First Choice Next
Individual and Family Health Plans Offered On and Off the Exchange

Provider Orientation

January 2025

FirstChoice℠ Next
A Product of Select Health of South Carolina, Inc.

Overview

FirstChoice℠ Next
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- Who We Are
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Who We Are

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About AmeriHealth Caritas

Select Health of South Carolina is part of the AmeriHealth Caritas Family of Companies and offers 4 different First Choice Health plan products.

The AmeriHealth Caritas Family of Companies ("AmeriHealth Caritas") is one of the nation's leaders in health care solutions for those most in need. We:

- Are headquartered in Philadelphia.
- Are a mission-driven organization with close to 40 years of experience serving low-income and chronically ill populations.
- Operate in 13 states and the District of Columbia.
- Serve nearly 5 million Medicaid, Medicare, Health Insurance Marketplace, and Children's Health Insurance Program (CHIP) Members.
- Utilize integrated managed care products, pharmaceutical benefit management, specialty pharmacy services, and behavioral health services.

For more information about AmeriHealth Caritas, visit our Corporate site, **www.amerihealthcaritas.com**.

Who We Are

FirstChoice℠ Next
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About First Choice Next

First Choice Next is the HMO Benefit program offered by Select Health of South Carolina, Inc.

- First Choice Next provides affordable health insurance on the Exchange. We are certified as a Qualified Health Plan (QHP) issuer.
- First Choice Next will deliver high quality, locally-based health care services to its Members, with our providers benefiting from enhanced collaboration and strategic care coordination programs
- For more information about First Choice Next, visit https://www.firstchoicenext.com.
- **Please note: this document applies to First Choice Next individual and family health insurance products both on and off Exchange.**

Coverage Area includes 17 South Carolina counties

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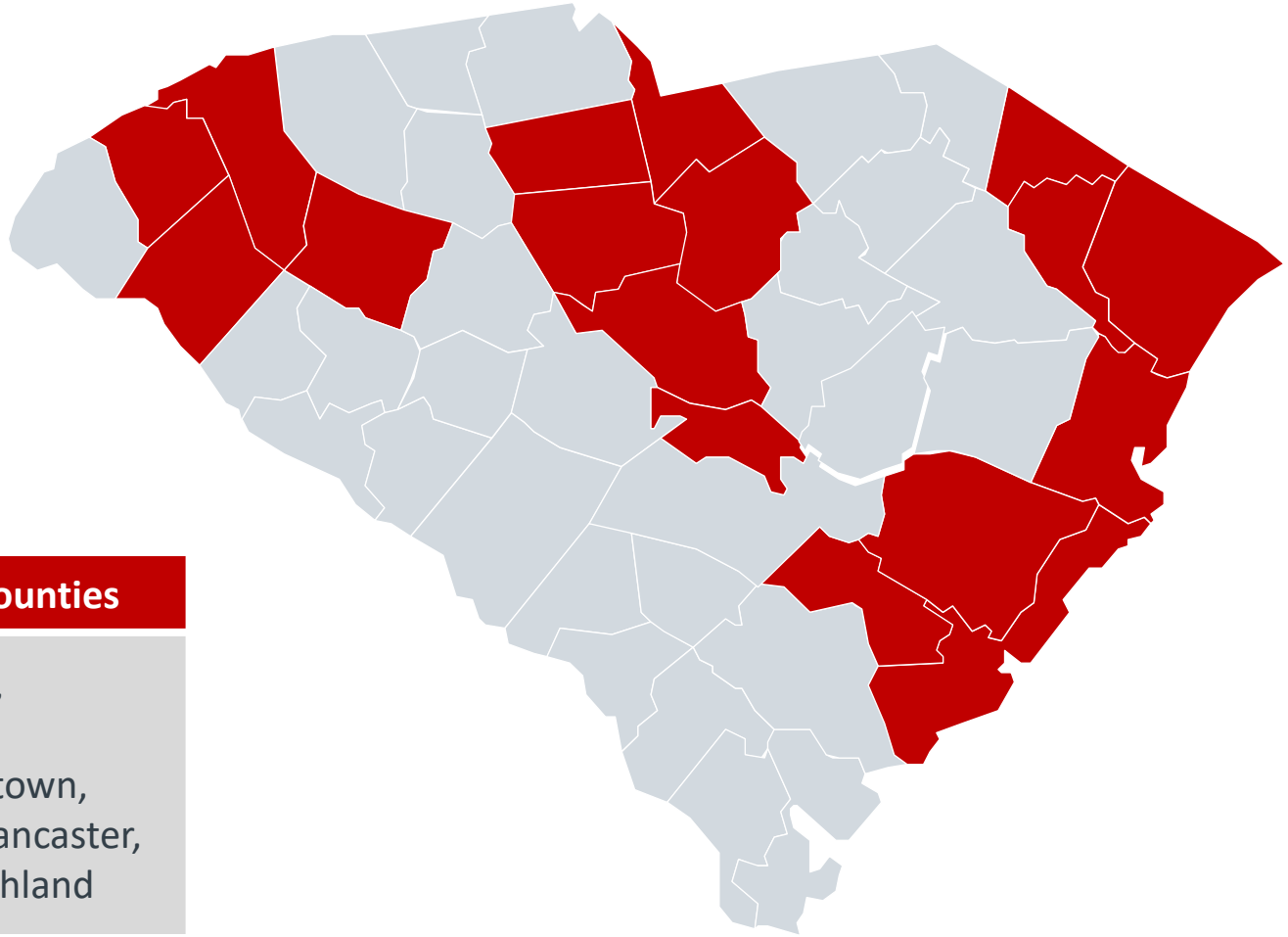

First Choice Next List of Counties

Anderson, Berkeley, Calhoun, Charleston, Chester, Dillon, Dorchester, Fairfield, Georgetown, Greenville, Horry, Kershaw, Lancaster, Laurens, Marion, Pickens, Richland

Additional First Choice Products offered by Select Health of South Carolina

Participating in the Exchange aligns with our vision to empower those in need across their full life journey.

Medicaid

First Choice by Select Health of South Carolina is a state-approved managed care organization (MCO) licensed by the Department of Insurance and contracted with the South Carolina Department of Health and Human Services to participate in the Healthy Connections program. First Choice is Select Health's Medicaid health plan.

We aim to continue to be there for Members if they must transition out of the South Carolina Exchange and need to gain Medicaid coverage through First Choice by Select Health of South Carolina.

Dual eligible products

First Choice VIP Care and VIP Care Plus offer specialized Medicare Advantage dual eligible special needs plans (D-SNPs) and Medicare-Medicaid plans (MMPs). Our approach integrates proven, established care management, preventive services, and other programs that effectively coordinate care for aged, blind, and disabled individuals.

The Exchange
(Health Insurance Marketplace®)

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The Exchange

Individuals and families can enroll for coverage online or with assistance from one of our brokers at firstchoicenext.com. We can:

- Determine eligibility for all health insurance programs, including Individual and Family Health Plans, Medicaid, Medicare and the Children's Health Insurance Program (CHIP).
- Provide direction for applying for Medicaid, Medicare or CHIP.
- Help Members shop for the plan that is right for them.
- Help Members enroll in Individual and Family Health Plan coverage.
- Determine eligibility for financial help (subsidies) with premiums and out of pocket costs.

The Exchange

Subsidies come in the form of:

- Advanced Premium Tax Credit (APTC) - a federal tax credit for individuals that reduces the amount Members pay for monthly health insurance premiums when they buy health insurance on the Exchange
- Cost Share Reductions (CSR) - a discount that lowers the amount that the Member has to pay for deductibles, copayments and co-insurance.

Benefit plans have cost shares* in the form of copays, coinsurance, and deductibles.

Some Members will qualify for assistance with their cost shares based on their income level and family size.

This assistance would be paid directly from the government to the Member's health plan.

*There are no cost shares for American Indian/Native American Members (Income Between 100% and 300% FPL) when they see an Indian Health Care Provider (IHCP).

Please see plan co-pays and co-insurance and deductibles for specific plans under "View Our Plans" at https://www.firstchoicenext.com.

Please note: Members who purchase insurance off-exchange are not eligible for subsidies and cost shares.

Provider Network Management
and
Administrative Provider Support

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Provider Network Management

When you join First Choice Next, a local and knowledgeable Provider Network Management Account Executive who is well-versed in both physical and behavioral health care will be assigned to your area.

Your dedicated Account Executive will routinely meet with you in person to provide orientations, review educational needs, and provide assistance with any questions you may have. Visit our Account Executive webpage to view your assigned Account Executive's contact information.

The Provider Services call center at **1-833-986-7277** and the local Medical Management team are also available to assist you.

Getting Started

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During onboarding, you will receive a letter advising that you have been credentialed and contains useful information for getting started as a First Choice Next provider.

The Welcome Letter will include information regarding the following:

- Confirm that you have been successfully credentialed
- An official welcome as a network provider
- Directions for secure portal setup on NaviNet
- Efficient claims processing
- Payment options and setup
- How to navigate our website for important information:
  - **Provider manual**: A guide to assist your practice in serving our Members
  - **Quick reference guide:** An all-in-one resource containing important contacts and information on prior authorization and referral requirements
  - **Drug Formulary** and pharmacy prior authorization process
  - **Claims Filing Instructions**
  - **Electronic claims submission**

Finalizing Participation in our Network

Please be certain that you have received the following before you start seeing First Choice Next Members:

1) A letter from First Choice Next saying that you have been successfully credentialed.

2) Your executed contract or addendum back from First Choice Next.

Online Provider Data Information Form

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The **Provider Data Information Form** will be available in the secure provider portal, NaviNet. This will allow you to review your demographic and practice information on file, attest to the accuracy of the information, and make any necessary changes. The process is as follows:

Log on to NAVINET.

- Click the **PDIF** (Provider Data Information Form) link.
- Select appropriate Health Plan (First Choice Next).
- Click the **Provider Data Information Form** (PDIF) link in the upper left hand corner navigation.
- On the **Provider Selection screen, click the "Please Select a Provider" menu and select a Provider, and hit "Submit"**.
- You will be taken to the "**Provider Self Service**" screen; in the bottom right portion of the page, click the box entitled "**Proceed to Provider Updates**".
- Click the box entitled "PDIF Update".
- Click the **Location Selection.**
- Click the box for the provider(s) for whom you want to attest and/or make changes and click the "Next" box in the bottom. right potion of the page.
- Review and make changes to the practitioner summaries, if applicable.
- Provide **Required Documentation**, if applicable.
- **Attest** and click the "Next" box in the bottom right potion of the page.

Providers are asked to review current demographic information as it is listed in the directory and submit updates or corrections once the PDIF link is posted on NaviNet.

Online Provider Data Information Form

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Please note: Providers will be given 30 days to attest to the accuracy of Information or submit any changes. Failure to respond in the specified time frame may result in claim denials.

Demographic changes will be reflected within the online provider directory within 14 business days. If the change is not reflected in 30 business days, please contact your Provider Network Management account executive.

If your practice is not registered with NaviNet, we highly recommend registering. To register, please visit https://register.navinet.net or contact your provider account executive. For additional guidance on this new feature, please contact First Choice Next Provider Services at 1-833-986-7277.

First Choice Next Public website

First Choice Next recognizes how busy our participating providers are. We are dedicated to supporting you and ensuring you have the information you need at your fingertips through the provider-focused section of our website. We keep you informed through several communication vehicles:

Website address: www.firstchoicenext.com.

- Provider manual.
- First Choice Next Website
- Claims and Billing manual.
- Quick Reference Guide.
- Provider education and training on:
  - Claims and billing.
  - Electronic payment options
  - Prior authorization and prior authorizations look up tool.
  - Member Rights and Responsibilities.

And provide searchable online tools:

- Online provider directory.
- Drug formularies.

Excellent provider communication and service is an organization-wide priority!

E-Solutions to Simplify Administration

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- Electronic claim submission and payment options.
- Accurate and secure reimbursements.
- Early detection of claims errors.
- NaviNet claim inquiry.
- EDI Member eligibility verification through your clearinghouse or practice management system.
- Faster claim payment and billing reconciliation through electronic funds transfer (EFT), Virtual Credit Card, (VCC), MedPay, and electronic remittance advice (ERA).
- Prior Authorization Look-up Tool.

Secure Provider Portal to Support Patient Care Management

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Our secure provider portal (https://navinet.navimedix.com) offers web-based solutions that allow providers and health plan to share critical administrative, financial, and clinical data in one place. This tool can help you manage patient care with quick access to:

- Member eligibility and benefits information, including Member in pending status
- Panel roster reports
- Care gap reports to identify needed services
- Member clinical summaries
- Social determinants of health information
- Admission and discharge reports
- Medical and pharmacy claims data
- Electronic submission of prior authorization requests

Contracting and Credentialing

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Contracting
How do I participate?

To provide service to First Choice Next Members, providers must execute a Participating Provider Agreement, and complete credentialing. All providers are re-credentialed at least every 36 months.

Provider Network Management

For Provider agreement/contract information:

ProviderRecruitmentNext@amerihealthcaritas.com

Credentialing/Recredentialing

If you have credentialing questions, call Provider Services at **1-833-986-7277**.

Provider Credentialing – CAQH

First Choice Next uses Council for Affordable Quality Healthcare (CAQH®) ProView®, formerly the Universal Provider Datasource®, which is designed to simplify and streamline the data collection process for credentialing and re-credentialing. ProView users send credentialing information to a single repository via a secure internet site to fulfill the credentialing requirement. **There is no cost to submit an application or participate with CAQH.**

If you are registered with CAQH:

Please contact your Provider Network account executive to grant authorization for First Choice Next to view your information in ProView.

If you are not a CAQH-participating provider, *we highly encourage you to subscribe by going to proview.caqh.org.* We will be glad to assist you in that process as needed.

Eligibility and Covered Services

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Eligibility and Enrollment
How do I verify eligibility?

Prior to rendering services, providers are responsible for verifying Member eligibility. You can check Member eligibility by:

- Logging in to our secure provider portal, a web-based application that allows providers and health plans to share critical administrative, financial, and clinical data in one place**.** You can access the provider portal at https://navinet.navimedix.com/sign-in, or via the First Choice Next website using the following path: ***For Providers > Tools and Services > NaviNet > Log in to NaviNet.***

  Note: For more information or to sign up for NaviNet® access, go to https://navinet.navimedix.com or call NaviNet Customer Support at **1-888-482-8057**.

- Contacting First Choice Next's Provider Services department at **1-833-986-7277** and using the automated real-time eligibility service by following the prompts for "Member eligibility."

- Using EDI eligibility verification transactions available from your clearinghouse or practice management system. This service supports batch access to eligibility verification and system-to-system verification, including point of service devices.

Delinquent Status Messaging on NaviNet

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Providers are responsible for checking the member's eligibility status prior to rendering services. Members in good standing can be confirmed in the **Eligibility and Benefits Inquiry** section of NaviNet, which can be accessed from the left-hand navigation of the Plan Central page.

Below are the provider portal delinquent status messages that will be displayed based on First Choice Next member eligibility status:

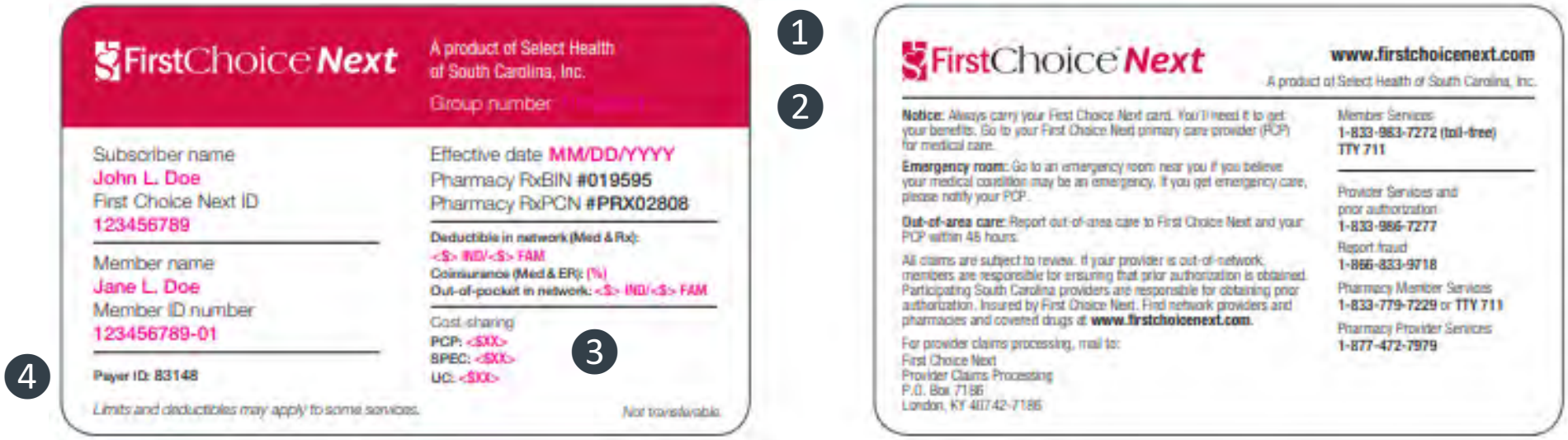
Member category	Delinquent period	Provider portal delinquent status message
APTC	First month	Active
	Second month to end of third month	Delinquent enrollee — All claims will be pended until outstanding premium payment is received. Claims will be rejected if payment is not received by the end of the grace period.
	After third month	Inactive
Non-APTC	Days 1 – 31	Suspended (claims pend)
	After 31 days	Inactive

First Choice by Select Health of South Carolina Family of Health Plans

First Choice operates 4 plans in the state of South Carolina. Providers will see 4 different member ID cards for the following plans:

- **First Choice Next (Exchange)**
- **First Choice (Medicaid)**
- **First Choice VIP Care (DSNP)**
- **First Choice VIP Care Plus (Medicare-Medicaid)**

Member ID Card – First Choice Next



Each Member of the family will receive their own card.

1 The legal tagline for First Choice Next, A Product of Select Health of South Carolina, Inc. is written on the upper left-hand corner.
2 In the "Group Number" field on the First Choice Next member ID card, the Group Number represents the specific product selected by the member and starts with initials NCG *(Gold),* NCS *(Silver)* or NCB *(Bronze)*.
3 The First Choice Next member ID card has copays, deductibles and has a subscriber and member name, whereas the First Choice Medicaid card has only a member name.
4 The Payer ID is displayed on the front of the card.

Member ID card – First Choice (Medicaid)

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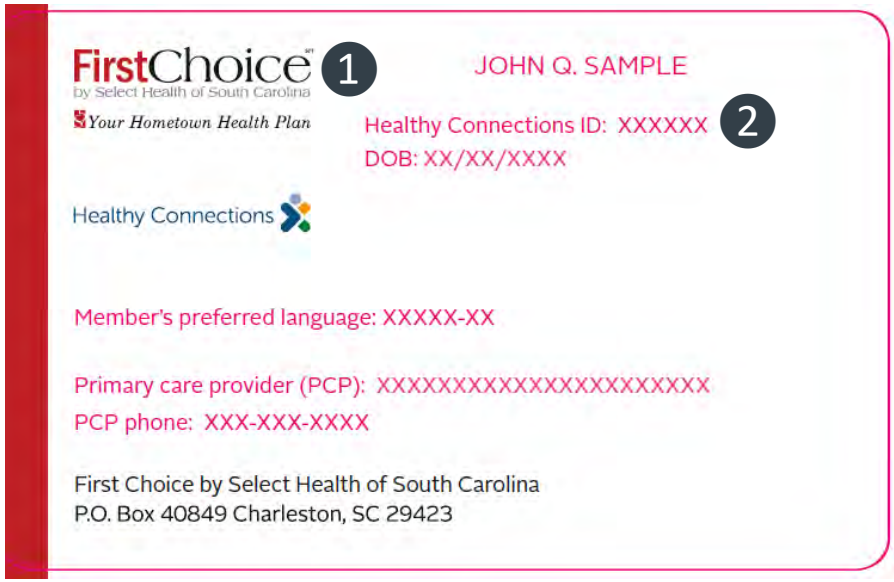

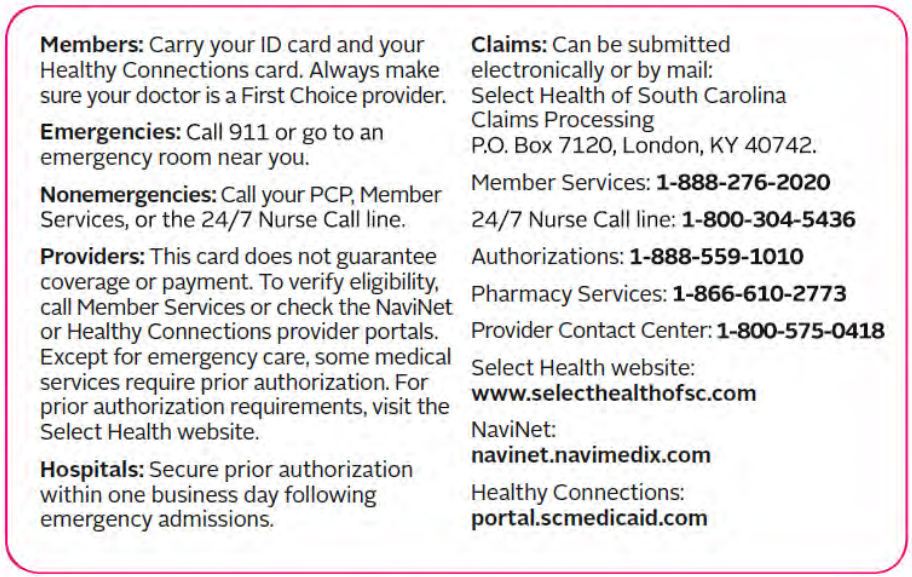

On our Medicaid ID there is 1 a First Choice by Select Health of South Carolina logo and a 2 Healthy Connections State Medicaid ID number that is not on the First Choice Next member card.

Member ID card – First Choice VIP Care (Medicare Advantage/Dual Special Needs Plan)

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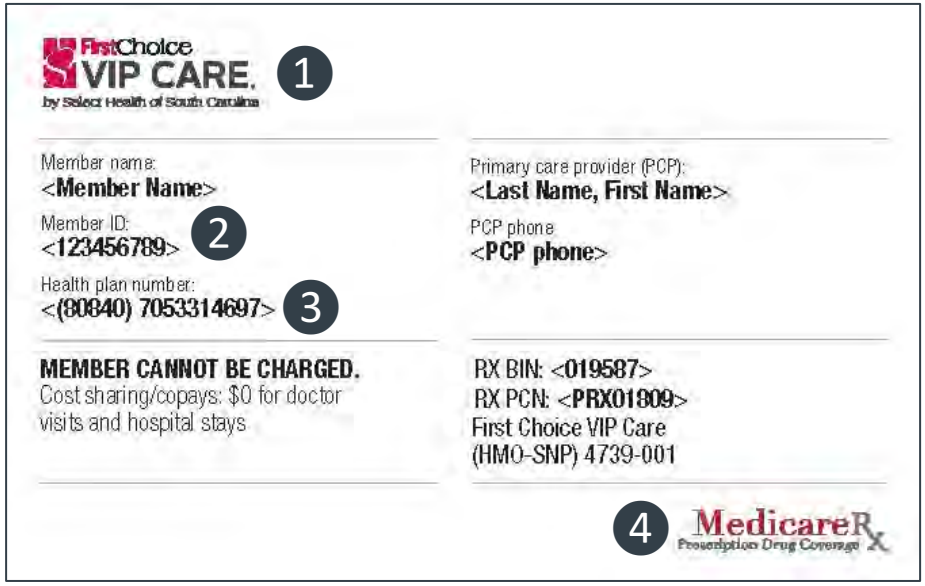

On our Medicare Advantage/D-SNP ID there is 1 the First Choice VIP Care by Select Health of South Carolina logo 2 a First Choice VIP Care Member ID 3 a Health plan ID number and 4 a MedicareRx logo at the bottom right corner.

Member ID card
First Choice VIP Care Plus (Medicare-Medicaid)

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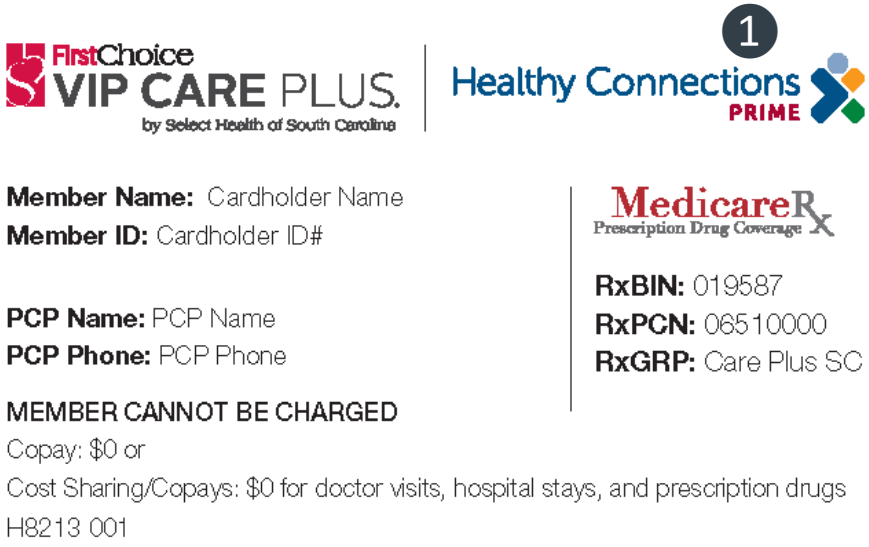

On our Medicare-Medicaid ID there is both 1 First Choice VIP Care Plus by Select Health of South Carolina and Healthy Connections Prime logo at the top of the card and 2 a First Choice VIP Care Plus Member ID.

Billing the Member for co-pays, co-insurance and deductibles

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Billing the Member

Copays, co-insurance and deductibles

Copays, co-insurance, and any unpaid portion of the deductible may be collected at the time of service.

Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the Secure Provider Portal at https://navinet.navimedix.com.

If the amount collected from the Member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the Member within 45 days.

Balance or Surprise Billing

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Members are protected from balance billing for:

Emergency services

If a Member has an emergency medical condition and gets emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). A Member **can't** be balance billed for these emergency services. This includes services the Member may get after they are in stable condition, unless they give written consent and give up their protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When a Member receives services at an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network, such as emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. In these cases, the most those providers may bill the Member is the plan's in-network cost-sharing amount. Providers **can't** balance bill the Member and may **not** ask the Member to give up their protections not to be balance billed.

Out of network providers

Out of network providers may need to bill for an unpaid balance after time of service. It is the out of network provider's responsibility to advise the Member and to obtain the Members acknowledgment in writing if products or services extend beyond First Choice Next's coverage so that the Member understands that they are liable for any costs beyond what First Choice Next will pay for.

Grace Period if a Member misses monthly premiums

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On-Exchange Members who receive Advance Premium Tax Credits:

- 3-month grace period
- First Choice Next will pay claims for the 1st month of the grace period.
- First Choice Next will pend claims for the 2nd and 3rd month of the grace period.
- If the Member pays their outstanding balance before the end of the 3rd month, we will process and adjudicate pended claims.
- If the Member does not pay their outstanding balance before the end of the 3rd month, we will terminate coverage as of the last day of the first month of grace period and deny all pended claims.

Off-Exchange Members or On-Exchange Members who DO NOT receive Advance Premium Tax Credits

- 31-day grace period.
- We pay claims for the full grace period.
- If a Member does not pay their outstanding balance before the end of the 31- day grace period, then we will terminate coverage as of the last day of the last month of which the premium was paid.

If a Member has lost coverage due to non-payment, and the provider provides services, First Choice Next will deny claims submitted for those services.

To identify when an APTC Member is in a delinquent payment status on his or her monthly insurance premiums, please see the **Eligibility and Benefits** Detail screen on NaviNet.

Member Rights

First Choice Next complies with applicable federal civil rights laws and does not discriminate on the basis of race; ethnicity; color; sex; religion; national origin; creed; marital status; age; Vietnam era or disabled veteran status; income level; gender identity; the presence of any sensory, mental, or physical handicap; or any other status protected by federal or state law.

First Choice Next is committed to complying with all applicable requirements under federal and state law and regulations pertaining to Member privacy and confidentiality rights.

Members have the right to:

Get information about:

- First Choice Next and its health care providers.
- Their rights and responsibilities.
- Their benefits and services.
- The cost of health care services and any required cost sharing.

Member Rights

- Expect that First Choice Next and its health care providers will treat them with dignity and respect and recognize their right to privacy.
- Get materials or help in languages and formats other than written English, such as braille, audio, or sign language, as indicated, at no cost to them.
- Receive help with interpretation services, as indicated, at no cost to them.
- Receive materials that are written in a manner and format that are easily understood and culturally sensitive.
- Have personal and health information and medical records kept private and confidential in accordance with all applicable requirements under federal and state law and regulations.
- Expect that First Choice Next will give them a copy of its Notice of Privacy Practices upon their request, and:
  - Approve or deny the release of identifiable medical or personal information, except when the release is required by law.

Member Rights

- Request a list of disclosures of protected health information that fall outside of treatment, payment, or health care operations.
- Request and receive a copy of their medical and claims records as allowed by applicable state and federal law.
- Ask that First Choice Next amend certain protected health information.
- Ask that any First Choice Next communication that contains protected health information be sent to them by alternative means or to an alternative address.
- Receive health care services consistent with applicable state and federal law.
- Talk with their health care provider about:
  - Treatment plans.
  - Information on available treatment options and alternatives, given in a way you understand.
  - The kinds of care they can choose to meet their medical needs, regardless of cost or benefit coverage.

Member Rights

- Be a part of decisions about their health care, including the right to refuse treatment. Their decision to do so will not negatively affect the way First Choice Next, its health care providers, or the U.S. Department of Health and Human Services (HHS) treats them.
- Make a complaint (grievance) or appeal about First Choice Next or its health care providers about the care provided to them, and for them to receive an answer.
- File a standard or an external review with applicable regulatory agencies if they are not satisfied with the outcome after completing the First Choice Next appeals process.
- Make an advance directive.
- Be given an opportunity to provide suggestions for changes to First Choice Next Member rights and responsibilities.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Member Rights

- Be free from discrimination prohibited by state and federal law.
- Be provided treatment in the least restrictive setting.
- Fully participate in the community and to work, live, and learn to the fullest extent possible.
- Be free to exercise their rights without adverse treatment from First Choice Next, its health care providers, or HHS.
- Have access to, and receive, quality health care services that are available and accessible to them in a timely manner.
- Furnished health care services that are sufficient in amount, duration, or scope and provided in a culturally competent manner to meet their specific needs.

Member Responsibilities

A Member has the *responsibility* to:

- Communicate, to the extent possible, information that First Choice Next and Participating Providers need in order to care for him or her;
- Follow the plans and instructions for care that he or she has agreed on with his or her Providers**.** This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
- Review all benefits and membership materials carefully and to follow the rules pertaining to the health plan;
- Ask questions to assure understanding of the explanations and instructions given;
- Treat others with the same respect and courtesy expected for him or herself;
- Keep scheduled appointments or give adequate notice of delay or cancellation.

First Choice Next
Health Benefit Levels and Co-Pays

Gold, Silver, Bronze and American Indian/Alaska Natives (AI/ANs)

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Affordable Care Act
Essential Health Benefits (EHBs)

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Essential health benefits are minimum requirements for all Exchange plans. Specific services covered in each broad benefit category can vary based on state requirements.

10 EHBs that all plans must include in their insurance plans
1. Ambulatory Patient Services: Outpatient services, producers, and tests
2. Emergency Services
3. Hospitalization
4. Pregnancy, Maternity, & Newborn Care
5. Mental Health and Substance use Disorder Services including Behavioral Health
6. Prescription Drugs
7. Rehabilitative Services: Devices and short-term disability services while recovering from injury
8. Lab Services
9. Preventive & Wellness Services including chronic disease management
10. Pediatric Services: Including oral* and vision care for ages up to 19

*ACA Requires all individual and small group ACA-compliant plans to cover **preventive services as required by the U.S. Department of Health and Human Services (HHS) at zero cost-sharing** even if the policyholder has not met their deductible*

* First Choice Next does not offer dental services, but will inform consumers of the availability of stand-alone pediatric dental plans during the plan selection and enrollment process.

Essential Health Benefits – No Cost Sharing

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There is no Member cost-sharing (i.e., $0 Copayment) for preventive services identified under the Affordable Care Act and provided to Members by a network provider. A complete list of preventive services with $0 member cost sharing can be found on the CMS website: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Note: The $0 copayment does *not* apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a copayment. However, if the Member is experiencing a significant problem that requires a problem-focused service that cannot be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring adjustment of medications, or follow-up at a shorter interval than would be normally anticipated, it would allow for application of a copayment.

Virtual Care, Vision and Dental Care

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Virtual Care

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

Vision care

Routine eye exam, one pair of glasses per year, and medical and surgical vision benefits are covered for children ages 0 – 19.

Dental Care

First Choice Next plans do not offer embedded pediatric dental coverage as there are stand-alone pediatric dental plans available in the exchange for purchase. First Choice Next will inform consumers of the availability of stand-alone pediatric dental plans during the plan selection and enrollment process.

Outpatient Laboratory

Laboratory services: Quest Diagnostics and DrugScan will provide outpatient lab services for First Choice Next Members.

Laboratory	Type	Phone	Website
DrugScan	General lab services	See website for locations and contact information.	https://drugscan.com/
Quest Diagnostics	General lab services	See website for locations and contact information.	https://questdiagnostics.com/

First Choice Next Individual and Family Health Plans

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AmeriHealth Caritas Next: Plan Offerings

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- **All Next Plans are HMOs**, but referrals are **not** required.
- Covered health services must be administered by a network provider unless there is an emergency. Emergency Room, Urgent Care and Ambulance will not require prior authorization and care can be received OON.
- Premium payment, if applicable, is required for the policy to become effective and stay in force.

First Choice Next Health Plans

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- The plan with the lowest monthly premium. This plan will work best for members if there will not be a need for a lot of health care services.
- This will be the highest cost for members when they receive health care services.

- The plan that divides the cost between the monthly premiums and out-of-pocket costs when members receive health care services.
- Pay a mid-range monthly premium.
- This will be the mid-range cost for members when they receive health care services.

- The plan that has a higher monthly premium but offers lower out-of-pocket costs. This plan will work best if members need regular health care services.
- This will be the lowest cost for when members receive health care services.

Multiple American Indian/ Native American plans are offered for each metal level.

PY25 Portfolio

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Bronze	Silver	Gold
Bronze Essential	Silver Off Marketplace	
Bronze Signature	Silver Signature	Gold Signature
Bronze Premier	Silver Premier	Gold Deluxe
	Silver Deluxe	

2025 Next Plans

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- **All plans are available in each state:**
  - Bronze: Essential
    - Expanded Bronze: Signature & Premier
  - Silver: Signature, Premier & Deluxe
    - Silver Off-Marketplace ONLY
  - Gold: Signature & Deluxe
- All plans except Silver Off-Marketplace have a Native American Zero Cost Share variation with all services covered in full with no deductible and no OOPM for qualified members

Bronze Plans

Essential, Signature, and Premier

FirstChoice℠ Next

A Product of Select Health of South Carolina, Inc.

2025 Next Bronze Plans: DE, FL, NC, SC

FirstChoice℠ Next
A Product of Select Health of South Carolina, Inc.

	AmeriHealth Caritas Next Bronze Essential	AmeriHealth Caritas Next Bronze Signature	AmeriHealth Caritas Next Bronze Premier
CSR Variation Type	Bronze Off/On/Limited Cost Sharing Plans	Expanded Bronze Off/On/Limited Cost Sharing Plans	Expanded Bronze Off/On/Limited Cost Sharing Plans
Individua/Family deductible	$9,200/ $18,400	$7,500/ $15,000	$3,500/ $7,000
Individual/ Family out-of-pocket maximum	$9,200/ $18,400	$9,200/ $18,400	$9,200/ $18,400
Coinsurance	0%	50%	50%
Primary care	$0 copayment/ Visit, after deductible	$50 copayment/ visit	$50 copayment/ visit
Specialist care	$0 copayment/ Visit, after deductible	$100 copayment/ visit	$100 copayment/ visit
Preventive care	No charge	No charge	No charge
Urgent Care	$0 copayment/ Visit, after deductible	$75 copayment/ visit	$75 copayment/ visit
Emergency Room	0% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic testing	0% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance, after deductible
Inpatient hospital	0% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient hospital	0% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient surgery	0% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance, after deductible

*In-network services and providers only except for Urgent Care, Emergency Room and Ambulance.

2025 Next Bronze Plans: FL, NC, SC

FirstChoice Next
A Product of Select Health of South Carolina, Inc.

	AmeriHealth Caritas Next Bronze Essential	AmeriHealth Caritas Next Bronze Signature	AmeriHealth Caritas Next Bronze Premier
CSR Variation Type	Bronze Off/On/Limited Cost Sharing Plans	Expanded Bronze Off/On/Limited Cost Sharing Plans	Expanded Bronze Off/On/Limited Cost Sharing Plans
Generic Drugs	$0 copayment/ prescription, after deductible	$25 copayment/ prescription	$30 copayment/ prescription
Preferred generic drugs	$0 copayment/ prescription, after deductible	$50 copayment/ prescription, after deductible	50% coinsurance/prescription, after deductible
Nonpreferred brand drugs	$0 coinsurance /prescription, after deductible	$100 copayment/ prescription, after deductible	50% coinsurance/prescription, after deductible
Specialty drugs	$0 coinsurance /prescription, after deductible	$500 copayment/ prescription, after deductible	50% coinsurance/prescription, after deductible

Limited Cost Sharing Plans Note:
Cost-sharing and deductibles are waived at Indian Health Care Providers (IHCP) or with IHCP referral at a non-IHCP.

Silver Plans

Off Marketplace, Signature, Premier, and Deluxe

FirstChoice℠ Next

A Product of Select Health of South Carolina, Inc.

2025 Next Silver Plans: DE, FL, NC, SC

FirstChoice℠ Next
A Product of Select Health of South Carolina, Inc.

AmeriHealth Caritas Next Silver Signature

CSR Variation Type	Silver Off/On/Limited Cost Sharing Plans	73% AV Level Silver Plan	87% AV Level Silver Plan	94% AV Level Silver Plan
Individual/ Family deductible	$5,000/$10,000	$3,000/$6,000	$500/$1,000	$0/$0
Individual/ Family out-of-pocket maximum	$8,000/$16,000	$6,400/$12,800	$3,000/$6,000	$2,000/$4,000
Coinsurance	40%	40%	30%	25%
Primary care	$40 copayment/visit	$40 copayment/visit	$20 copayment/visit	No charge
Specialist care	$80 copayment/ visit	$80 copayment/ visit	$40 copayment/visit	$10 copayment/visit
Preventive care	No charge	No charge	No charge	No charge
Urgent Care	$60 copayment/visit	$60 copayment/visit	$30 copayment/visit	$5 copayment/visit
Emergency Room	40% coinsurance, after deductible	40% coinsurance, after deductible	30% coinsurance, after deductible	25% coinsurance
Diagnostic testing	40% coinsurance, after deductible	40% coinsurance, after deductible	30% coinsurance, after deductible	25% coinsurance
Inpatient hospital	40% coinsurance, after deductible	40% coinsurance, after deductible	30% coinsurance, after deductible	25% coinsurance
Outpatient hospital	40% coinsurance, after deductible	40% coinsurance, after deductible	30% coinsurance, after deductible	25% coinsurance
Outpatient surgery	40% coinsurance, after deductible	40% coinsurance, after deductible	30% coinsurance, after deductible	25% coinsurance

*In-network services and providers only except for Urgent Care, Emergency Room and Ambulance.

2025 Next Silver Plans: FL, NC, SC

FirstChoice Next
A Product of Select Health of South Carolina, Inc.

AmeriHealth Caritas Next Silver Signature

CSR Variation Type	Silver Off/On/Limited Cost Sharing Plans	73% AV Level Silver Plan	87% AV Level Silver Plan	94% AV Level Silver Plan
Generic Drugs	$20 copayment/ prescription	$20 copayment/ prescription	$10 copayment/ prescription	No charge
Preferred generic drugs	$40 copayment/ prescription	$40 copayment/ prescription	$20 copayment/ prescription	$15 copayment/ prescription
Nonpreferred brand drugs	$80 copayment/ prescription, after deductible	$80 copayment/ prescription, after deductible	$60 copayment/ prescription, after deductible	$50 copayment/ prescription
Specialty drugs	$350 copayment/ prescription, after deductible	$350 copayment/ prescription, after deductible	$250 copayment/ prescription, after deductible	$150 copayment/ prescription

*In-network services and providers only except for Urgent Care, Emergency Room and Ambulance.

Limited Cost Sharing Plans Note:
Cost-sharing and deductibles are waived at Indian Health Care Providers (IHCP) or with IHCP referral at a non-IHCP

2025 Next Silver Plans: FL, NC, SC

FirstChoice Next
A Product of Select Health of South Carolina, Inc.

	AmeriHealth Caritas Next Silver Premier				AmeriHealth Caritas Next Silver OFF-MARKETPLACE
CSR Variation Type	Silver Off/On/Limited Cost Sharing Plans	73% AV Level Silver Plan	87% AV Level Silver Plan	94% AV Level Silver Plan	Silver Off Marketplace Only
Individual/ Family deductible	$0/$0	$0/$0	$0/$0	$0/$0	$4,500/$9,000
Individual/ Family out-of-pocket maximum	$9,200/$18,400	$7,350/$14,700	$2,850/$5,700	$1,800/$3,600	$9,200/$18,400
Coinsurance	50%	50%	30%	25%	30%
Primary care	$55 copayment/visit	$55 copayment/visit	$45 copayment/visit	No charge	$15 copayment/visit
Specialist care	$110 copayment/visit	$110 copayment/visit	$90 copayment/ visit	$10 copayment/ visit	$30 copayment/ visit
Preventive care	No charge	No charge	No charge	No charge	No charge
Urgent Care	$80 copayment/visit	$80 copayment/visit	$65 copayment/visit	$5 copayment/visit	$45 copayment/visit
Emergency Room	50% coinsurance	50% coinsurance	30% coinsurance	25% coinsurance	30% coinsurance, after deductible
Diagnostic testing	50% coinsurance	50% coinsurance	30% coinsurance	25% coinsurance	30% coinsurance, after deductible
Inpatient hospital	50% coinsurance	50% coinsurance	30% coinsurance	25% coinsurance	30% coinsurance, after deductible
Outpatient hospital	50% coinsurance	50% coinsurance	30% coinsurance	25% coinsurance	30% coinsurance, after deductible
Outpatient surgery	50% coinsurance	50% coinsurance	30% coinsurance	25% coinsurance	30% coinsurance, after deductible

*In-network services and providers only with the exception of Urgent Care, Emergency Room and Ambulance.

2025 Next Silver Plans: FL, NC, SC

FirstChoice Next
A Product of Select Health of South Carolina, Inc.

	AmeriHealth Caritas Next Silver Premier				AmeriHealth Caritas Next Silver OFF-MARKETPLACE
CSR Variation Type	Silver Off/On/Limited Cost Sharing Plans	73% AV Level Silver Plan	87% AV Level Silver Plan	94% AV Level Silver Plan	Silver Off Marketplace Only
Generic Drugs	$35 copayment/ prescription	$35 copayment/ prescription	$15 copayment/ prescription	No charge	$15 copayment/ prescription
Preferred generic drugs	$200 copayment/ prescription	$200 copayment/ prescription	$30 copayment/ prescription	$15 copayment/ prescription	$100 copayment/ prescription
Nonpreferred brand drugs	50% coinsurance	50% coinsurance	30% coinsurance	25% coinsurance	40% coinsurance after deductible
Specialty drugs	50% coinsurance	50% coinsurance	30% coinsurance	25% coinsurance	40% coinsurance after deductible

*In-network services and providers only except for Urgent Care, Emergency Room and Ambulance.
Limited Cost Sharing Plans Note:
Cost-sharing and deductibles are waived at Indian Health Care Providers (IHCP) or with IHCP referral at a non-IHCP

2025 Next Silver Plans: DE, FL, NC, SC

FirstChoice℠ Next
A Product of Select Health of South Carolina, Inc.

	AmeriHealth Caritas Next Silver Deluxe			
CSR Variation Type	Silver Off/On/Limited Cost Sharing Plans	73% AV Level Silver Plan	87% AV Level Silver Plan	94% AV Level Silver Plan
Individual/ Family deductible	$4,500/$9,000	$4,300/$8,600	$850/$1,700	$0/$0
Individual/ Family out-of-pocket maximum	$9,200/$18,400	$7,350/$14,700	$2,500/$5,000	$1,300/$2,600
Coinsurance	30%	30%	10%	10%
Primary care	$15 copayment/visit	$15 copayment/visit	$10 copayment/visit	No charge
Specialist care	$30 copayment/visit	$30 copayment/visit	$20 copayment/visit	$10 copayment/visit
Preventive care	No charge	No charge	No charge	No charge
Urgent Care	$45 copayment/visit	$45 copayment/visit	$30 copayment/visit	$15 copayment/visit
Emergency Room	30% coinsurance, after deductible	30% coinsurance, after deductible	10% coinsurance, after deductible	10% coinsurance
Diagnostic testing	30% coinsurance, after deductible	30% coinsurance, after deductible	10% coinsurance, after deductible	10% coinsurance
Inpatient hospital	30% coinsurance, after deductible	30% coinsurance, after deductible	10% coinsurance, after deductible	10% coinsurance
Outpatient hospital	30% coinsurance, after deductible	30% coinsurance, after deductible	10% coinsurance, after deductible	10% coinsurance
Outpatient surgery	30% coinsurance, after deductible	30% coinsurance, after deductible	10% coinsurance, after deductible	10% coinsurance

*In-network services and providers only with the exception of Urgent Care, Emergency Room and Ambulance.

2025 Next Silver Plans: FL, NC, SC

FirstChoice℠ Next
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	AmeriHealth Caritas Next Silver Deluxe			
CSR Variation Type	Silver Off/On/Limited Cost Sharing Plans	73% AV Level Silver Plan	87% AV Level Silver Plan	94% AV Level Silver Plan
Generic Drugs	$15 copayment/ prescription	$15 copayment/ prescription	$15 copayment/ prescription	$15 copayment/ prescription
Preferred generic drugs	$100 copayment/ prescription	$100 copayment/ prescription	$100 copayment/ prescription	$100 copayment/ prescription
Nonpreferred brand drugs	40% coinsurance, after deductible	40% coinsurance, after deductible	40% coinsurance, after deductible	40% coinsurance
Specialty drugs	40% coinsurance, after deductible	40% coinsurance, after deductible	40% coinsurance, after deductible	40% coinsurance

Limited Cost Sharing Plans Note:
Cost-sharing and deductibles are waived at Indian Health Care Providers (IHCP) or with IHCP referral at a non-IHCP

Gold Plans

Signature and Deluxe

FirstChoice℠ Next

A Product of Select Health of South Carolina, Inc.

2025 Next Gold Plans: DE, FL, NC, SC

FirstChoice℠ Next
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	AmeriHealth Caritas Gold Signature	AmeriHealth Caritas Gold Deluxe
CSR Variation Type	Gold Off/On/Limited Cost Sharing Exchange Plans	Gold Off/On/Limited Cost Sharing Exchange Plans
Individua/ Family deductible	$1,500/ $3,000	$850/ $1,700
Individual/ Family out-of-pocket maximum	$7,800/ $15,600	$7,500/ $15,000
Coinsurance	25%	20%
Primary care	$30 copayment/visit	$15 copayment/visit
Specialist care	$60 copayment/visit	$30 copayment/visit
Preventive care	No charge	No charge
Urgent Care	$45 copayment/visit	$45 copayment/visit
Emergency Room	25% coinsurance, after deductible	20% coinsurance, after deductible
Diagnostic testing	25% coinsurance, after deductible	20% coinsurance, after deductible
Inpatient hospital	25% coinsurance, after deductible	20% coinsurance, after deductible
Inpatient hospital	25% coinsurance, after deductible	20% coinsurance, after deductible
Outpatient hospital	25% coinsurance, after deductible	20% coinsurance, after deductible
Outpatient surgery	25% coinsurance, after deductible	20% coinsurance, after deductible

*In-network services and providers only except for Urgent Care, Emergency Room and Ambulance.

2025 Next Gold Plans: FL, NC, SC

FirstChoice℠ Next
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	AmeriHealth Caritas Gold Signature	AmeriHealth Caritas Gold Deluxe
CSR Variation Type	Gold Off/On/Limited Cost Sharing Exchange Plans	Gold Off/On/Limited Cost Sharing Exchange Plans
Generic Drugs	$15 copayment/ prescription	$15 copayment/ prescription
Preferred generic drugs	$30 copayment/ prescription	$100 copayment/ prescription
Nonpreferred brand drugs	$60 copayment/ prescription	40% coinsurance/prescription, after deductible
Specialty drugs	$250 copayment/ prescription	40% coinsurance/prescription, after deductible

Limited Cost Sharing Plans Note:
Cost-sharing and deductibles are waived at Indian Health Care Providers (IHCP) or with IHCP referral at a non-IHCP

Important PY25 Changes

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- **Hospice** will be covered in full after deductible for all plans
- **Pre & Post Natal visits** will be covered in full on all plans (no deductible)
- **Urgent Care** will be covered OON, similar to ER & Ambulance

Important PY25 Changes (continued) - Fifty Percent Coinsurance

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Coinsurance has been increased to **50%** for some services -

- **Bariatric Surgery** – Covered **only** in DE/NC
- **TMJ** – Not covered in SC; Must use plan coinsurance in NC/FL
- **Infertility** – Not covered in SC/FL; Must use coinsurance in DE
- **DME**
- **Prosthetics & Orthotics**

Pharmacy

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Pharmacy Prior Authorization

Pharmacy Services issues prior authorization for drugs on the formulary that require prior authorization.

For prior authorization, providers may contact Pharmacy Provider Services at **1-877-472-7979** between 8 a.m. and 6 p.m. ET, Monday through Friday.

After business hours, Saturdays, Sundays, and holidays, please call the 24/7 Pharmacy Member Services number at **1-833-779-7229.**

To obtain prior authorization, a prescriber should contact First Choice Next by:

- Submitting a web request under Pharmacy at amerihealthcaritasnext.com, or
- Faxing a completed Prior Authorization form to **1-844-470-2508.**

Pharmacy prior authorization forms can be found at **https://ppa.performrx.com/PublicUser/OnlineForm/OnlineFDBSingleForm.aspx?cucu_id=Y65L6nti7Fh2jJt8A7Rsjw%3d%3d.**

Mail Order Prescriptions

- Mail order cost share is 2.5 times retail cost (for a 31- to 90-day supply).

Claims, Billing, and Payment

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Electronic Claim Submission

All claims submitted by providers **must** be billed on the CMS-1500 or UB-04, or the electronic equivalent (via EDI) of these standard forms.

First Choice Next contracts with Change Healthcare – one of the largest electronic data interchange (EDI) clearinghouses in the country – to offer state-of-the-art EDI and other electronic billing services. As long as you have the ability to send EDI claims to Change Healthcare, whether through direct submission to Change Healthcare's **ConnectCenter** or through another clearinghouse or vendor, you may submit claims electronically.

If you are **not** set up for electronic submission:

- Contact your practice management software vendor or EDI software vendor.
- First Choice Next's EDI payer ID: **57103**.
- If you are not already signed up for electronic claim submission, and would like to submit through Change Healthcare's **ConnectCenter** go to: https://physician.connectcenter.changehealthcare.com/#/site/home?payer=214629 or contact Change Healthcare at **1-800-527-8133, option 2** for assistance.
- If you need assistance with beginning electronic submissions, you may also contact AmeriHealth Caritas EDI Technical Support at AHCnext@amerihealthcaritas.com or call 1-833-301-3377.

Electronic Claims Submission - Submit to the correct plan!!!!

FirstChoice Next
A Product of Select Health of South Carolina, Inc.

IMPORTANT REMINDER:

First Choice Next, First Choice (our Medicaid plan), First Choice VIP Care (our Medicare Advantage plan), and First Choice VIP Care Plus (our Medicare-Medicaid plan) are all offered under the Select Health of South Carolina, Inc. umbrella. Claim submission methods differ depending upon the product.

Please be careful to submit your claims to the correct plan. Improper claims submission will result in payment delays or claim denials. If you have questions, please call provider services.

Important Information								
Plan Name	First Choice		First Choice Next		First Choice VIP Care		First Choice VIP Care Plus	
Plan Type	Medicaid		Individual and Family Health Plans both on and off the Exchange		Medicare Advantage (D-SNP)		Medicare-Medicaid	
Provider Services	1-800-741-6605		1-833-986-7277		1-800-521-6007		1-855-327-4980	
Plan Website	www.selecthealthofsc.com/		www.firstchoicenext.com/		www.firstchoicevipcare.com		www.firstchoicevipcareplus.com	
Change Healthcare Payer ID (CPID)	Professional	Institutional	Professional	Institutional	Professional	Institutional	Professional	Institutional
	2890	7544	9425	7042	9248	6087	7193	8631
Plan Payer ID	23285		57103		32456		77009	

Paper Claim Submission

First Choice Next does accept paper claims. However, plan providers are encouraged to submit their claims electronically for more efficient and timely adjudication, processing and payment of claims.

Paper claims may be submitted to:

First Choice Next
Attn: Provider Claims Processing Department
P.O. Box 7186
London, KY 40742-7186

Electronic Payment Options

Change Healthcare is now partnering with ECHO Health, Inc. (ECHO), a leading innovator in electronic payment solutions, to offer more electronic payment options and to allow healthcare providers to process electronic payments more efficiently.

First Choice Next's EDI payer ID: **57103**

Through ECHO, First Choice Next offers four payment options:

- Electronic Funds Transfer (EFT)
- Virtual Credit Card (VCC)
- MedPay
- Paper check

Electronic Payment Options

Electronic Funds Transfers (EFT)

EFT is the preferred payment option of First Choice Next. Electronic funds transfers allow you to receive your payments by depositing them directly to the bank account you designate rather than receiving them by paper check or VCC. If you are new to EFT, you must enroll with ECHO for EFT from First Choice Next.

Electronic Payment Options

New to EFT Payments: If you are interested in receiving payment via EFT, setting up EFT is fast and straightforward. In addition to your banking account information, you will need to provide an ECHO payment draft number and payment amount as part of the enrollment authentication.

- To sign-up to receive EFT from **First Choice Next** and any affiliated plans, visit https://enrollments.echohealthinc.com/efteradirect/enroll. You only need to enroll once for **First Choice Next and any** affiliated plans and **there is no fee**.

- To sign up for EFT, from **all** payers you work with to process payments on the ECHO platform, visit https://enrollments.echohealthinc.com/. **A fee for this service may be required.**

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Electronic Payment Options

Existing EFT Users: If you only have one bank account registered with Change Healthcare, and you are currently receiving EFT payments, your payments will continue to be transmitted electronically by EFT.

If you have more than one bank account registered with Change Healthcare or you have multiple NPIs that will have different bank accounts, please contact ECHO at **1-888-492-5579** at your earliest convenience to ensure that your EFT account is set up correctly and your EFT payments continue successfully.

To ensure continuous receipt of Electronic Remittance Advices (ERAs), you will need to update your practice management system and/or notify your vendor to make the necessary updates to accept the **ECHO Payer ID 58379** in addition to the **First Choice Next payer ID 57103**

Electronic Payment Options

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Virtual Credit Card (VCC)

If you are not currently registered to receive payments electronically, you will receive VCC payments as your **default payment** method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, your Explanation of Payment/Remittance Advice (EOP/RA), and an instruction page for processing. **Normal transaction fees apply based on your merchant acquirer relationship.** To opt out of this VCC payment method, you can contact ECHO directly at **1-888-492-5579**.

Please note: You must have an ECHO draft number to opt out. If you have received previous payments from ECHO, you may use the draft number from another payer. Otherwise you will need to receive one VCC from First Choice Next in order to opt out.

Electronic Payment Options

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Med-Pay

Offered in partnership with Deluxe Corporation, this payment option includes the digital presentment of three payment modalities – 1) eCheck; 2) VCC; 3) ACH/EFT. Med-Pay is specifically targeted to providers who have never enrolled for ACH/EFT and have opted-out of VCC. If you do not want to receive Med-Pay, be sure to sign up for EFT immediately after opting out of VCC.

Paper check

Paper checks are available, but First Choice Next recommends electronic payments as they are faster and more convenient

If your have questions regarding VCC, EFT, Med-Pay please call Echo Health at **1-888-492-5579, option 2.**

Electronic Remittance Advice

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Electronic Remittance Advice (ERA)

When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will be accessible to download from the ECHO provider portal (www.providerpayments.com).

Claim Filing Deadlines

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Type of Claim	Description & Time Frame
Original Claim	Must be submitted to the Plan within **180 calendar days** from the date services were rendered or compensable items were provided.
Rejected Claim	Is not registered in the claim processing system and can be resubmitted as a new claim. Corrected and resubmitted within **180 calendar days from the date of services.**
Denied Claims	Are those that were processed in the claims system. They may have a payment attached or may have been denied. A corrected claim may be submitted within **365 calendar days** of the original date of service to have the claim reprocessed.
Out of Network providers	Must be submitted to the Plan within **180 calendar days** from the date services were rendered or compensable items were provided.

For more information, please refer to the Claims and Billing Manual.

Claim Inquiry Adjustment

Inquiries are questions from providers regarding how a claim is processed. Providers may file an inquiry no later than 180 days from the date of service or 60 calendar days after payment, denial or recoupment of a timely claims submission, whichever is latest. You may open a claims investigation via NaviNet with the claims adjustment inquiry function. Requests for adjustments may also be submitted by telephone to Provider Services at **1-833-986-7277** or by written correspondence to:

First Choice Next
Attn: Claim Inquiry
P.O. Box 7186
London, KY 40742-7186

Claim types that are eligible for submission through the Claim Inquiry Adjustment option are:
Updated eligibility.

- Updated/on file authorization.
- Duplicate payment received.
- Claim underpaid.
- Claim overpaid.

All requests will be responded to within 30 business days.

For more information, please refer to the NantHealth Claims Investigation user guide on your NaviNet Plan Central page.

Claims Disputes

Providers who receive an unsatisfactory response to a claim inquiry/adjustment request may submit a claim dispute within 60 days of the date of the denial. Claim disputes will be resolved within 30 calendar days.

Claim Disputes must be submitted in writing, with supporting documentation, to:

First Choice Next
Attn: Claim Disputes
P.O. Box 7186
London, KY 40742-7186

Integrated Care

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An Integrated Approach to Care

FirstChoice℠ Next
A Product of Select Health of South Carolina, Inc.

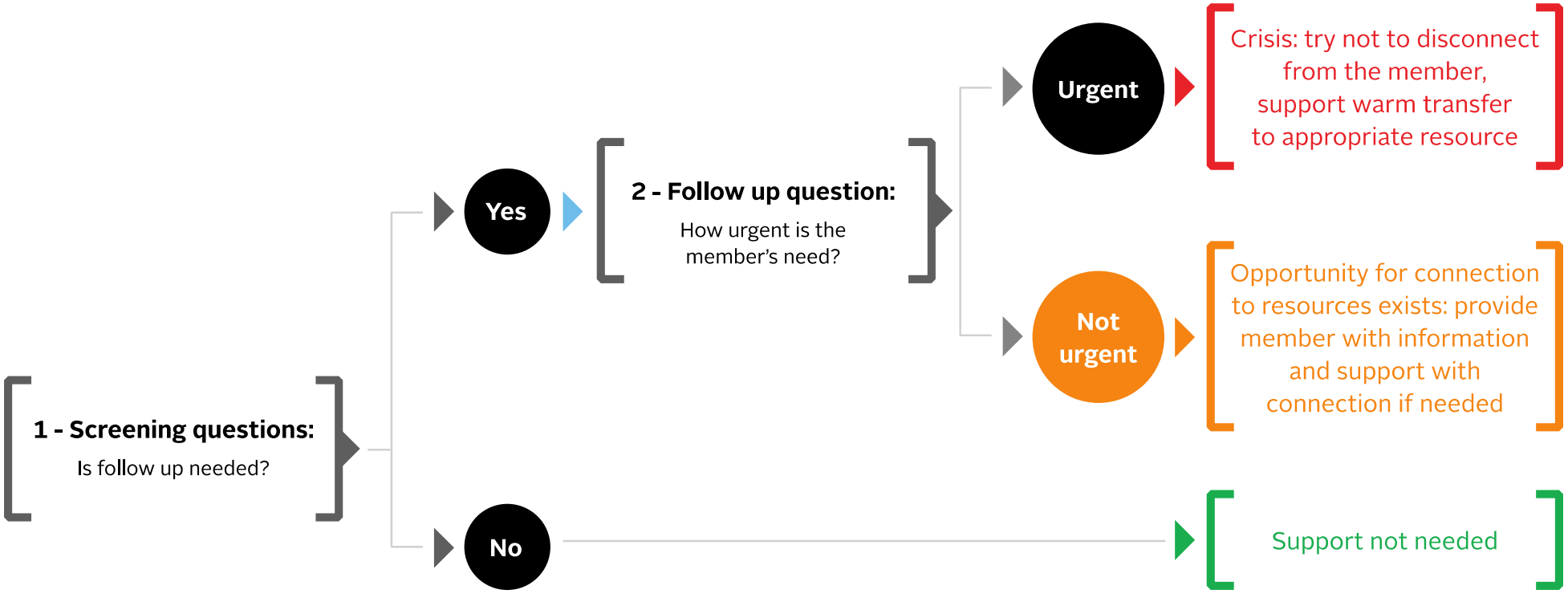
Our multifaceted approach addresses the needs of our Members, connecting them with the health care and services they need to get well and stay well.
Our approach includes:

- Engaging, educating, and empowering Members to actively participate in improving their health outcomes.
- Providing Members with the information they need when they need it through our use of personal outreach and Member portals.
- Providing person-centered treatment planning in which the Member identifies their care team Members, including natural and professional supports of their choosing.
- Using and supporting the growth of community-based services.

Social Determinants of Health (SDOH)

First Choice Next will assess, identify, and address health care and social determinants of health needs in the populations we serve, enabling them to live healthier lives and achieve maximum independence.

First Choice Next administers universal SDOH screenings with escalation pathways for actionable Member support.



Let Us Know

First Choice Next is eager to partner with the provider community in supporting our Members who may require more support. The ***Let Us Know*** program allows us to collaborate in engaging our Members and managing their health care.

If you have a Member who could use support from our Care Management team, here are a few ways to ***Let Us Know:***

Let Us Know options	Examples of reasons for referral:
Call our Rapid Response and Outreach Team **1-833-472-7708** **Fax** the Member Intervention Form, located at www.firstchoicenext.com, to **1-866-477-7229** **Visit** www.firstchoicenext.com to submit an electronic referral. For guidance on completing this form, or to inquire about a submission, please call **1-833-472-7708.**	❑ Pharmacy consult on controlled substances ❑ Assistance locating a specialty provider ❑ Education on plan benefits and resources ❑ Assistance with appointment scheduling ❑ Unmet resource/SDOH screening or follow-up (e.g., transportation, food pantry, or housing application) ❑ Education on health conditions ❑ Screening for mental health or substance use services ❑ Crisis follow-up resources (recent suicide attempt or bereavement after a death by suicide)

Sharing Data With Providers

FirstChoice Next
A Product of Select Health of South Carolina, Inc.

Note: Information on this page is based on claim data.

Member Information

Member Name:
Date of Birth:

Gender:
Member Id:

Primary Doctor (PCP):
Address 1:

Address 2:
City, State, Zip:
Phone Number:

Care Manager Information

Name:
Phone:

My Important Tests & Services (within the last 24 months)

Condition	Service	Status	LastService	Due by	Goal
Preventive Health Vaccine	Hepatitis A Vaccination Series	Missing			Once per Lifetime
Preventive Health Vaccine	Hepatitis B Vaccination Series	Missing			Once per Lifetime
Preventive Health Vaccine	Pneumococcal Vaccination 2 Part Series - 23 Valent Pneumococcal	Up-to-date	10/27/2016		Once per Lifetime
Preventive Health Vaccine	Pneumococcal Vaccination 2 Part Series - Prevnar 13	Missing			Once per Lifetime

Social Determinants (within the last 12 months)

Category	Date Answered	Self-reported member information
Housing	12/4/2017	No concern reported
Food	12/4/2017	Food insecurity
Utilities	12/4/2017	Difficulty paying for utilities
Transportation	12/4/2017	No concern reported
Health literacy	12/4/2017	No concern reported
Education	12/4/2017	Less than high school equivalency
Phone	12/4/2017	Difficulty paying for phone
Child care	12/4/2017	No concern reported
Everyday items	12/4/2017	Difficulty getting everyday items
Clothing	12/4/2017	Difficulty getting needed clothing

Responses to SDOH screening appear on the Member Clinical Summary available to providers through the Provider Portal.

Risk Score Integration

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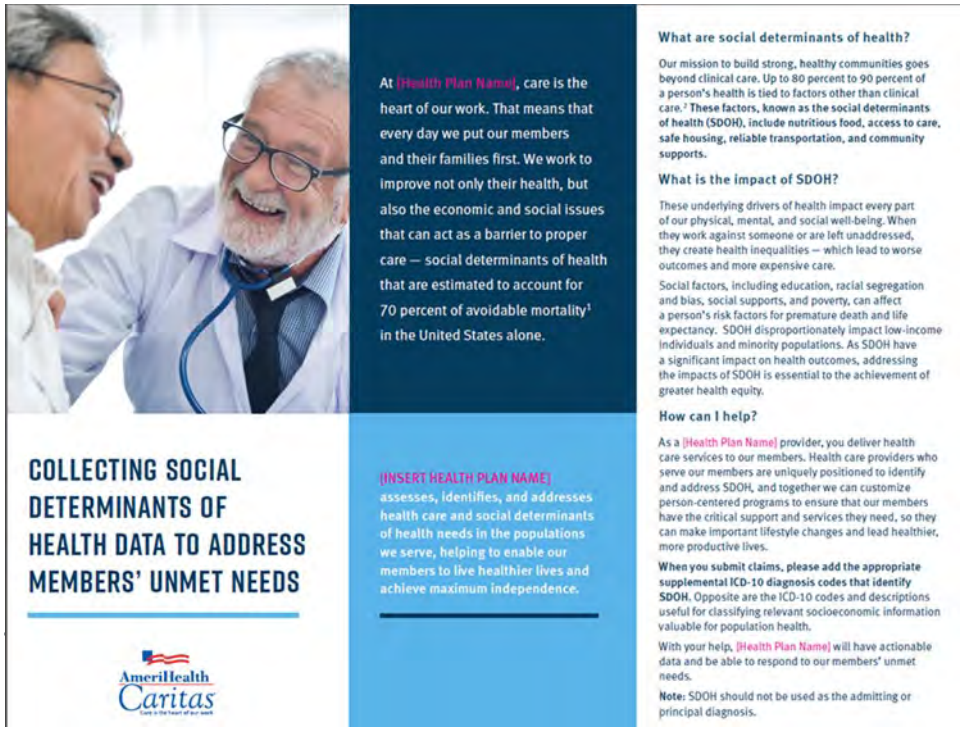
Risk scores are used to guide care management outreach and as triggers for the level of intervention.

International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) Z codes refer to factors influencing health status.

The following self-reported data elements and relevant ICD.10 Z codes enhance AmeriHealth Caritas risk score modeling:

- Distance from PCP office
- Poverty index
- Housing
- Food
- Transportation
- Utilities
- Health literacy
- Legal circumstances
- Physical environment
- Employment status
- Safety (exposure to trauma, stress, or violence)
- Social isolation
- Technology (access)



Please include the appropriate supplemental ICD-10 diagnosis codes on your claim to report SDOH.

Note: SDoH should **not** be used as the admitting or principal diagnosis.

For information about the applicable ICD-10 codes, please refer to the plan website.

Behavioral Health Crisis Line

- South Carolina statewide crisis line: 1-833-364-2274
- National Crisis Line: 988
- 911 Emergency

Care Coordination Through Collaboration

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These are the core components to our First Choice Next population health program:

Bright Start® (maternity management): This program assists expectant mothers by promoting healthy behaviors and controlling risk factors during pregnancy. The program is based on the Prenatal Care Guidelines from the American College of Obstetricians and Gynecologists (ACOG).

Rapid Response and Outreach Team (RROT): This team of non-clinical Care Connectors address the needs of Members and support providers and their staff.

Care management: This voluntary program serves Members identified as needing comprehensive and disease-specific assessments and reassessments, along with the development of person-centered goals with a focus on prevention.

Care coordination: Care coordination programs address Members' health care needs while assessing for and addressing social needs and barriers and providing hands-on coordination.

Providers needing care management or care coordination for a First Choice Next Member should contact RROT at 833-472-7708.

Utilization Management
Prior Authorization

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Utilization Management
Prior Authorization

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Certain services or supplies may be subject to prior authorization to determine whether they are medically necessary and being provided by a network provider. Providers are responsible for obtaining any necessary prior authorization (PA) before rendering services.

1. Search for the service in our prior authorization look up tool found in the Provider section of the First Choice Next website.
2. Providers can also submit requests for prior authorization through Jiva™, our web based prior authorization request tool found on NaviNet.
3. Fax the appropriate Prior Authorization form, found in the forms section of the website to Utilization Management
   - Physical Health Prior Auth: 833-329-8686
   - Behavioral Health: 833-472-3290
4. Call Utilization Management team at 877-486-7229

Prior Authorization Lookup Tool

The Prior Authorization Lookup Tool is located in the Provider section of the First Choice Next website.

To find out if a service needs prior authorization, simply type a Current Procedural Terminology (CPT) code in the space allotted to get started.

Click **Submit.**

The tool will tell you if that service needs prior authorization

Important notice

This tool provides general information for outpatient services performed by a participating provider.

The following services always require prior authorization:

- Elective inpatient services
- Urgent inpatient services
- Services from a nonparticipating provider

Prior Authorization Lookup Tool

The results of this tool are not a guarantee of coverage or authorization. If you have questions about this tool or a service, call Utilization Management at **1-877-486-7229**.

Every attempt is made to provide the most current prior authorization information on the Look Up Tool, however, this does not guarantee payment. Payment of claims is dependent upon eligibility, covered services, provider contracts, correct coding and billing practices. If you are uncertain that prior authorization is needed please submit a request for an accurate response. Prior Authorization forms are found in the Provider section of the website.

Services requiring prior authorizations are subject to change.

A Member does not need prior authorization for emergency services or to see a primary care physician.

First Choice Next does not require referrals for any service.

Imaging — Evolent

First Choice Next's radiology benefits vendor, Evolent, provides utilization management review and authorization for non-emergent, advanced, outpatient imaging procedures.

The following radiology services, when performed as an outpatient service, require prior authorization:

- CT/CTA scans
- CCTA/FFR
- Echocardiography
- MRA
- MRI
- Nuclear Cardiology Services
- PET scans
- PET/CT Fusion

The ordering provider is responsible for obtaining a prior authorization number for the requested radiology service. Evolent will request patient symptoms, past clinical history, and prior treatment information, and the ordering provider should have this information available at the time of the call.

Evolent – How to Submit Authorization

The ordering facility or provider must obtain the appropriate prior authorization via Evolent's website or by calling Evolent.

Ordering providers:

- To initiate a request for an authorization, please contact Evolent via their website at www.radmd.com, or via toll-free number at **1-800-327-1209**.
- To check the status of an authorization, please contact Evolent via their website at www.radmd.com, or via interactive voice response (IVR) system at **1-800-327-1209.**

Rendering providers:

- To check the status of an authorization, please contact Evolent via their website at www.radmd.com, or via IVR system at **1-800-327-1209**.

Culturally and Linguistically Appropriate Services (CLAS)

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What is CLAS?

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) were created to advance health equity, improve quality of care, and eliminate health care disparities.

First Choice Next recognizes the need to effectively respond to a diverse and multicultural patient population, and to understand and address issues that lead to health disparities.

In an effort to deliver culturally competent, respectful, appropriate care to Members who have limited English proficiency (LEP); who are low literacy proficient (LLP); who represent diverse, multicultural backgrounds; or who may have special health needs, First Choice Next offers ongoing CLAS training.

Please refer to the Provider Manual for more information or visit the CLAS web page at www.firstchoicenext.com.

What is Health Equity?

The Health Equity (HE) Strategy is an integrated, community-centered, root cause approach to address systemic health disparities in order to foster and improve equity for all Members.

In conjunction with CLAS, HE forms a strategic approach to:

- Ensure quality care is equitable
- Identification and reduction of health disparities
- Structure programs and activities responsive to Members cultural and linguistic needs.

First Choice Next develops HE program goals relevant to the National CLAS Standards and the NCQA's Health Equity Accreditation criteria. These standards and guidelines focus on collecting race, ethnicity, language (REL), sexual orientation and gender identity data, and using this information to be responsive to Member cultures, including through Culturally and Linguistically Appropriate Services (CLAS) programs.

To promote diversity and cultural responsiveness First Choice Next encourages providers to share REL in order to ensure an adequate provider network for Members. Collection of provider REL helps First Choice Next create better programs and reduce disparities.

Interpretation and Translation Services

Barriers in communication can impact quality of care. First Choice Next offers language services to facilitate better communication between Members and their providers.

Free aids and services for disabled Members

First Choice Next provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language Services

First Choice Next provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If a Member needs these services, contact Member Services at **1-833-983-7272 (TTY: 711)**

Member Grievances and Appeals

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Member Grievances

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

A member or their authorized representative, or their provider can file a grievance with First Choice Next at any time. The member can do so in writing or over the phone. Grievances must be submitted within one year after the date of occurrence of the action that initiated the grievance. The Grievance process is voluntary.

Once we have received the member's grievance, we will send them or their authorized representative a written acknowledgement within 90 days of receipt of the grievance.

Member Grievances

Upon resolution of the grievance we will send the member and, if applicable, their authorized representative a written notice within 90 days of receiving the grievance.

To file a grievance by phone:
Member Services
Hours of operation: 8am-8pm, Monday – Friday
Phone: 1-833-983-7272

To file a grievance by mail:
First Choice Next
Attn: Member Complaints and Grievances
P.O. Box 7202
London, KY 40742-7202

Member Appeals

If First Choice Next decides to deny coverage, reduce, limit, suspend, or terminate a service a Member is receiving, the Member will receive a written "Adverse Benefit Determination."

If the Member does not agree with the decision outlined in the Adverse Benefit Determination, or if the plan has failed to act in a timely manner, the Member may file an appeal.

The appeal:

- Must be filed within 180 calendar days of the Notice of Adverse Benefit Determination.
- May be filed on the Member's behalf by the Member's authorized representative (e.g., a family Member or friend) or by the Member's provider with the Member's written consent.
- May appeal to the state's Appeal process

To file an appeal by phone call Member's Services: 1-833-983-7272

Call **To file an appeal by mail:**
First Choice Next
Member appeals:
P.O. Box 7202
London, KY 40742-7202

South Carolina Department of Insurance Appeal Process

South Carolina Department of Insurance is available to provide assistance to the Member on First Choice Next's internal appeals and grievance issues.

Contact information:

South Carolina Department of Insurance
1201 Main Street
Suite 1000
Columbia, SC 29201
Phone: 803-737-6160

Provider Complaints and Appeals

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Provider Complaints

A Provider Complaint is an opportunity for the Provider to bring issues to the Plan.

Provider Complaints include dissatisfaction regarding any administrative aspect of the operations, activities, or behavior of First Choice Next associates, except for any dispute over which the Provider has appeal rights. Providers are required to register their complaint within 45 days of the incident. First Choice Next will review the information and provide written notice of its decision within 30 calendar days of our receipt of the complaint/grievance.

Providers are encouraged to settle complaints/disputes by phone or in person with their dedicated Account Executive.

They may also call Provider Services at **1-833-986-7277** or register a complaint by written correspondence to:

First Choice Next
Provider Complaints
P.O. Box 7201
London, KY 40742-7201

Provider Appeals

First Choice Next providers may file an appeal of an adverse action by First Choice Next. Adverse actions include, but are not limited to:

- Actions against a provider for reasons related to program integrity.
- Termination of a Provider Agreement before the agreement period has ended for reasons other than when First Choice Next's Fraud Control Unit or a government agency has required the plan to terminate the agreement.
- Denial of claims for services rendered that have not been filed as a Member appeal.
- Actions taken by the health plan in response to a violation by the provider of the health plan Provider Agreement.

Provider appeals must be filed in writing and within 180 calendar days of:

- The date of the plan's notice of the adverse action to be taken, or
- The date on which the plan should have taken a required action but failed to do so.

Providers may file a Member grievance or appeal on behalf of a Member only when the Member has authorized the provider to do so in writing.

Compliance

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Fraud Prevention Program

First Choice Next has an established enterprise-wide Program Integrity Department with a proven record in preventing, detecting, investigating and mitigating fraud, waste, and abuse (FWA). Local First Choice Next staff, including a Special Investigation Unit Manager and Investigator, will be supported by the Program Integrity Department.

- ***Fraud*** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- ***Waste*** means the overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.
- ***Abuse*** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the insurance exchange program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Exchange insurance program.

Fraud Prevention Program

The Special Investigations Unit (SIU) team proactively identifies potential incidents of suspected fraud and abuse as part of its program for ongoing monitoring and auditing.

The SIU investigates allegations such as:

- Missing documentation of services purportedly rendered;
- Billing for services not rendered;
- Alteration or forgery of documentation;
- Misrepresentation of services provided; and/or
- Receipt of benefits due to potentially fraudulent actions.

Fraud Prevention Program

As a network provider, you are responsible for reporting suspected fraud, waste and abuse issues.

Reporting issues to First Choice Next.

If you are aware of a potential or actual fraud, waste, or abuse issue, we encourage you to report the issue to the Special Investigations Unit by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**, which is available 24/7 and allows for the anonymous reporting of issues.
- Emailing fraudtip@amerihealthcaritas.com; or
- Complete the anonymous online fraud intake form found on at ameriheathcaritasnext.com.
- Mailing a written statement to:

Special Investigations Unit
First Choice Next
PO Box 7318
London, KY 40742

Comprehensive Compliance Program

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The First Choice Next Compliance department has implemented a Comprehensive Compliance Program to ensure compliance with all applicable federal and state laws.

If you have a compliance or privacy concern, we encourage you to contact our Compliance department. You can report issues to the Compliance department by:

- Calling the toll-free Compliance Hotline at **1-866-833-9718**, which is available 24/7 and allows for the anonymous reporting of issues.
- Using our online reporting tool at www.amerihealth.ethicspoint.com, which is available 24/7 and allows for anonymous reporting of issues.
- Emailing us:

  AmeriHealth Caritas Next Compliance: ACNXcompliance@amerihealthcaritas.com

  AmeriHealth Caritas Corporate Compliance: corpcompliance@amerihealthcaritas.com

  AmeriHealth Caritas Corporate Privacy: privacy@amerihealthcaritas.com

Compliance is a shared responsibility and calls upon us to do the right thing in the right way.

Fraud Prevention Program

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Reporting issues to the appropriate entity for the state of South Carolina

South Carolina Department of Social Services
Office of Inspector General
P.O. Box 1520
Columbia, SC 29202

Call 1-800-694-8518

Website: Online intake form available at
https://dss.sc.gov/about/fraud/

Advance Directives

First Choice Next requires its contracted providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care.

Providers must document in a Member's medical record and plan of care whether the Member has executed an advance directive.

Providers may find advance directive resources at:
https://www.caringinfo.org/planning/advance-directives/by-state/

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Resources

For a current list of
First Choice Next
phone and fax numbers,
please refer to the
Provider Quick Reference Guide at
firstchoicenext.com.

Questions


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