether or not the rescission has an adverse effect on any particular benefit at that time).

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

   1. Seriously jeopardize the life or health of the enrollee; or

   2. Seriously jeopardize the enrollee's ability to regain maximum function; or

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

In making a decision, we will take any urgent medical needs into account. As long as we receive the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, we will notify the enrollee and the enrollee's provider of the benefit determination, whether adverse or not, within 24 hours for urgent concurrent requests and within 72 hours for urgent prospective requests after the plan's receipt of the request. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment shall be made in accordance with this plan.

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

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

To obtain prior authorization or verify requirements for inpatient or outpatient services, including which other types of facility admissions need prior authorization, you can discuss with your provider and/or have your provider call our Provider Services team at 1-888-369-0247, Monday through Friday, 8 a.m. to 7 p.m., excluding holidays.

2. Benefit Determinations – Prescription Drugs. AmeriHealth Caritas DC strives to provide you with high-quality and cost-effective drug coverage.

We use AmeriHealth Caritas DC's Pharmacy Benefit Manager (PBM) to help manage your prescription drug benefits and make benefit determinations. You will need to get your prescription medications filled from a network pharmacy to obtain coverage. Prescriptions can be filled at a retail network pharmacy, through our mail-order network pharmacy, or a network specialty pharmacy. You will need to show your enrollee 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.

A. 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 [amerihealthcaritasdc.com/hdcp/welcome] or call us at 1-844-214-2474.

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

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

AmeriHealth Caritas DC'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.

1. 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.

2. 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. Enrollees 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.

3. 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.

4. Age limits (AL). Age limits are designed to prevent potential harm to enrollees 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.

5. 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.

6. 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.

7. Nonformulary drugs. While most drugs are covered, a small number of drugs are not covered because there are safe, effective, and more affordable alternatives available. All of the alternative drug products are approved by the FDA and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. If you and

your provider feel that a formulary drug is not right for your health condition and that the nonformulary drug is medically necessary, your provider can ask for an exception request.

8. Noncovered drugs with over-the-counter alternatives. AmeriHealth Caritas DC 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 DC 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 DC 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.

B. Prior authorization and exception requests. For formulary drugs that have restrictions such a prior authorization (PA), step therapy (ST), quantity limitations (QL), and age limitations (AL), a prior authorization request may be submitted for decisions. AmeriHealth Caritas DC'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 DC's PBM will review the requests and will determine if a request is consistent with our medical necessity guidelines.

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

   1. Electronically: Directly to AmeriHealth Caritas DC's PBM, through Electronic Prior Authorization (ePA) in your Electronic Health Record (EHR) tool software, or you can submit through either of the following online portals:

      a) CoverMyMeds

      b) Surescripts

   2. By fax: 844-480-2486 for standard (nonurgent) requests 1-855-350-0284 for expedited (fast)* requests

   3. By mail:

200 Stevens Drive
Philadelphia, PA 19113
CC: 236

4. By phone: 1-844-214-2474

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

Once all necessary and relevant information to make a decision is received, AmeriHealth Caritas DC'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 24 hours.

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 at AmeriHealth Caritas DC.

3. Grievances. A Grievance is a formal complaint submitted by a covered person about:

A. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A complaint submitted by a covered person about a decision rendered only because that the health benefit plan has a benefits exclusion for the health care services in question is not a grievance if the exclusion of the service requested is clearly stated in the Evidence of Coverage.

B. Claims payment and handling or reimbursement for services.

C. The contractual relationship between a covered person and an insurer.

You, your authorized representative, or your provider can file a grievance with us. You can do so in writing or over the phone. If the provider files a grievance on behalf of the enrollee and we do not have record of the enrollees' consent; the grievance team will need to secure the enrollees consent for the grievance. The grievance process is voluntary.

A grievance should be provided to us by you or your authorized representative by phone at Enrollee Services at 1-844-214-2470 (TTY 711)], 8 a.m. - 6 p.m., Monday through Friday excluding holidays or in writing at:

AmeriHealth Caritas District of Columbia
Healthy DC Plan
Enrollee Services Grievances Department
200 Stevens Drive Philadelphia, PA 19113

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 2 business days of receiving it. A complaint submitted by an enrollee 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 90 calendar days of receiving your grievance. On rare occasions, you or we may ask for an additional 14 calendar days for resolution, especially if more information is needed that would be helpful to resolving your grievance. We will notify you verbally of any extension and send you written notice within two calendar days explaining the reason for the extension.

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

A. The qualifications of the person or persons who reviewed your grievance.

B. A statement from the reviewers summarizing the grievance.

C. The reviewers' decision in clear terms and the basis for the decision.

D. A reference to any documentation used as a basis for the decision.

At any time, you can request free copies of all records and other information we have relevant to your written grievance, including the name of any health care professional we consulted. To obtain copies, please contact Enrollee Services at 1-844-214-2470 (TTY 711), 8 a.m. - 6 p.m., Monday through Friday excluding holidays.

4. Appeals

A. Standard Appeals. You or your authorized representative, including your provider, can file an appeal of an adverse determination verbally by calling Enrollee Services at 1-844-214-2470 (TTY 711), 8 a.m. - 6 p.m., Monday through Friday excluding holidays. You can file in writing by faxing to 1-844-214-2475 or mailing to:

AmeriHealth Caritas District of Columbia
Healthy DC Plan
Attention: Appeal Coordinator
Enrollee Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

We must receive a signed authorized representative form to process an appeal from your provider. An appeal must be filed within 180 days from the date of our written notice denying your claim or your request for service. The appeal procedure is voluntary on the part of the enrollee and an appeal may be initiated and/or proposed by the enrollee or authorized representative, including their provider.

For verbal appeals, the date you make your verbal appeal counts as the date of receipt of your appeal. Once we have received your appeal, we will begin researching your appeal. Within ten 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.

1. Getting Your Case File: 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 Enrollee Services at 1-844-214-2470 (TTY 711), 8 a.m. - 6 p.m., Monday through Friday excluding holidays.

If your review required physician review, the physician reviewing your appeal will:

a) Not have been involved in the previous decision on your claim or request for service.

b) Have the appropriate training in your condition or disease.

c) Not be a subordinate of any person involved in the initial decision to deny services.

2. Submitting Evidence: You or your authorized representative, including your provider, can submit evidence or testimony to support your appeal by calling Enrollee Services at 1-844-214-2470 (TTY 711), 8 a.m. - 6 p.m., Monday through Friday excluding holidays. You can submit evidence or testimony in writing by faxing to 1-844-214-2475 or mailing to:

AmeriHealth Caritas District of Columbia
Healthy DC Plan
Attention: Appeal Coordinator
Enrollee Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

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. A standard non-formulary pharmacy appeal is resolved within 72 hours. 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 Enrollee Services at 1-844-214-2470 (TTY 711), 8 a.m. - 6 p.m., Monday through Friday excluding holidays.

Note: You cannot request an extension of services after the original authorization has ended. For more details, please contact Enrollee Services.

B. Expedited (Emergency) Appeals. An expedited appeal can be requested by you, your authorized representative, or your provider either verbally or in writing. You, your representative, or provider can file a request for an expedited appeal with our Enrollee Services department by phone at 1-844-214-2470 (TTY 711), 8 a.m. - 6 p.m., Monday through Friday excluding holidays. You can file in writing by faxing to 1-844-214-2475 or mailing to:

AmeriHealth Caritas District of Columbia
Healthy DC Plan – Expedited Appeals
Attention: Appeal Coordinator
Enrollee Appeal Department

We will give you a written or oral decision on an expedited appeal within 72 hours after we get your appeal. For expedited non-formulary pharmacy appeals, they are resolved within 24 hours. If we decide that your request is not an emergency, we will notify you within 72 hours and your appeal will be moved to the standard appeal process. If you disagree, you have the right to file a grievance.

An expedited appeal will be made available when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Your provider can also file a verbal request for an expedited appeal. We will not require written follow-up for a verbal request for an expedited appeal. We may require documentation of the medical justification for an expedited appeal.

We will assign your request for an expedited appeal to a clinical peer. You will have the opportunity to provide evidence in support of your appeal by phone, in writing, or in person. If we deny the request for the appeal to be processed in an expedited manner, we will handle the request as a standard appeal and will send written notice to you or your authorized representative that we have denied your request for an expedited appeal. You have the right to submit a grievance 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 enrollees and their providers immediately, same day, but no not exceed the expedited timeframe after receiving the request. We will communicate our decision in writing within 24 hours after verbal notification was provided. If the expedited review is a concurrent review determination, we will remain liable for the coverage of health care services until the covered person has been notified of the determination. You or your authorized representative may access any medical records or other documents that we have and that are related to the subject of the expedited appeal at no cost to you. The physician reviewing your expedited appeal will:

1. Not have been involved in the previous decision on your claim or request for service.

2. Have the appropriate training in your condition or disease.

3. Not be a subordinate of any person involved in the initial decision to deny services.

C. <u>For Both Standard and Emergency Appeals.</u> If you want more time to submit information to support your appeal, you can ask us to delay our decision up to 14 more calendar days. Also, if we need to gather more information to decide your appeal, we can take up to 14 more calendar days to make our decision. If we need extra time, we will attempt to give prompt verbal notice, and a written notice is sent within two (2) calendar days.

D. Independent External Review Procedure. District of Columbia law makes available to you an independent external review of adverse determination decisions made by AmeriHealth Caritas DC. The external review will be performed by a third-party Independent Review Organization (IRO) who is not associated with AmeriHealth Caritas DC. 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:

1. Receive an adverse determination decision.

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

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

If you have any questions or concerns regarding the independent external review process, please contact Enrollee Services at 1-844-214-2470 (TTY 711), 8 a.m. - 6 p.m., Monday through Friday excluding holidays.

If you are not satisfied with the help provided by Enrollee Services, you may contact the District of Columbia Office of Health Care Ombudsman and Bill of Rights for help. The Office of Health Care Ombudsman and Bill of Rights was established by the Council of the District of Columbia to assist individuals insured by health plans in the District of Columbia and to assist uninsured District of Columbia consumers. They can help answer your questions about the appeals process and give you advice. You may call the Health Care Ombudsman at (202) 724-7491 (OFFICE) or 1-877-685-6391 (TOLL-FREE); TTY users should call 711. You may also email the Health Care Ombudsman at healthcareombudsman@dc.gov. You can also contact the Health Care Ombudsman by postal mail at

District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
441 4th St. N.W., Suite 250 North
Washington, D.C. 20001

or by fax: (202) 442- 6724

E. 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:

1. You completed our appeal process and received a final determination from us; or

2. You received notification that we have agreed to waive the exhaustion requirement; or

3. 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

4. You submit an expedited external review request at the same time as an expedited internal appeal with us

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

F. Eligibility for Independent External Review. For your request to be eligible for external review:

1. Your coverage with us must be in effect when the adverse determination decision was issued;

2. The service for which the adverse determination was issued appears to be a covered service under your policy; and

3. 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.

4. Your request must be a consideration of whether AmeriHealth Caritas DC is complying with the surprise billing and cost-sharing protections under the Public Health Service Act or be a determination that resulted in an adverse determination decision for reasons of:

    a) 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

    b) A rescission in coverage.

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

G. Standard External Review Requests. Your request for standard external review must be submitted in writing to AmeriHealth Caritas DC within four months of receiving our notice of final determination that the services in question are not approved. You or your authorized representative can submit this request by faxing 1-844-214-2475 or writing to:

AmeriHealth Caritas District of Columbia
Healthy DC Plan
Attention: External Review Request

Enrollee Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

H. Expedited External Review Requests. An expedited external review of an adverse determination decision may be available if:

1. 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

2. Your request for external review concerns admission, availability of care, continued stay, or health care service for which you received emergency care as defined by state law, but have not been discharged from the facility.

Expedited external review requests must be submitted within four months of the date on your final determination notice. You can submit your request verbally by contacting Enrollee Services at 1-844-214-2470, 8 a.m. - 6 p.m., Monday through Friday excluding holidays], by faxing at1-844-214-2475, or writing to:

AmeriHealth Caritas District of Columbia
Healthy DC Plan
Attention: External Review Request
Enrollee Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

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

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

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

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

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

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

1. Accept the case for standard external review if our internal appeal process was already completed, or

2. Require the completion of our internal appeal process before you may make another request for an external review.

J. 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 determination or final determination to the IRO within five business days of receipt of your request for standard external review and as expeditiously as possible (not to exceed 72 hours) for expedited external review requests. If we do not provide all pertinent information to the IRO within the time frame outlined above, it will not delay the conduct of your external review and the IRO may end the external review and make a decision to reverse the adverse determination or final determination. If this occurs, the IRO will immediately contact us and you or your authorized representative.

K. 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 notified of the IRO's decision to reverse a decision to deny, limit, or delay services that were not furnished while the appeal was pending, HDCP will authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. If you are no longer covered by us at the time we receive notice of the IRO's decision to reverse the adverse determination, we will only provide coverage for those services or supplies you actually received or would have received before disenrollment if the service had not been denied when first requested. If notified of the IRO's decision to reverse a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, HDCP will or the District, as indicated, must pay for those services.

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

ATTACHMENT B

DESCRIPTION OF COVERED SERVICES

Table of Contents

I. Detail of Benefits

COMPLEX CHRONIC OR HIGH-RISK ACUTE DISEASE MANAGEMENT

The following benefits are available to Enrollees to manage the care of complex chronic or high-risk acute diseases when provided by Designated Providers.

A. Chronic Care Coordination Program (CCP). Benefits will be provided for a Designated Provider to work telephonically or otherwise with a chronically ill Enrollee and his/her treating physician or nurse practitioner to develop and implement a treatment plan.

B. Complex Case Management (CCM). Specialty Case Managers will initiate and perform CCM services, as deemed Medically Necessary by the Enrollee's treating physician or nurse practitioner Benefits include:

1. Assessment of Enrollee/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;

2. Education of Enrollee/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;

3. Assistance in navigating and coordinating health care services and understanding benefits;

4. Assistance in arranging for a primary care physician to deliver and coordinate the Enrollee's care with Specialty Case Managers;

5. Assistance in arranging consultation(s) with physician Specialists;

6. Locating community resources, and other organizations/support services to supplement the Care Plan;

7. Implementation of a Care Plan in consultation with the Enrollee’s treating physician or nurse practitioner.

C. Comprehensive Medication Review (CMR). Benefits will be provided for a pharmacist's review of medications and consultation with the Enrollee to improve the effectiveness of pharmaceutical therapy.

D. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to an Enrollee with a chronic condition or disease in conjunction with the EMP for maintenance of the Enrollee's chronic condition or disease.

E. Expert Consultation Program (ECP). Benefits will be provided for a review by a Specialist of an Enrollee's medical records where the Enrollee has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

F. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in the Home-Based Care Management Plan.

1. The HBS coordinates care through an SCM or LCC for Enrollees in a Care Plan who need considerable support at home, sometimes on a prolonged basis. Services provided may include a home health aide, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following a home-based assessment by an HCC and become part of the overall plan of care maintained by the LCC or SCM responsible for the Enrollee.

2. The need for a Home-Based Care Management Plan is determined by the SCM or LCC, working under the direction of the Enrollee's treating physician or nurse practitioner. Benefits will be provided for the HBS when the Enrollee is specifically referred to the HBS by an SCM or an LCC for full assessment and integrated home-based services pursuant to a Home-Based Care Management Plan. To be eligible for the HBS, the Enrollee must have a home-based assessment performed and completed by a Designated Provider.

   A person is deemed to be in a Home-Based Care Management Plan only after the home-based assessment is completed and the plan is subsequently approved by the Enrollee's treating physician or nurse practitioner and the SCM or LCC.

3. To maintain participation in the HBS, the Enrollee must:

   a) Participate fully with the Care Plan and Home-Based Care Management Plan and the Enrollee's treating physician or nurse practitioner; and,

   b) Engage in regular communication with the HCC, LCC and/or SCM.

4. Covered Services rendered to the Enrollee provided through or as a result of the Home-Based Care Management Plan will not count toward any visit limits stated in the Schedule of Benefits.

HOME HEALTH CARE SERVICES

Covered Home Health Care Services

Benefits are provided for:

A. Continued care and treatment provided by or under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services of a home health aide, medical social worker, or registered dietician may be provided, but must be performed under the supervision of a licensed professional (RN or LPN) nurse.

B. Drugs and medications directly administered to the patient during a covered home health care visit and incidental Medical Supplies directly expended in the course of a covered home health care visit are covered.

C. Home Health Care Services authorized or approved as Medically Necessary under the utilization management requirements as meeting the conditions for coverage.

Purchase or rental of Durable Medical Equipment is not covered under this provision but may be covered elsewhere in the plan.

This benefit is available for 90 visits per episode. A new episode of care begins if the Enrollee does not receive home health care services for the same or a different condition for 60 consecutive days.

Conditions for Coverage

Benefits are provided when:

A. The Enrollee must be confined to home due to a medical, non-psychiatric condition. "Home" cannot be an institution, convalescent home, or any facility which is primarily engaged in rendering medical or rehabilitative services to sick, disabled, or injured persons.

B. The Home Health Care visits are a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if Home Health Care visits were not provided, the Enrollee would have to be admitted to a hospital or Skilled Nursing Facility).

C. The Enrollee requires and continues to require Skilled Nursing Care or rehabilitation services in order to qualify for home health aide services or other types of Home Health Care Services.

D. The need for Home Health Care Services is not Custodial in nature.

E. Services of a home health aide, medical social worker, or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).

F. All services must be arranged and billed by the Qualified Home Health Agency. Providers may not be retained directly by the Enrollee.

Additional Home Health Care Benefits

A. Home Visits Following Surgical Removal of a Testicle
For an Enrollee who receives less than 48 hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis, benefits will be provided for:

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

2. An additional home visit if prescribed by the Enrollee's attending physician.

3. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

B. Home Visits Following a Mastectomy
1. Inpatient Coverage Following a Mastectomy, or who undergoes a Mastectomy on an outpatient basis, benefits will be provided for:

a) One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

b) An additional home visit if prescribed by the Enrollee's attending physician.

2. Inpatient Coverage Following a Mastectomy, coverage will be provided for a home visit if prescribed by the Enrollee's attending physician

3. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

C. Postpartum Home Visits

Home visits following delivery are covered in accordance with the most current standards published by the American College of Obstetricians and Gynecologists.

1. **Benefits** will be provided for:

a) One home visit scheduled to occur within 24 hours after hospital discharge; and

b) An additional home visit if prescribed by the attending physician.

2. For a mother and newborn child who remain in the hospital, benefits will be provided for a home visit if prescribed by the attending physician.

3. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

HOSPICE CARE SERVICES

Covered Hospice Care Services

Benefits will be provided for the services listed below when provided by a Qualified Hospice Care Program. Coverage for hospice care services is subject to certification of the need and continued appropriateness of such services in accordance with utilization management requirements.

A. Inpatient and outpatient care;
B. Intermittent Skilled Nursing Care;
C. Medical social services for the terminally ill patient and his or her Immediate Family;
D. Counseling, including dietary counseling, for the terminally ill Enrollee;
E. Non-Custodial home health visits.
F. Services, visits, medical/surgical equipment, or supplies, including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Enrollee;
G. Laboratory test and x-ray services;
H. Medically Necessary ground ambulance;
I. Family Counseling will be provided to the Immediate Family and the Family Caregiver before the death of the terminally ill Enrollee; and
J. Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Enrollee for the six (6) month period following the Enrollee's death or fifteen (15) visits, whichever occurs first.

Hospice Eligibility Period

The hospice eligibility period begins on the first date hospice care services are rendered and terminates one hundred eighty (180) days later or upon the death of the terminally ill Enrollee, if sooner.

INPATIENT HOSPITAL SERVICES

Covered Inpatient Hospital Services

An Enrollee will receive benefits for the Covered Services listed below when admitted to a hospital. Coverage of inpatient hospital services is subject to certification by utilization management for Medical Necessity. Benefits are provided for:

A. Room and Board
Room and board in a semiprivate room (or in a private room when Medically Necessary).

B. Physician, Medical, and Surgical Services
Medically Necessary inpatient physician, medical, and surgical services provided by or under the direction of the attending physician and ordinarily furnished to a patient while hospitalized.

C. Services and Supplies
Related inpatient services and supplies that are not Experimental/Investigational and ordinarily furnished by the hospital to its patients, including:

1. The use of:
   a) Operating rooms;
   b) Treatment rooms; and
   c) Special equipment in the hospital.

2. Drugs, medications, solutions, biological preparations, anesthesia, and services associated with the administration of the same.
3. Medical and surgical supplies.

4. Blood, blood plasma, and blood products, and related donor processing fees that are not replaced by or on behalf of the Enrollee. Administrations of infusions and transfusions are covered.

5. Surgically implanted Prosthetic Devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants, and pacemakers. Available benefits under this provision do not include items such as dental implants, fixed or removable dental Prosthetics, artificial limbs, or other external Prosthetics, which may be provided under other provisions of this Description of Covered Services.

6. Medical social services.

Hysterectomies
Coverage will be provided for vaginal and abdominal hysterectomies. Coverage includes a minimum stay in the hospital of:

A. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and

B. Not less than forty-eight (48) hours for a vaginal hysterectomy. In consultation with the Enrollee's attending physician, the Enrollee may elect to stay less than the minimum prescribed above when appropriate.

MEDICAL DEVICES AND SUPPLIES

Definitions:

Durable Medical Equipment means equipment which:

A. Is primarily and customarily used to serve a medical purpose;

B. Is not useful to a person in the absence of illness or injury;

C. Is ordered or prescribed by a health care provider;

D. Is consistent with the diagnosis;

E. Is appropriate for use in the home;

F. Is reusable; and

G. Can withstand repeated use.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry, including a disease for which the state screens newborn babies.

Low Protein Modified Food Product means a food product that is:

A. Specially formulated to have less than 1 gram of protein per serving; and

B. Intended to be used under the direction of a physician for the dietary treatment of an Inherited Metabolic Disease.

C. Low Protein Modified Food Product does not include a natural food that is naturally low in protein.

Medical Devices means Durable Medical Equipment, medical formulas, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medically Necessary Food means a food, including a low-protein modified food product or an amino acid preparation product, a modified fat preparation product, or a nutritional formula that is specially formulated and processed for the partial or exclusive feeding of an individual by means of oral intake or enteral feeding by tube, and intended for dietary management of an individual who, because of therapeutic or chronic medical needs, has limited or impaired capacity to ingest, digest, absorb, or metabolize ordinary foodstuffs or certain nutrients or who has other specially medically determined nutrient requirements, the dietary management of which cannot be achieved by modification of the normal diet alone.

Medical Supplies means items that:

A. Are primarily and customarily used to serve a medical purpose;

B. Are not useful to a person in the absence of illness or injury;

C. Are ordered or prescribed by a health care provider;

D. Are consistent with the diagnosis;

E. Are appropriate for use in the home;

F. Cannot withstand repeated use; and

G. Are usually disposable in nature.

Orthotic Devices means orthoses and braces which:

A. Are primarily and customarily used to serve a therapeutic medical purpose;

B. Are prescribed by a health care provider;

C. Are corrective appliances that are applied externally to the body to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;

D. May be purely passive support or may make use of spring devices; and

E. Include devices necessary for post-operative healing.

Prosthetic Devices means devices which:

A. Are primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or

B. Are primarily intended to replace all or part of an organ or body part that was absent from birth; or

C. Are intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and

D. Are prescribed by a health care provider; and

E. Are removable and attached externally to the body.

Covered Services

A. Durable Medical Equipment

Rental, or purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a health care provider for therapeutic use for an Enrollee's medical condition.

Payment for rental will not exceed the total cost of purchase. Payment is limited to the least expensive Medically Necessary Durable Medical Equipment adequate to meet the Enrollee's medical needs. Payment for Durable Medical Equipment includes related charges for handling, delivery, mailing, shipping, and taxes.

B. Medical Supplies

C. Medically Necessary Foods

Coverage will be provided for medically necessary food ordered as necessary by a provider for the following diseases or conditions:

1. Inflammatory bowel disease, including Crohn's disease, ulcerative colitis, and indeterminate colitis;
2. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
3. Immunoglobulin E- and non-Immunoglobulin E-mediated allergies to food proteins;
4. Food protein-induced enterocolitis syndrome;
5. Eosinophilic disorders, including eosinophilic esophagitis, eosinophilic gastroenteritis, eosinophilic colitis, and post-transplant eosinophilic disorders;
6. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract, including short bowel syndrome and chronic intestinal pseudo-obstruction;
7. Malabsorption due to liver or pancreatic disease;
8. Inherited metabolic disorders; and
9. Any other diseases or conditions as determined by the Mayor..

D. Nutritional Substances

Enteral and elemental nutrition when Medically Necessary.

E. Diabetes Equipment and Supplies

1. Coverage will be provided for all Medically Necessary and medically appropriate equipment and diabetic supplies necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

2. Coverage includes Medically Necessary and medically appropriate equipment and diabetic supplies necessary for the treatment of insulin- dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.

3. Benefits for insulin syringes and other diabetic supplies described herein are covered on P. B31, Prescription Drugs. All other diabetic equipment is covered as a medical device or supply.

F. Hair Prosthesis

Benefits are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

G. Orthotic Devices and Prosthetic Devices Benefits include:

1. Supplies and accessories necessary for effective functioning of a Covered Service;

2. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and

3. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

Repairs

Benefits for the repair, maintenance, or replacement of covered Durable Medical Equipment are limited as follows:

A. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating, and checking of equipment.

B. Coverage of repairs costs is limited to adjustment required by normal wear or by a change in the Enrollee's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the appliance, prosthetic, or equipment.

C. Replacement coverage is limited to once every two (2) years due to irreparable damage and/or normal wear, or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Enrollee or of a family member are not covered.

Benefit Limits

Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

Benefits will be limited to the lower cost of purchase or rental, taking into account the length of time the Enrollee requires, or is reasonably expected to require the equipment, and the durability of the equipment, etc. The purchase price or rental cost must be the least expensive of its type adequate to meet the medical needs of the Enrollee. If the Enrollee selects a deluxe version of the appliance, device, or equipment not determined to be Medically Necessary, will pay an amount that does not exceed payment for the basic device and the Enrollee will be fully responsible for paying the remaining balance.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Definitions

Mental Illness and Emotional Disorders are broadly defined as including any mental disorder, mental illness, psychiatric illness, mental condition, or psychiatric condition (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis, or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Partial Hospitalization means the provision of medically directed intensive or intermediate short-term treatment in a licensed or certified facility or program for treatment of Mental Illnesses, Emotional Disorders, and Drug and Alcohol Abuse.

Qualified Partial Hospitalization Program means a licensed or certified facility or program that provides medically directed intensive or intermediate short-term treatment for Mental Illness,

Emotional Disorder, Drug Abuse or Alcohol Abuse for a period of less than twenty- four (24) hours, but more than four (4) hours in a day.

Qualified Treatment Facility means a non-hospital residential facility certified by the District of Columbia or by any jurisdiction in which it is located, as a qualified non-hospital provider of treatment for Drug Abuse, Alcohol Abuse, Mental Illness, or any combination of these, in a residential setting. A non-hospital residential facility includes any facility operated by the District of Columbia, any state or territory or the federal government to provide these services in a residential setting. It is not a facility licensed as a general or special hospital. A non- hospital residential facility also must meet or exceed guidelines established for such a facility.

Outpatient Mental Health and Substance Abuse Services

Covered Services include the following:

A. Diagnosis and treatment for Mental Illness and Emotional Disorders at health care provider offices, other outpatient health care provider medical offices and facilities, and in Qualified Partial Hospitalization Programs.

B. Diagnosis and treatment for Substance Abuse, including detoxification and rehabilitation services as an outpatient in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program.

C. Other covered medical services and medical Ancillary Services for conditions related to Mental Illness, Emotional Disorders, and Substance Abuse.

D. Office visits for medication management in connection with Mental Illness, Emotional Disorders, and Substance Abuse.

E. Methadone maintenance treatment.

F. Partial Hospitalization in a Qualified Partial Hospitalization Program.

Inpatient Mental Health and Substance Abuse Services

Benefits are provided when the Enrollee is admitted as an inpatient in a hospital or other approved health care facility for treatment of Mental Illness, Emotional Disorders, and Substance Abuse as follows:

A. Hospital benefits will be provided, as described on P. B6 and P. B42, Inpatient Hospital Services, of this Description of Covered Services, on the same basis as a medical (non-Mental Health or Substance Abuse) admission.

B. Services provided to a hospitalized Enrollee, including physician visits, charges for intensive care, or consultative services, and that such services were medically required to diagnose or treat the Enrollee's condition.

The following benefits apply if the Enrollee is an inpatient in a hospital covered under inpatient hospitalization benefits following certification of the need and continued appropriateness of such services in accordance with utilization management requirements:

1. Health care provider visits during the Enrollee's hospital stay;

2. Intensive care that requires a health care provider's attendance;

3. Consultation by another health care provider when additional skilled care is required because of the complexity of the Enrollee's condition; and

C. Benefits are available for diagnosis and treatment for Substance Abuse, including inpatient detoxification and rehabilitation services in an acute care hospital or Qualified Treatment Facility. Enrollees must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs.

OUTPATIENT FACILITY, OFFICE, AND PROFESSIONAL SERVICES

See P. B32, Utilization Management, for Covered Services that require prior authorization.

Office Visits

Benefits are available for office visits for the diagnosis and treatment of a medical condition, including care and consultation provided by primary care providers and specialists.

Laboratory Tests, Radiologic Imaging, and Diagnostic Procedures.

Coverage is provided for laboratory tests, radiologic imaging (X-rays, CAT Scans, MRIs, MRAs, etc.), and diagnostic procedures.

Preventive Services

In addition to the benefits listed in this provision, the Insurer will provide benefits for health exams and other services for the prevention and detection of disease, at intervals appropriate to the Enrollee's age, sex, and health status, in accordance with the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010. At a minimum, benefits for preventive services listed in this provision will be provided once per Benefit Period.

Benefits will be provided for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). This includes benefits for preventive maternity care. Updated new recommendations will be added to the preventive benefits listed in this provision at the schedule established by the Secretary of Health and Human Services.

Benefits for preventive care include the following:

Cancer Screening Services Benefits include:

1. Prostate Cancer Screening
   Benefits are available when rendered in accordance with the most current American Cancer Society's guidelines and include a medically recognized diagnostic examination, annual digital rectal examinations, and the prostate-specific antigen (PSA) tests.

2. Colorectal Cancer Screening
   Colorectal cancer screening provided in accordance with the latest guidelines issued by the American Cancer Society.

3. Pap Smears
   Benefits are available for pap smears, including tests performed using FDA approved gynecological cytology screening technologies, at intervals appropriate to the Enrollee's age and health status.

4. Breast Cancer Screening

At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention of breast cancer will be considered the most current other than those issued in or around November 2009.

Human Papillomavirus Screening Test

1. Coverage is provided for a Human Papillomavirus Screening Test at the screening intervals supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
2. Human Papillomavirus Screening Test means any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus and is approved for this purpose by the FDA.

Immunizations

Coverage is provided for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Immunizations required solely for travel or work are not covered.

A recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered to be:

1. In effect after it has been adopted by the Director of the Centers for Disease Control and Prevention; and
2. For routine use if it is listed on the immunization schedules of the Centers for Disease Control and Prevention.

Well Child Care

With respect to infants, children, and adolescents, coverage is provided for evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

Adult Preventive Care

Benefits include health care services incidental to and rendered during an annual visit at intervals appropriate to the Enrollee's age, sex , and health status, including evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Preventive Gynecological Care

Benefits include recommended preventive services that are age and developmentally appropriate as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Prevention and Treatment of Obesity

Benefits will be provided for:

1. Well child care visits for obesity evaluation and management;

2. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);

3. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and,

4. Office visits for the treatment of childhood obesity.

5. Limitations
   Benefits for preventive care and screening for obesity are available to all Enrollees.

Osteoporosis Prevention and Treatment Services

Definitions

Bone Mass Measurement means a radiologic or other scientifically proven technology for the purpose of identifying bone mass or detecting bone loss.

Bone Mass Measurement may be covered for an Enrollee:

1. Who is estrogen deficient and at clinical risk for osteoporosis;

2. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

3. Receiving long-term glucocorticoid (steroid) therapy;

4. With primary hyperparathyroidism; or,

5. Being monitored to assess the response to, or efficacy of, an approved osteoporosis drug therapy.

Benefits for Bone Mass Measurement for the prevention, diagnosis, and treatment of osteoporosis are covered when requested by a Health Care Provider for an Enrollee.

Professional Nutritional Counseling and Medical Nutrition Therapy
Benefits are available for Medically Necessary Professional Nutritional Counseling and Medical Nutrition Therapy.

Family Planning Services Benefits
will be provided for:

A. Non-Preventive Gynecological Care
   Benefits are available for Medically Necessary gynecological care. Benefits for preventive gynecological care are described on P. B15 "Preventive Services."

B. Contraceptive Methods and Counseling
   Covered Benefits:

1. Contraceptive patient education and counseling for all Enrollees with reproductive capacity.

2. Benefits will be provided for all FDA approved contraceptive drugs and devices for all Enrollees, and sterilization procedures and other contraceptive methods for female Enrollees that must be administered to the Enrollee in the course of a covered outpatient or inpatient treatment.

3. Coverage will be provided for the insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs that are approved by the FDA.

4. Vasectomies for male Enrollees and surgical reversal of vasectomies for male Enrollees.

5. Elective abortion for purposes for which federal funding is available.

See P. B31, Prescription Drugs, for coverage for self-administered FDA- approved contraceptive drugs and devices.

Maternity Services

If you are pregnant, federal law does not allow Healthy DC Plan to cover you. You can enroll in DC Medicaid. You must immediately let Healthy DC know so you can be enrolled in DC Medicaid. Either log into your account at https://www.dchealthlink.com or call Healthy DC Plan at 833-432-7526 or let AmeriHealth Caritas DC know to help get your pregnancy covered.

The following maternity services are provided for all female Enrollees.

A. Preventive Services

1. Routine outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one postpartum office visit;

2. Prenatal laboratory tests and diagnostic services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration;

3. Preventive laboratory tests and services rendered to a newborn during a covered hospitalization for delivery, identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B," the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening; and

4. Breastfeeding support, supplies, and consultation.

5. These services, except for breastfeeding equipment, are covered to the same extent as other preventive services.

B. Non-Preventive Services

1. Outpatient obstetrical care and professional services for all prenatal and post-partum complications. Services include prenatal and post-partum office visits and Ancillary Services provided during those visits, such as Medically Necessary laboratory tests and diagnostic services.

2. Inpatient care for delivery: Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as an Enrollee in the newborn's own right.

3. Postpartum Home Visits. See P. B5, Home Health Care Services.

C. Newborn Coverage. Coverage includes:

1. Medically Necessary routine newborn visits including admission and discharge exams and visits for the collection of adequate samples for hereditary and metabolic newborn screening;

2. Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and

3. Routine hearing screening consisting of one of the following:

   a. Auditory brain stem response;

   b. Otoacustic emissions; or

   c. Other appropriate, nationally recognized, objective physiological screening test.

   Additionally, benefits will be provided for infant hearing screenings and all necessary audiological examinations provided using any technology approved by the United States Food and Drug Administration, and as recommended by the most current standards addressing early hearing detection and intervention programs by the National Joint Committee on Infant Hearing. Such coverage will include follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss. Infant as used here is defined according to the most current recommendation of the American Academy of Pediatrics.

D. Infertility Services

Benefits are available for the testing and treatment of infertility.

Coverage will be provided for the following services:

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).

- Treatment and/or procedures performed specifically to enable conception regardless of an infertility condition.
- Artificial Insemination & intrauterine insemination regardless of an infertility condition.
- Invitro, GIFT, ZIFT, etc.
- Standard fertility preservation services.
- Access to reproductive services for the purpose of pre-implantation genetic testing and embryo selection when parent(s), though fertile, are known carriers of genes associated with birth defects.
- Surgical Procedures, Inpatient, Outpatient and Physician's Services (including Lab and Radiology Tests, Counseling).
- Minimum 3 complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals or from any oocyte retrieval performed prior to January 1, 2025.
- Medical costs related to an embryo transfer to be made from an enrollee to a third-party; except, that the enrollee's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure.
- Cryopreserved Reproductive Material Storage
- Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility)

Allergy Services

Benefits are available for allergy testing and treatment, including allergy serum and the administration of injections.

Rehabilitation Services

A. Definitions

Physical Therapy (PT) includes the short-term treatment that can be expected to result in a significant improvement of a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Occupational Therapy (OT) means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition. Occupational Therapy services do not include the adjustment or manipulation of any of the osseous structures of the body or spine.

Speech Therapy (ST) means the treatment of communication impairment and swallowing disorders. Speech Therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation, including cognitive rehabilitation.

B. Covered Benefits

Coverage includes benefits for rehabilitation services including Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness or injury.

The goal of rehabilitation services is to return the individual to his/her prior skill and functional level.

This benefit is available for 30 visits per episode. A new episode of care begins if the Enrollee does not receive rehabilitation services for the same or a different condition for 60 consecutive days.

Spinal Manipulation

A. Covered Services

Coverage is provided for Medically Necessary spinal manipulation, evaluation, and treatment for the musculoskeletal conditions of the spine when provided by a licensed chiropractor, doctor of osteopathy (D.O.), or other eligible practitioner.

B. Limitations. Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

Habilitative Services

Coverage includes Medically Necessary Habilitative services that help an Enrollee keep, learn, or improve skills and functioning for daily living, including, but not limited to, applied behavioral analysis for the treatment of autism spectrum disorder.

This benefit is available for 30 visits per episode. A new episode of care begins if the Enrollee does not receive habilitative services for the same or a different condition for 60 consecutive days.

Outpatient Therapeutic Treatment Services

Benefits are available for outpatient services rendered in a health care provider's office, in the outpatient department of a hospital, in an ambulatory surgical facility, or other outpatient facility in connection with a medical or surgical procedure covered on P. B12, Outpatient Facility, Office, and Professional Services. Benefits include services and treatments such as:

A. Hemodialysis and peritoneal dialysis;

B. Chemotherapy;

C. Radiation therapy, including oncology dialysis;

D. Cardiac Rehabilitation benefits are provided to Enrollees who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding recommendation for Cardiac Rehabilitation. Coverage is provided for all Medically Necessary services. Services must be provided at an approved place of service equipped and approved to provide Cardiac Rehabilitation.

E. Pulmonary Rehabilitation benefits are provided to Enrollees who have been diagnosed with significant pulmonary disease, or who have undergone certain surgical procedures of the lung. Coverage is provided for all Medically Necessary services. Services must be provided at a approved place of service equipped and approved to provide pulmonary rehabilitation.

F. Infusion and transfusion services;

G. Electroshock therapy; and

H. Radioisotope treatment.

Blood and Blood Products

Benefits are available for blood and blood products (including derivatives and components) that are not replaced by or on behalf of the Enrollee.

Organ and Tissue Transplants

A. Coverage is provided for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures.

B. Covered Services include the following:

1. The expenses related to registration at transplant facilities. The place of registry is subject to review.

2. Organ procurement charges including harvesting, recovery, preservation, and transportation of the donated organ.

3. Cost of hotel lodging and air transportation for the recipient Enrollee and a companion (or the recipient Enrollee and two companions if the recipient Enrollee is under the age of eighteen (18) years) to and from the site of the transplant.

4. There is no limit on the number of re-transplants that are covered.

5. If the Enrollee is the recipient of a covered organ/tissue transplant, Donor Services (as defined below) are covered to the extent that the services are not covered under any other health insurance plan or contract.

   Donor Services means services covered under the which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure which are directly related to donating the organ or tissue.

6. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant.

High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant

Benefits will be provided for high dose chemotherapy bone marrow or stem cell transplant treatment that is not Experimental/ Investigational, when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

Clinical Trial Patient Cost Coverage

A. Definitions

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the Group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group, National Cancer

Institute Community Clinical Oncology Program, AIDS Clinical Trials Group, and Community Programs for Clinical Research in AIDS.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the

relationship of the institution to the federal Department of Health and Human Services, and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Qualified Enrollee, as used in this section, means an Enrollee who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to the treatment of cancer or other life-threatening disease or condition, and the provider who recommended the Enrollee for the clinical trial has concluded that the Enrollee's participation in such trial is appropriate to treat the disease or condition, or the Enrollee's participation is based on medical and scientific information.

Routine Patient Costs means the costs of all Medically Necessary items and health care services consistent with the Covered Services that are typically provided for an Enrollee who is not enrolled in a clinical trial that are incurred as a result of the treatment being provided to the Qualified Enrollee for purposes of the clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

B. Covered Services

1. Benefits for Routine Patient Costs to a Qualified Enrollee in a clinical trial will be provided if the Qualified Enrollee's participation in the clinical trial is the result of:

   a) Treatment provided for a life-threatening disease or condition; or

   b) Prevention, early detection, and treatment studies on cancer.

2. Coverage for Routine Patient Costs will be provided only if:

   a) The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or,

   b) The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening disease or condition;

   c) The treatment is being provided in a federally funded or approved clinical trial approved by one of the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and quality, the Centers for Medicare and Medicaid Services, an NIH Cooperative Group, an NIH Center, the FDA in the form of an investigational new drug

   application, the federal Department of Veterans Affairs, the federal Department of Energy or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant, or an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH;

d) The treatment is being provided under a drug trial that is exempt from the requirement of an investigational new drug application.

e) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

f) There is no clearly superior, non-investigational treatment alternative;

g) The available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

3. Coverage is provided for the Routine Patient Costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Qualified Enrollee's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

Diabetes Equipment and Supplies, and Self-Management Training

A. If deemed necessary, diabetes outpatient self-management training and educational services, including Medical Nutrition Therapy, will be provided through an in-person program supervised by an appropriately licensed, registered, or health care provider whose scope of practice includes diabetes education or management.

B. Coverage information for diabetic equipment and supplies is located on P. B9, Medical Devices and Supplies and P. B31, Prescription Drugs.

Dental Services

Benefits will be provided to all Enrollees for the following:

Accidental Injury

A. Covered Benefits

Dental benefits will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if the injury did not arise while or as a result of biting or chewing, and treatment is commenced within six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within six (6) months of the injury, treatment began within six (6) months of the earliest date that it would be medically appropriate to begin such treatment.

As used in this provision, accidental injury means an injury to Sound Natural Teeth as a result of an external force or trauma resulting in damage to a tooth or teeth, surrounding bone and/or jaw.

B. Conditions and Limitations

Benefits are limited to Medically Necessary dental services as a restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury. Except as listed here, or on P. B22, Treatment for Cleft Lip or Cleft Palate or Both, describing benefits for the treatment of cleft lip or cleft palate or both, dental care is excluded from coverage. Benefits for oral surgery are described below under the heading of Oral Surgery.

C. Exclusions
Injuries to teeth that are not Sound Natural Teeth are not covered. Injuries as a result of biting or chewing are not covered.

Oral Surgery

Benefits include:

A. Medically Necessary procedures, to attain functional capacity, correct a congenital anomaly (excluding odontogenic congenital anomalies or anomalies limited to the teeth), reduce a dislocation, repair a fracture, excise tumors, non-odontogenic cysts or exostoses, or drain abscesses involving cellulitis and are performed on the lips, tongue, roof, and floor of the mouth, sinuses, salivary glands or ducts, and jaws.

B. Medically Necessary procedures as needed as a result of an accidental injury, when the Enrollee requests oral surgical services or dental services for Sound Natural Teeth and supporting structures or the need for oral surgical services or dental services for Sound Natural Teeth and supporting structures is identified in the patient's medical records within sixty (60) days of the accident. Benefits for such oral surgical services will be provided up to three (3) years from the date of injury.

C. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.

All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae (orthognathic surgery) for Cosmetic or other purposes or for correction of the malocclusion unrelated to a functional impairment that cannot be corrected non-surgically are excluded.

Treatment for Cleft Lip or Cleft Palate or Both

Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological, and speech/language treatment for cleft lip or cleft palate or both.

Outpatient Surgical Procedures

A. Benefits are available for surgical procedures performed by a health care provider on an outpatient basis including, but not limited to, colonoscopy, sigmoidoscopy, and endoscopy.

B. Benefits are available for services in a hospital outpatient department or in an ambulatory surgical facility, in connection with a covered surgical procedure, including:

1. Use of operating room and recovery room.

2. Use of special procedure rooms.

3. Diagnostic procedures, laboratory tests, and radiology services.

4. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

5. Medical and surgical supplies.

6. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Enrollee. Administration of infusions is covered.

Anesthesia Services for Medical or Surgical Procedures

Benefits are available for the administration of general anesthesia in connection with a covered medical or surgical procedure. To be eligible for separate coverage, a health care provider other than the operating surgeon or assistant at surgery must administer the anesthesia. For example, a local anesthetic used while performing a medical or surgical procedure is not generally viewed as a separately covered charge.

Reconstructive Surgery

Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.

Reconstructive Breast Surgery

Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy.

A. Reconstructive breast surgery means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts.

   Reconstructive breast surgery includes:
   1. Augmentation mammoplasty;
   2. Reduction mammoplasty; and
   3. Mastopexy.

B. Benefits are provided for all stages of reconstructive breast surgery performed on the non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery on the diseased breast is performed.

C. Benefits are provided regardless of whether the Mastectomy was performed while the Enrollee was covered under the Evidence of Coverage; Agreement.

D. Coverage will be provided for treatment of physical complications at all stages of Mastectomy, including lymphedemas, in a manner determined in consultation with the Enrollee and the Enrollee's attending physician.

Limited Service Immediate Care

Coverage is provided for treatment of common conditions or ailments which require rapid and specific treatment that can be administered in a limited duration of time. Limited Service Immediate Care services are non-emergency and non-urgent services.

Services are provided in Limited Service Immediate Care Centers, which are mini- medical office chains typically staffed by nurse practitioners with an on-call physician. Examples of common ailments for which a layperson who possesses an average knowledge of health and medicine would seek Limited Service Immediate Care, include but are not limited to: ear, bladder, and sinus infections, pink eye, flu, and strep throat.

Urgent Care Services

Benefits are available for Urgent Care received from an Urgent Care center.

Emergency Services

Benefits are available for Emergency Services received in or through a hospital emergency room. Benefits include coverage for the costs of a voluntary HIV test, performed during an Enrollee's visit to a hospital emergency room, regardless of the reason for the hospital emergency room visit.

Ambulance Services

Benefits are available for Medically Necessary air and ground ambulance services.

If the Enrollee is outside the United States and requires treatment by a medical professional, benefits will be provided to transport the Enrollee to the nearest location where more appropriate medical care is available. Benefits include air or ground ambulance services, when Medically Necessary.

PEDIATRIC DENTAL SERVICES

Subject to the terms and conditions of this Description of Covered Services, benefits will be provided for the following Covered Dental Services when rendered and billed for by a Dentist as specified in the attached Schedule of Benefits.

Class I - Preventive and Diagnostic Services

A. Services limited to twice per Benefit Period.

1. Oral examination including oral health risk assessment
2. Routine cleaning of teeth (dental prophylaxis)
3. Topical application of fluoride
4. Bitewing x-ray (not taken on the same date as those in B. below)
5. Pulp vitality tests; additional tests may be allowed for accidental injury and trauma, or other emergency

B. Services limited to one per 60 months

1. Intraoral complete series x-ray (full mouth x-ray including bitewings)
2. One panoramic x-ray and one additional set of bitewing x-rays

C. Services limited to once per tooth per 36 months: sealants on permanent molars

D. Space maintainers when Medically Necessary due to the premature loss of a posterior primary tooth

E. Services as required

1. Palliative Treatments once per date of service
2. Emergency Oral Exam once per date of service
3. Periapical and occlusal x-rays limited to the site of injury or infection
4. Professional consultation rendered by a Dentist, limited to one consultation per condition per Dentist other than the treating Dentist
5. Intraoral occlusal x-ray
6. One cephalometric x-ray

Class II - Basic Services

A. Direct placement fillings limited to:

1. Silver amalgam, resin-based composite, compomer, glass-ionomer or equivalent material accepted by the American Dental Association and/or the United States Food and Drug Administration

2. Direct pulp caps and indirect pulp caps

B. Non-Surgical periodontic services limited to:

1. Periodontal scaling and root planning once per 24 months per quadrant

2. Full mouth debridement to enable comprehensive periodontal procedure one per lifetime

3. Periodontal maintenance procedures four per 12 months

C. Simple extractions performed without general anesthesia once per tooth per lifetime

Class III - Major Services - Surgical

A. Surgical periodontic services

1. Gingivectomy or gingivoplasty limited to one treatment per 36 months per Enrollee per quadrant or per tooth

2. Osseous Surgery (including flap entry and closure) limited to one treatment per 36 months per Enrollee per quadrant

3. Limited or complete occlusal adjustments in connection with periodontal treatment when services are received on a different date than restorative services

4. Mucogingival Surgery limited to grafts and plastic procedures; one treatment per site limited to one site or quadrant every 36 months

B. Endodontics

1. Apicoectomy

2. Pulpotomy for deciduous teeth once per tooth per lifetime per Enrollee

3. Root canal for permanent teeth once per tooth per lifetime per Enrollee

4. Root canal retreatment performed on permanent teeth limited to once per tooth per lifetime per Enrollee

5. Root resection once per tooth per lifetime per Enrollee

6. Pulpal therapy once per tooth per lifetime per Enrollee

7. Endodontic therapy once per tooth per lifetime per Enrollee

C. Oral Surgical services as required

1. Simple and Surgical extractions, including impactions once per tooth per lifetime per Enrollee

2. Oral Surgery, including treatment for cysts, tumors and abscesses

3. Biopsies of oral tissue if a biopsy report is submitted

4. General anesthesia, intravenous (IV) sedation/analgesia, analgesia, and non-intravenous conscious sedation when Medically Necessary and administered by a Dentist who has a license, permit, or certificate to administer conscious sedation or general anesthesia or board-certified anesthesiologist (MD, DO, DDS, DMD).

5. Hemi-section

6. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

7. Vestibuloplasty

8. Services limited to once per lifetime per tooth:

    a. Coronectomy

    b. Tooth transplantation

    c. Surgical repositioning of teeth

    d. Alveoloplasty

    e. Frenulectomy

    f. Excision of pericoronal gingiva

Class IV - Major Services - Restorative

A. Crowns

1. Metal and/or porcelain/ceramic crowns and crown build-ups limited to one per 60 months per tooth

2. Metal and/or porcelain/ceramic inlays and onlays limited to one per 60 months per tooth

3. Stainless steel crowns

4. Recementation of crowns and/or inlays limited to once in any twelve (12) month period

5. Metal and/or porcelain/ceramic pontics limited to one per 60 months per tooth

B. Dental Implants are covered procedures only if determined to be Medically Necessary. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures, and only the second phase of treatment (the prosthodontic phase of placing of the implant crown or partial denture) will be a Covered Dental Service.

1. Endosteal implant limited to one per 60 months

2. Surgical placement of interim implant body limited to one per 60 months

3. Eposteal implant limited to one per 60 months

4. Transosteal implant limited to one per 60 months

5. Implant supported complete denture

6. Implant supported partial denture

C. Dentures

1. Partial removable dentures, upper or lower, limited to one per 60 months

2. Complete removable dentures, upper or lower, limited to one per 60 months

3. Pre-operative radiographs required

4. Pre-treatment estimate, as described in the Estimate of Eligible Benefits section is recommended for Enrollees

5. Tissue conditioning prior to denture impression

6. Repairs to denture as required including: repair resin denture base, repair cast framework, addition of tooth or clasp to existing partial denture, replacement of broken tooth, repairs or replacement of clasp, recement fixed partial denture

D. Denture adjustments and relining limited to: Full or partial removable (upper or lower) dentures: once per 24 months, but not within six months of initial placement

E. Repair of prosthetic appliances and removable dentures, full and/or partial.

F. Occlusal guard, by report, limited to one per 12 months for Enrollees.

G. Occlusal adjustment, limited, if provided when no other restorative procedure is provided on the same date of service, limited to two per 12 months

H. Occlusal adjustment, complete, if provided when no other restorative procedure is provided on the same date of service, limited to one per 12 months

Class V - Orthodontic Services

A. Benefits for orthodontic services will only be available if the Enrollee:

1. Has fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown being exposed (unless the tooth is impacted or congenitally missing); and

2. Has a severe, dysfunctional, handicapping malocclusion and is determined to be Medically Necessary.

B. All comprehensive orthodontic services require a pre-treatment estimate (PTE) by the Insurer, as described in the Estimate of Eligible Benefits section. The following documentation must be submitted with the request for a PTE:

1. ADA 2006 or newer claim form with service code requested;

2. A complete series of intra-oral photographs;

3. Diagnostic study models (trimmed) with waxbites or OrthoCad electronic equivalent, and

4. Treatment plan including anticipated duration of active treatment.

C. Covered benefits if a PTE is approved

1. Retainers

a) One set (included in comprehensive orthodontics)

b) Replacement allowed one per arch per lifetime within 12 months of date of debanding, if necessary

c) Rebonding or recementing fixed retainer

2. Pre-orthodontic treatment visit

3. Braces once per lifetime

4. Periodic treatment visits; not to exceed 24 months (the Enrollee must be eligible for Covered Dental Services on each date of service).

D. Payment policy: one initial payment for comprehensive orthodontic treatment, a pre-orthodontic treatment visit and periodic orthodontic treatment visits (not to exceed 24 periodic orthodontic treatment visits).

Additional periodic orthodontic treatment visits beyond 24 will be the orthodontist's financial responsibility and not the Subscriber's. Subscribers may not be billed for broken, repaired, or replacement of brackets or wires. Visits to repair or replace brackets or wires are not separately reimbursable from periodic visits.

E. In cases where the Enrollee has been approved for comprehensive orthodontic benefits, and the parent has decided they do not wish to have the child begin treatment at this time or any time in the near future, the provider may bill for their records, to include the treatment plan, radiographs, models, photos, etc. and explaining the situation on the claim for payment. The reimbursement for these records is the same as if the orthodontic services had been rendered.

F. If the case is denied, the provider will be informed that the orthodontic treatment will not be covered. However, Covered Dental Services will include the pre-orthodontic visit which included treatment plan, radiographs, and/or photos, records and diagnostic models for full treatment cases only.

PEDIATRIC VISION SERVICES

Covered Services

Coverage will be provided for pediatric vision benefits for children in accordance with the Federal Employee Program Blue Vision high plan. Benefits include:

A. One routine eye examination, including dilation, if professionally indicated, each Benefit Period. A vision examination may include, but is not limited to:

1. Case history;

2. External examination of the eye and adnexa;

3. Ophthalmoscopic examination;

4. Determination of refractive status;

5. Binocular balance testing;

6. Tonometry test for glaucoma;

7. Gross visual field testing;

8. Color vision testing;

9. Summary finding; and

10. Recommendation, including prescription of corrective lenses.

B. Frames and Spectacle Lenses or Contact Lenses

1. Prescribed frames and spectacle lenses or contact lenses, including directly related provider services such as:

a) Measurement of face and interpupillary distance;

b) Quality assurance; and

c) Reasonable aftercare to fit, adjust and maintain comfort and effectiveness.

2. One pair of frames per Benefit Period; and

3. One pair of prescription spectacle lenses per Benefit Period

a) Spectacle lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, ultraviolet protective coating, standard progressives, and plastic photosensitive lenses (Transitions®).

b) Polycarbonate lenses are covered in full for monocular patients and patients with prescriptions > +/- 6.00 diopters.

c) All spectacle lenses include scratch resistant coating with no additional Copayment. There may be an additional charge at Walmart and Sam's Club.

4. Contact Lenses

a) Contact lens evaluation, fitting, and follow-up care.

b) Elective contact lenses (in place of frames and spectacle lenses):

(1) One pair of elective prescription contact lenses per Benefit Period; or,

(2) Multiple pairs of disposable prescription contact lenses per Benefit Period.

c) One pair of Medically Necessary prescription contact lenses per Benefit Period in lieu of other eyewear.

(1) Prior authorization must be obtained from the Vision Care Designee by calling the Vision Care Designee at the telephone number on the Enrollee's identification card.

(2) Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. Contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions:

keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and/or irregular astigmatism.

C. Low vision services, including one comprehensive Low Vision evaluation every 5 years, 4 follow-up visits in any 5-year period and prescribed low vision aid optical devices, such as high-powered spectacles, magnifiers and telescopes.

1. Ophthalmologists and optometrists specializing in low vision care will evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for Enrollees with low vision.

2. Prior authorization is required for low vision services. Vision Providers will obtain the necessary prior authorization for these services.

Limitations

Benefits for the treatment of medical conditions of the eye are covered under P. B12, Outpatient Facility, Office, and Professional Services.

SKILLED NURSING FACILITY SERVICES

See P. B32, Utilization Management, for Covered Services that require prior authorization.

Covered Skilled Nursing Facility Services

When the Enrollee meets the conditions for coverage listed on P. B4, Conditions for Coverage, the services listed below are available to Enrollees in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;
B. Inpatient physician and medical services provided by or under the direction of the attending physician; and
C. Services and supplies that are not Experimental/Investigational, and ordinarily furnished by the facility to inpatients for diagnosis or treatment.

Conditions for Coverage

Skilled Nursing Facility care must meet the following conditions for coverage:

A. The admission to the Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Enrollee were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).
B. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.
C. The Enrollee must require Skilled Nursing Care or skilled rehabilitation services which are:
    1. Required on a daily basis;
    2. Not Custodial; and
    3. Only provided on an inpatient basis.

Custodial Care is Not Provided

Benefits will not be provided for any day in a Skilled Nursing Facility that is primarily for Custodial Care. Services may be deemed Custodial Care even if:

A. An Enrollee cannot self-administer the care;
B. No one in the Enrollee's household can perform the services;
C. Ordered by a physician;
D. Necessary to maintain the Enrollee's present condition; or
E. Covered by Medicare

II. Prescription Drugs

Covered Services

Benefits will be provided for Prescription Drugs, including but not limited to:

a. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preferred Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. See P. B14, Family Planning Services, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.

b. Human growth hormones. Prior authorization is required.

c. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preferred Preventive Drug List.

   Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preferred Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

d. Injectable medications that are self-administered and the prescribed syringes.

e. Standard covered items such as insulin, glucagon and anaphylaxis kits.

f. Fluoride products.

g. Diabetic Supplies.

h. Oral chemotherapy drugs.

i. Hormone replacement therapy drugs.

III. Utilization Management

Failure to meet the requirements of the utilization management program may result in a reduction or denial of benefits even if the services are Medically Necessary.

Utilization Management

Benefits are subject to review and approval under utilization management requirements. Through utilization management, the Insurer will:

1. Review Enrollee care and evaluate requests for approval of coverage in order to determine the Medical Necessity for the services;
2. Review the appropriateness of the hospital or facility requested; and,
3. Determine the approved length of confinement or course of treatment in accordance with established criteria.

In addition, utilization management may include additional aspects such as prior authorization, and/or preadmission testing requirements, concurrent review, and discharge planning.

If coverage is reduced or excluded for failure to comply with utilization management requirements, the reduction or exclusion may be applied to all services related to the treatment, admission, or portion of the admission for which utilization management requirements were not met. The terms that apply to an Enrollee's coverage for failure to comply with utilization management requirements are stated in the Schedule of Benefits.

Enrollee Responsibility

It is the Enrollee's responsibility to ensure that providers associated with the Enrollee's care cooperate with utilization management requirements. This includes initial notification in a timely manner, responding to inquiries and, if requested, allowing representatives to review medical records on-site or in the Insurer's offices. If the Insurer is unable to conduct utilization reviews, Enrollee benefits may be reduced or excluded from coverage.

Hospital Inpatient Services

A. All hospitalizations require prior authorization (except for maternity and Emergency admissions as specified). The Enrollee must contact (or have the provider contact the Insurer) at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not feasible to delay the admission for five (5) business days due to the Enrollee's medical condition, the Insurer must receive notification of the admission as soon as possible but in any event within forty- eight (48) hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later.

Emergency Admissions

The Insurer may not render an adverse decision solely because the Insurer was not notified of the emergency admission within the prescribed period of time after that admission if the Enrollee's condition prevented the hospital from determining the Enrollee's insurance status or the Insurer's emergency admission requirements.

B. Inpatient Mental Illness and Alcohol and/or Substance Abuse Services

The Enrollee must contact the Insurer (or have the provider contact the Insurer) at least five (5) business days prior to an elective or scheduled admission. If the admission cannot be scheduled in advance because care is required immediately due to the Enrollee's condition, the Insurer must receive notification of the admission as soon as possible but in any event within forty-eight (48) hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later.

For emergency admissions, the Insurer may not render an adverse decision solely because the Insurer was not notified of the emergency admission within the prescribed period of time after that admission if the Enrollee's condition prevented the hospital from determining the Enrollee's insurance status or emergency admission requirements.

C. Organ and Tissue Transplants

Transplants and related services must be coordinated, and prior authorization must be obtained. Prior authorization is not required for cornea transplants and kidney transplants. Coverage for related medications is available on P. B31, Prescription Drugs.

D. Inpatient Hospice Care Services

E. Home Health Services

F. Skilled Nursing Facility Services

G. Outpatient Services at Hospital or Ambulatory Facility

H. Medical Devices and Supplies

The Enrollee must contact the Insurer prior to the purchase or rental of the following Medical Devices and Supplies to obtain prior authorization of such purchase or rental:

1. Beds - specialty beds such as heavy duty, pediatric, extra wide, and specialty mattresses

2. Prosthetic Devices

3. Microprocessor limbs
   a. Cochlear implants
   b. Speech generating devices

4. Respiratory Devices
   a. Oral airway devices
   b. Apnea monitor

5. Mobility Devices, Wheelchairs (power and/or custom), and Power Operated Vehicles

6. Phototherapy Devices

7. Specialty Medical Devices and Equipment
    a. defibrillators
    b. wound therapy electrical pumps
    c. hair prosthesis

8. Repairs of Durable Medical Equipment

The Insurer will determine the Medical Necessity for the covered Medical Devices and Supplies and the appropriateness of the type of appliance, device, equipment or supply requested. Failure to contact the Insurer in advance of the purchase or rental and/or failure and refusal to comply with the authorization given may result in reduction or denial of coverage for the Medical Device or Supply.

Covered Services not listed in this provision do not require prior authorization. The Insurer reserves the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures the Enrollee and/or the providers must follow. The Insurer will notify the Enrollee of these changes at least forty-five (45) days in advance.

Prior authorization is not required for any Covered Services when Medicare is the primary insurer.

Concurrent Review and Discharge Planning.

Following timely notification, the Insurer will instruct the Enrollee or the Enrollee's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment.

IV. Exclusions and Limitations

General Exclusions

Coverage is not provided for:

A. Any services, tests, procedures, or supplies which determine are not necessary for the prevention, diagnosis, or treatment of the Enrollee's illness, injury, or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Enrollee's particular case.

B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for clinical trials.

C. The cost of services that:
   1. Are furnished without charge; or
   2. Are normally furnished without charge to persons without health insurance coverage; or
   3. Would have been furnished without charge if an Enrollee were not covered under any health insurance.

   This exclusion does not apply to:
   1. Medicaid;
   2. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of an Enrollee's military service.

D. Any service, supply, drug or procedure that is not specifically listed in the Enrollee's Individual Enrollment Agreement as a covered benefit or that do not meet all other conditions and criteria for coverage. Provision of services by a health care provider does not, by itself, entitle an Enrollee to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.

E. Routine, palliative, or Cosmetic foot care, including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

F. Routine eye examinations and vision services. This exclusion does not apply to evidence-informed preventive care and screenings, including vision care, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents and as stated on P. B28, Pediatric Vision Services.

G. Any type of dental care (except treatment of accidental bodily injuries, oral surgery, cleft lip or cleft palate or both and pediatric dental services), including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies. Benefits for accidental bodily injury are described on P. B21, Dental Services. Benefits for oral surgery are described on P. B22, Oral Surgery. Benefits for treatment of cleft lip, cleft palate or both are described on P. B22, Treatment for Cleft Lip or Cleft Palate or Both. Benefits for pediatric dental services are described on P. B24, Pediatric Dental Services. All other procedures involving the teeth or areas and structures surrounding and/or supporting the teeth, including surgically altering the mandible

or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented functional impairment are excluded.

H. Cosmetic surgery (except benefits for reconstructive breast surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention.

I. Treatment rendered by a health care provider who is the Enrollee's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew, or resides in the Enrollee's home.

J. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained without a prescription and self-administered by the Enrollee, except as listed as a Covered Service above, including but not limited to: cosmetics or health and beauty aids, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supplies dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

K. Foods or formulas consumed as a sole source of supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.

L. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.

M. Fees and charges relating to fitness programs, weight loss, or weight control programs, physical or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac Rehabilitation and pulmonary rehabilitation programs are covered as described on P. B18, Outpatient Facility, Office, and Professional Services.

N. Maintenance programs for Physical Therapy, Speech Therapy, and Occupational Therapy for those services as stated on P. B17; and Cardiac Rehabilitation and pulmonary rehabilitation as stated in Outpatient Therapeutic Treatment Services on P. B18.

O. Medical or surgical treatment for obesity, weight reduction, dietary control or commercial weight loss programs, including morbid obesity. This exclusion does not apply to:
   1. Well child care visits for obesity evaluation and management;
   2. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
   3. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
   4. Office visits for the treatment of childhood obesity; and

5. Professional Nutritional Counseling and Medical Nutrition Therapy as described in this Description of Covered Services.

Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.

R. Services that are beyond the scope of the license of the provider performing the service.

S. Services that are solely based on court order or as a condition of parole or probation.

T. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.

U. Acupuncture services, except when approved or authorized by the Insurer when used for anesthesia.

V. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved, even though they may have therapeutic value or be provided by a health care provider.

W. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers compensation law.

X. Private duty nursing.

Y. Non-medical services. including, but is not limited to:
   1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care provider or the health care provider's staff.
   2. Administrative fees charged by a physician or medical practice to an Enrollee to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under the Evidence of Coverage; Agreement are available for Covered Services rendered to the Enrollee by a health care provider.

Z. Rehabilitation services, including Speech Therapy, Occupational Therapy, or Physical Therapy, for conditions not subject to improvement.

AA. Non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.

BB. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.

CC. Transportation and travel expenses (except for Medically Necessary air and ground ambulance services, and services listed under 'Organ and Tissue Transplants', of this Description of Covered Services), whether or not recommended by a health care provider.

DD. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

EE. Services, drugs, or supplies the Enrollee receives without charge while in active military service.

FF. Habilitative Services delivered through early intervention and school services.

GG. Custodial Care.

HH. Services or supplies received before the Effective Date of the Enrollee's coverage under the Evidence of Coverage; Agreement.

II. Durable Medical Equipment or Medical Supplies associated or used in conjunction with non-covered items or services.

JJ. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

KK. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation program designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

LL. Chiropractic services or spinal manipulation treatment other than spinal manipulation treatment for musculoskeletal conditions of the spine.

MM. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.

Pediatric Dental Services

A. Limitations

1. Covered Dental Services must be performed by or under the supervision of a Dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.

2. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures including precision attachments and custom denture teeth.

3. If Enrollee switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, the Insurer shall pay as if only one Dentist rendered the service.

4. We will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).

5. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for an Enrollee’s condition, benefits will be based upon the lowest cost alternative procedure.

B. Exclusions

Benefits will not be provided for:

1. Replacement of a denture or crown as a result of loss or theft.

2. Replacement of an existing denture or crown that is determined to be satisfactory or repairable.

3. Replacement of dentures, implants, metal and/or porcelain crowns, inlays, onlays, pontics and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of this Description of Covered Services and are judged to be adequate and functional.

4. Gold foil fillings.

5. Periodontal appliances.

6. Oral orthotic appliances, unless specifically listed as a Covered Dental Service.

7. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.

8. Intentional tooth reimplantation or transplantation.

9. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.

10. Additional fees charged for visits by a Dentist to the Enrollee's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. The Insurer shall provide the benefits for the dental service as if the visit was rendered in the Dentist’s office during normal office hours.

11. Transseptal fiberotomy.

12. Orthognathic Surgery.

13. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.

14. Any orthodontic services after the last day of the month in which Covered Dental Services ended.

15. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist’s charges and billed for by them.

16. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.

17. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.

18. Provision splinting, intracoronal and extracoronal.

19. Endodontic implant.

20. Fabrication of athletic mouthguard.

21. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

22. Adjustments to maxillofacial prosthetic appliance.

23. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral).

24. Bridges and recementation of bridges.

Pediatric Vision Services

A. Benefits will not be provided for the following Diagnostic services, except as listed on P. B28, Pediatric Vision Services.

B. Services or supplies not specifically approved by the Vision Care Designee where required in this Description of Covered Services.

C. Orthoptics, vision training, and low vision aids.

D. Non-prescription (Plano) lenses and/or glasses, sunglasses or contact lenses.

E. Except as otherwise provided, Vision Care services that are strictly Cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

F. Services and materials not meeting accepted standards of optometric practice.

G. Services and materials resulting from the Enrollee's failure to comply with professionally prescribed treatment.

H. Office infection control charges.

I. State or territorial taxes on vision services performed.

J. Special lens designs or coatings other than those described herein.

K. Replacement of lost and/or stolen eyewear.

L. Two pairs of eyeglasses in lieu of bifocals.

M. Insurance of contact lenses.

Organ and Tissue Transplants

Benefits will not be provided for the following:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts that are covered under this Description of Covered Services.

B. Any hospital or professional charges related to any accidental injury or medical condition of the donor of the transplant material.

C. Any charges related to transportation, lodging, and meals unless authorized or approved.

D. Services for an Enrollee who is an organ donor when the recipient is not an Enrollee.

E. Donor search services.

F. Any service, supply, or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

Inpatient Hospital Services

Coverage is not provided (or benefits are reduced, if applicable) for the following:

A. Private room, unless Medically Necessary. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.

B. Non-medical items and Convenience Items, such as television and phone rentals, guest trays, and laundry charges.

C. Except for covered Emergency Services and maternity care, a health care facility admission or any portion of a health care facility admission (other than Medically Necessary Ancillary Services) that had not been approved whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing.

Home Health Care Services

Coverage is limited to 90 Visits per Episode. A new Episode of care begins if the Enrollee does not receive Home Health Care Services for the same or different condition for 60 consecutive days.

Coverage is not provided for:

A. Custodial Care.

B. Private duty nursing.

Hospice Care Services

Benefits will not be provided for the following:

A. Services, visits, medical equipment, or supplies not authorized.

B. Financial and legal counseling.

C. Any services for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

D. Reimbursement for volunteer services.

E. Chemotherapy or radiation therapy, unless used for symptom control.

F. Services, visits, medical equipment, or supplies not required to maintain the comfort and manage the pain of the terminally ill Enrollee.

G. Custodial Care, domestic, or housekeeping services.

H. Meals on Wheels or other similar food service arrangements.

I. Rental or purchase of renal dialysis equipment and supplies. Benefits for dialysis equipment and supplies are available on P. B7, Medical Devices and Supplies.

Outpatient Mental Health and Substance Abuse

Coverage is not provided for:

A. Services solely on court order or as a condition of parole or probation.

B. Intellectual disability, after diagnosis.

C. Psychoanalysis.

Inpatient Mental Health and Substance Abuse

Coverage is not provided for:

A. Admissions as a result of a court order or as a condition of parole or probation.

B. Custodial Care.

C. Admissions solely for observation or isolation.

Medical Devices and Supplies

Benefits will not be provided for purchase, rental, or repair of the following:

A. Convenience Items
Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for an Enrollee (e.g., an exercycle or other physical fitness equipment, elevators, hoyer lifts, and shower/bath bench).

B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).

C. Exercise equipment
Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen, or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).

D. Institutional equipment
Any device or appliance that is appropriate for use in a medical facility and not appropriate for use in the home (e.g., parallel bars).

E. Environmental control equipment
Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses or contact lenses, dental prostheses, appliances, or hearing aids (except as otherwise provided herein for cleft lip or cleft palate or both or as stated in Pediatric Dental Services (P. B24) and Pediatric Vision Services (P. B28)).

G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories or inserts.

H. Medical equipment/supplies of an expendable nature, except those specifically listed as covered Medical Devices and Supplies in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

I. Tinnitus maskers

Skilled Nursing Facility Services

Benefits are limited to a maximum of 60 days per benefit period.

Benefits will not be covered for:

A. Custodial Care

B. Care provided on an Outpatient basis.

Habilitative/Rehabilitative Service

Benefits are limited to a maximum of 30 visits per episode.

V. Patient-Centered Medical Home

Definitions

Care Coordination Team means the health care providers involved in the collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet the Enrollee's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan means the plan directed by a health care provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Patient-Centered Medical Home Program ("PCMH") means medical and associated services directed by the PCMH team of medical professionals to:

A. Foster the health care provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;

B. Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and

C. Exchange medical information with other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

Qualifying Individual means an Enrollee with a chronic condition, serious illness or complex health care needs, requiring coordination of health services and who agrees to participate in the PCMH.

Covered Benefits

Benefits will be provided for the costs associated with the coordination of care for the Qualifying Individual's medical conditions, including:

A. Assess the Qualifying Individual's medical needs;

B. Provide liaison services between the Qualifying Individual and the health care provider(s) and the Care Coordination Team;

C. Create and supervise the Care Plan;

D. Educate the Qualifying Individual and family regarding the Qualifying Individual's disease and self-care techniques;

E. Arrange consultations with Specialists and assist with obtaining Medically Necessary supplies and services, including community resources, for the Enrollee; and

F. Assess treatment compliance.

Limitations

Benefits provided through the Patient-Centered Medical Home Program are available only when provided by an approved health care provider who has elected to participate in the PCMH.

ATTACHMENT C

SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Healthy DC Plan Program Individual Enrollment Agreement/Evidence of Coverage.

AmeriHealth Caritas DC pays only for Covered Services. The Enrollee pays for services, supplies or care that are not covered. The Enrollee pays any applicable Copayment or Coinsurance. Services that are not listed in the Description of Covered Services, or are listed in the Exclusions and Limitations, are not Covered Services.

When determining the benefits an Enrollee may receive, AmeriHealth Caritas DC considers all provisions and limitations in the Agreement as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain Utilization Management requirements will also apply. When these requirements are not met, payments may be reduced or denied.

DEDUCTIBLE AND OTHER COST-SHARING
There is no Deductible or other Cost-Sharing (i.e., Co-Pays or Coinsurance)

OUT-OF-POCKET MAXIMUM
There is no Out-of-Pocket Maximum.

BENEFITS AND LIMITS
See Chart Below. **IMPORTANT: This benefits package must comply with the Affordable Care Act's essential health benefits and benefits required under D.C. law. These benefits are different from Medicaid. Examples of services covered under Medicaid that are not required to be covered in the commercial market include: adult dental, adult vision, and non-emergency transportation to medical services (including bus, subway, and taxi vouchers, wheelchair vans, and ambulance).**

ADULT DENTAL AND VISION BENEFITS
If enhanced Premium Tax Credits under Internal Revenue Code § 36B(b)(3)(A)(iii) are extended for taxpayers, adult dental and vision benefits covered by DC Medicaid must be included as covered benefits by the Healthy DC Plan. Negotiated Medicaid provider rates apply. The DC Medicaid fee schedules apply in the absence of negotiated Medicaid provider rates.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				P. B12 under "Office Visits"
Specialist Visit	Yes	Covered	No				P. B12 under "Office Visits"
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				P. B12 under "Office Visits"
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				P. B18, B22, & B33.
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				P. B22 under "Outpatient Surgical Procedures"
Hospice Services	Yes	Covered	Yes	180	Day(s) per Benefit Period		P. B5
Routine Dental Services (Adult)	No	Not Covered	No				N/A, not covered.
Infertility Treatment	Yes	Covered	No				P. B16
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				N/A, not covered.
Private-Duty Nursing	No	Not Covered	No				N/A, not covered.
Routine Eye Exam (Adult)	No	Not Covered	No				N/A, not covered.
Urgent Care Centers or Facilities	Yes	Covered	No				P. B23
Home Health Care Services	Yes	Covered	Yes	90	Visit(s) per Episode		P. B3 A new episode of care begins if the enrollee does not receive Home Health Care for the same or a different condition for 60 consecutive days. Prior authorization is required.
Emergency Room Services	Yes	Covered	No				P. B23
Emergency Transportation/Ambulance	Yes	Covered	No				P. B24
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				P. B6 Prior authorization is required except for emergency admissions and all maternity admissions. Hospitalization solely for rehabilitation limited to ninety (90) days per Benefit Period.
Inpatient Physician and Surgical Services	Yes	Covered	No				P. B6 Including Mental Health/Substance Use Disorder P. B11
Bariatric Surgery	No	Not Covered	No				N/A, not covered.
Cosmetic Surgery	No	Not Covered	No				N/A, not covered.
Skilled Nursing Facility	Yes	Covered	Yes	60	Day(s) per Benefit Period		P. B30 Enrollee must require care on a daily basis, care must not be custodial, and care must only be provided on an inpatient basis. Prior authorization is required.
Prenatal and Postnatal Care	Yes	Covered	Yes				P. B16 If you are pregnant, federal law does not allow

Delivery and All Inpatient Services for Maternity Care	Yes	Covered	Yes				Healthy DC Plan to cover you, You can enroll in DC Medicaid. You must immediately let Healthy DC know so you can be enrolled in DC Medicaid. Either log into your account at https://www.dchealthlink.com or call Healthy DC Plan at 833-432-7526 or let AmeriHealth Caritas DC know to help get your pregnancy covered
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				P. B11
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				P. B11
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				P. B11
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				P. B11
Generic Drugs	Yes	Covered	No				P. B31
Preferred Brand Drugs	Yes	Covered	No				P. B31
Non-Preferred Brand Drugs	Yes	Covered	No				P. B31
Specialty Drugs	Yes	Covered	No				P. B31
Outpatient Rehabilitation Services	Yes	Covered	Yes	30	Visit(s) per Episode		P. B17 A new episode of care begins if the enrollee does not receive rehabilitation services for the same or a different condition for 60 consecutive days.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Episode		P. B18 A new episode of care begins if the enrollee does not receive habilitative services for the same or a different condition for 60 consecutive days.
Chiropractic Care	Yes	Covered	No			Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.	P. B18 Coverage is provided for medically necessary spinal manipulation, evaluation, and treatment for the musculoskeletal conditions of the spine when provided by a licensed chiropractor, doctor of osteopathy (D.O.), or other eligible practitioner.
Durable Medical Equipment	Yes	Covered	No				P. B7
Hearing Aids	No	Not Covered	No				Not covered, exclusion cited on P. B42
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				P. B12
Preventive Care/Screening/Immunization	Yes	Covered	No				P. B12; Immunization P. B13
Routine Foot Care	No	Not Covered	No				N/A; not covered
Acupuncture	No	Not Covered	No				N/A; not covered
Weight Loss Programs	No	Not Covered	No				N/A; not covered
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Benefit Period		P. B28 Pediatric benefits may be accessed out-of-network at no cost to covered person
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Benefit Period		P. B28 Pediatric benefits may be accessed out-of-network at no cost to covered person

Dental Check-Up for Children	Yes	Covered	Yes	2	Procedure(s) per Benefit Period		P. B24 Pediatric benefits may be accessed out-of-network at no cost to covered person
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Episode		P. B17 A new episode of care begins if the enrollee does not receive rehabilitation services for the same or a different condition for 60 consecutive days.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Episode		P. B17 A new episode of care begins if the enrollee does not receive rehabilitation services for the same or a different condition for 60 consecutive days.
Well Baby Visits and Care	Yes	Covered	No				P. B13 Pediatric benefits may be accessed out-of-network at no cost to covered person
Laboratory Outpatient and Professional Services	Yes	Covered	No				P. B12
X-rays and Diagnostic Imaging	Yes	Covered	No				P. B12
Basic Dental Care - Child	Yes	Covered	No				P. B24 Pediatric benefits may be accessed out-of-network at no cost to covered person
Orthodontia - Child	Yes	Covered	Yes	1	Treatment(s) per Lifetime		P. B27 Pediatric benefits may be accessed out-of-network at no cost to covered person
Major Dental Care - Child	Yes	Covered	No				P. B26 Pediatric benefits may be accessed out-of-network at no cost to covered person
Basic Dental Care - Adult	No	Not Covered	No				N/A; not covered
Orthodontia - Adult	No	Not Covered	No				N/A; not covered
Major Dental Care – Adult	No	Not Covered	No				N/A; not covered

Abortion for Which Public Funding is Prohibited	Yes	Not Covered	No				P. B15

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Transplant	Yes	Covered	No			Non-human organs and their implantation; hospital or professional charges related to any accidental injury or medical condition of the donor of the transplant material; charges related to transportation, lodging, and meals unless authorized or approved by the insurance carrier; services for an enrollee who is an organ donor when the recipient is not an Enrollee; and donor search services are not covered.	P. B19 Transplants and related services must be coordinated, and prior authorization must be obtained. Prior authorization is not required for cornea transplants and kidney transplants.
Accidental Dental	Yes	Covered	No			Injuries to teeth that are not Sound Natural Teeth are not covered. Injuries as a result of biting or chewing are not covered.	P. B21 Only medically necessary dental services such as restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury is covered.
Dialysis	Yes	Covered	No				P. B18
Allergy Testing	Yes	Covered	No				P. B17
Chemotherapy	Yes	Covered	No				P. B18
Radiation	Yes	Covered	No				P. B18
Diabetes Education	Yes	Covered	No				P. B21 under "Diabetes Equipment and Supplies, and Self-Management Training"
Prosthetic Devices	Yes	Covered	No			Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service are not covered.	P. B9
Infusion Therapy	Yes	Covered	No				P. B18
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				P. B22

Nutritional Counseling	Yes	Covered	No				P. B14
Reconstructive Surgery	Yes	Covered	No				P. B23 Surgical procedures must be medically necessary, as determined, and must be operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

Pursuant to 45 CFR § 156.122(a), Healthy DC Plan carriers must cover at least the greater of: 1) one drug in every United States Pharmacopeia (USP) category and class; or 2) the same number of prescription drugs in each category and class as the EHB-benchmark plan (included below).

CATEGORY	CLASS	SUBMISSION COUNT
Analgesics	Nonsteroidal Anti-inflammatory Drugs	19
Analgesics	Opioid Analgesics, Long acting	9
Analgesics	Opioid Analgesics, Short-acting	18
Anesthetics	Local Anesthetics	1
Anti-Addiction/ Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	2
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Dependence	4

Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Reversal Agents	1
Anti-Addiction/ Substance Abuse Treatment Agents	Smoking Cessation Agents	1
Antibacterials	Aminoglycosides	3
Antibacterials	Antibacterials, Other	13
Antibacterials	Beta-lactam, Cephalosporins	8
Antibacterials	Beta-lactam, Penicillins	5
Antibacterials	Carbapenems	0
Antibacterials	Macrolides	4
Antibacterials	Quinolones	4
Antibacterials	Sulfonamides	2
Antibacterials	Tetracyclines	4
Anticonvulsants	Anticonvulsants, Other	5
Anticonvulsants	Calcium Channel Modifying Agents	3
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Modulating Agents	9
Anticonvulsants	Sodium Channel Agents	6
Antidementia Agents	Antidementia Agents, Other	1
Antidementia Agents	Cholinesterase Inhibitors	3
Antidementia Agents	N-methyl-D-aspartate (NMDA) Receptor Antagonist	1
Antidepressants	Antidepressants, Other	7
Antidepressants	Monoamine Oxidase Inhibitors	3
Antidepressants	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	13
Antidepressants	Tricyclics	11
Antiemetics	Antiemetics, Other	8
Antiemetics	Emetogenic Therapy Adjuncts	5
Antifungals	No USP Class	11
Antigout Agents	No USP Class	6

CATEGORY	CLASS	SUBMISSION COUNT
Antimigraine Agents	Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists	0
Antimigraine Agents	Ergot Alkaloids	3
Antimigraine Agents	Prophylactic	4
Antimigraine Agents	Serotonin (5-HT) Receptor Agonist	6
Antimyasthenic Agents	Parasympathomimetics	1
Antimycobacterials	Antimycobacterials, Other	2
Antimycobacterials	Antituberculars	6
Antineoplastics	Alkylating Agents	3
Antineoplastics	Antiandrogens	5
Antineoplastics	Antiangiogenic Agents	2
Antineoplastics	Antiestrogens/Modifiers	4
Antineoplastics	Antimetabolites	3
Antineoplastics	Antineoplastics, Other	6
Antineoplastics	Aromatase Inhibitors, 3rd Generation	3
Antineoplastics	Enzyme Inhibitors	0
Antineoplastics	Molecular Target Inhibitors	16
Antineoplastics	Monoclonal Antibody/Antibody-Drug Conjugates	0
Antineoplastics	Retinoids	2
Antineoplastics	Treatment Adjuncts	4
Antiparasitics	Anthelmintics	3
Antiparasitics	Antiprotozoals	13
Antiparkinson Agents	Anticholinergics	2
Antiparkinson Agents	Antiparkinson Agents, Other	4
Antiparkinson Agents	Dopamine Agonists	5
Antiparkinson Agents	Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors	3
Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	2
Antipsychotics	1st Generation/Typical	10
Antipsychotics	2nd Generation/Atypical	10
Antipsychotics	Treatment-Resistant	1
Antispasticity Agents	No USP Class	3
Antivirals	Anti-cytomegalovirus (CMV) Agents	1
Antivirals	Anti-hepatitis B (HBV) Agents	4
Antivirals	Anti-hepatitis C (HCV) Agents	1
Antivirals	Antiherpetic Agents	3

CATEGORY	CLASS	SUBMISSION COUNT
Antivirals	Anti-HIV Agents, Integrase Inhibitors (INSTI)	2
Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	6
Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	13
Antivirals	Anti-HIV Agents, Other	3
Antivirals	Anti-HIV Agents, Protease Inhibitors (PI)	7
Antivirals	Anti-influenza Agents	4
Antivirals	Antiviral, Coronavirus Agents	0
Anxiolytics	Anxiolytics, Other	4
Anxiolytics	Benzodiazepines	8
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	5
Bipolar Agents	Bipolar Agents, Other	8
Bipolar Agents	Mood Stabilizers	4
Blood Glucose Regulators	Antidiabetic Agents	17
Blood Glucose Regulators	Glycemic Agents	1
Blood Glucose Regulators	Insulins	10
Blood Products and Modifiers	Anticoagulants	7
Blood Products and Modifiers	Blood Products and Modifiers, Other	6
Blood Products and Modifiers	Hemostasis Agents	0
Blood Products and Modifiers	Platelet Modifying Agents	7
Cardiovascular Agents	Alpha-adrenergic Agonists	4
Cardiovascular Agents	Alpha-adrenergic Blocking Agents	4
Cardiovascular Agents	Angiotensin II Receptor Antagonists	8
Cardiovascular Agents	Angiotensin-converting Enzyme (ACE) Inhibitors	10
Cardiovascular Agents	Antiarrhythmics	14
Cardiovascular Agents	Beta-adrenergic Blocking Agents	12
Cardiovascular Agents	Calcium Channel Blocking Agents, Dihydropyridines	7
Cardiovascular Agents	Calcium Channel Blocking Agents, Nondihydropyridines	2
Cardiovascular Agents	Cardiovascular Agents, Other	5
Cardiovascular Agents	Diuretics, Loop	4
Cardiovascular Agents	Diuretics, Potassium-sparing	2
Cardiovascular Agents	Diuretics, Thiazide	5
Cardiovascular Agents	Dyslipidemics, Fibric Acid Derivatives	2

CATEGORY	CLASS	SUBMISSION COUNT
Cardiovascular Agents	Dyslipidemics, HMG CoA Reductase Inhibitors	7
Cardiovascular Agents	Dyslipidemics, Other	7
Cardiovascular Agents	Mineralocorticoid Receptor Antagonists	2
Cardiovascular Agents	Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)	0
Cardiovascular Agents	Vasodilators, Direct-acting Arterial	2
Cardiovascular Agents	Vasodilators, Direct-acting Arterial/Venous	3
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Amphetamines	4
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	5
Central Nervous System Agents	Central Nervous System, Other	8
Central Nervous System Agents	Fibromyalgia Agents	3
Central Nervous System Agents	Multiple Sclerosis Agents	6
Dental and Oral Agents	No USP Class	7
Dermatological Agents	Acne and Rosacea Agents	11
Dermatological Agents	Dermatitis and Pruritus Agents	22
Dermatological Agents	Dermatological Agents, Other	12
Dermatological Agents	Pediculicides/Scabicides	4
Dermatological Agents	Topical Anti-infectives	15
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral Replacement	4
Electrolytes/ Minerals/ Metals/ Vitamins	Electrolyte/Mineral/Metal Modifiers	4
Electrolytes/ Minerals/ Metals/ Vitamins	Phosphate Binders	3
Electrolytes/ Minerals/ Metals/ Vitamins	Potassium Binders	1
Electrolytes/ Minerals/ Metals/ Vitamins	Vitamins	0
Gastrointestinal Agents	Anti-Constipation Agents	5
Gastrointestinal Agents	Anti-Diarrheal Agents	4
Gastrointestinal Agents	Antispasmodics, Gastrointestinal	3
Gastrointestinal Agents	Gastrointestinal Agents, Other	8
Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	3
Gastrointestinal Agents	Protectants	2
Gastrointestinal Agents	Proton Pump Inhibitors	6
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment	No USP Class	5
Genitourinary Agents	Antispasmodics, Urinary	8
Genitourinary Agents	Benign Prostatic Hypertrophy Agents	8
Genitourinary Agents	Genitourinary Agents, Other	6

CATEGORY	CLASS	SUBMISSION COUNT
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	No USP Class	8
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)	No USP Class	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)	No USP Class	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Anabolic Steroids	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Androgens	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	14
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	16
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Selective Estrogen Receptor Modifying Agents	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)	No USP Class	2
Hormonal Agents, Suppressant (Adrenal or Pituitary)	No USP Class	6
Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	2
Immunological Agents	Angioedema Agents	2
Immunological Agents	Immunoglobulins	0
Immunological Agents	Immunological Agents, Other	10
Immunological Agents	Immunostimulants	2
Immunological Agents	Immunosuppressants	13
Inflammatory Bowel Disease Agents	Aminosalicylates	4
Inflammatory Bowel Disease Agents	Glucocorticoids	6
Metabolic Bone Disease Agents	No USP Class	10
Ophthalmic Agents	Ophthalmic Agents, Other	2
Ophthalmic Agents	Ophthalmic Anti-allergy Agents	6
Ophthalmic Agents	Ophthalmic Anti-Infectives	15
Ophthalmic Agents	Ophthalmic Anti-inflammatories	10
Ophthalmic Agents	Ophthalmic Beta-Adrenergic Blocking Agents	4
Ophthalmic Agents	Ophthalmic Intraocular Pressure Lowering Agents, Other	8
Ophthalmic Agents	Ophthalmic Prostaglandin and Prostamide Analogs	4
Otic Agents	No USP Class	8
Respiratory Tract/ Pulmonary Agents	Antihistamines	9
Respiratory Tract/ Pulmonary Agents	Anti-inflammatories, Inhaled Corticosteroids	8
Respiratory Tract/ Pulmonary Agents	Antileukotrienes	3

CATEGORY	CLASS	SUBMISSION COUNT
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Anticholinergic	4
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Sympathomimetic	11
Respiratory Tract/ Pulmonary Agents	Cystic Fibrosis Agents	3
Respiratory Tract/ Pulmonary Agents	Mast Cell Stabilizers	1
Respiratory Tract/ Pulmonary Agents	Phosphodiesterase Inhibitors, Airways Disease	2
Respiratory Tract/ Pulmonary Agents	Pulmonary Antihypertensives	5
Respiratory Tract/ Pulmonary Agents	Pulmonary Fibrosis Agents	0
Respiratory Tract/ Pulmonary Agents	Respiratory Tract Agents, Other	5
Skeletal Muscle Relaxants	No USP Class	8
Sleep Disorder Agents	Sleep Promoting Agents	9
Sleep Disorder Agents	Wakefulness Promoting Agents	2

ATTACHMENT D

AMENDMENTS/NOTICES/RIDERS

PATIENT PROTECTION DISCLOSURE NOTICE

Primary Care Provider Designation

AmeriHealth Caritas DC generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you. Until you make this designation, AmeriHealth Caritas DC designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the AmeriHealth Caritas DC at the customer service telephone number listed on your identification card.

Obstetrics and Gynecological Care

You do not need prior authorization from AmeriHealth Caritas DC or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of AmeriHealth Caritas DC health care professionals who specialize in obstetrics or gynecology, contact AmeriHealth Caritas DC at customer service telephone number listed on your identification card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Nothwithstanding any other provision of this Agreement, you have coverage and you're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services, air ambulance services, and certain services at an in-network hospital or ambulatory surgical center by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services, air ambulance services, or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the federal government at: **1-800-985-3059** or the District of Columbia Department of Insurance, Securities & Banking at *https://disb.dc.gov/page/request-help-dealing-financial-institutions-form* or call **202-727-8000.**

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.