AmeriHealth Traditional Med

AmeriHealth NEW JERSEY

Benefits That Require Pre-Authorization

Referred Care

AmeriHealth participating doctors and hospitals will pre-certify treatments for you through the Patient Care Management (PCM) team. When receiving services from a non-participating Provider, you will be responsible for obtaining the pre-certification for those services by contacting the PCM team, using the toll-free number shown on your identification card. The PCM team, made up of physicians and nurses, evaluates the proposed plan of care for payment of benefits. The PCM team notifies the physician/provider whether services are approved for coverage. If the PCM team does not have sufficient information or the information evaluated does not support the coverage, the physician/provider and member are notified verbally and in writing of the decision. Members, providers or other individuals acting on behalf of the member, with the member's consent, may appeal the decision. At any time during the evaluation process or the appeal, the provider, member, or designee may provide additional information to support the request.

Services that require pre-certification or pre-authorization include but are not limited to:

- All Non-Emergency Inpatient Hospital Admissions; Emergency admissions must be certified within two (2) business days after admission.
- Home Health Care in lieu of Hospitalization
- Outpatient Private Duty Nursing (over 100 hours)
- Durable Medical Equipment and Prosthesis (purchase/rental over $1,500)
- CT
- MRI
- MRA
- Nuclear Cardiac Studies
- PET Scans

Members are not responsible for payment of services if the participating provider does not obtain pre-certification or pre-authorization of services. Failure to pre-certify or pre-authorize required services provided by a non-participating provider will result in a reduction of benefits for the member.

Inpatient Hospital Stays

During and after an approved hospital stay, members of AmeriHealth's Patient Care Management team are monitoring your stay to review whether you receive the most medically appropriate and timely care and to see that a plan for your discharge is in place and to coordinate services that may be needed following discharge.

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AmeriHealth Insurance Company of New Jersey
www.amerihealth.com

Continuity of Care

New Traditional Med Members

New Traditional Med members may continue an ongoing course of treatment with a non-participating health care provider for a transitional period of up to 60 days from the effective date of enrollment into the plan subject to the requirements set forth herein and in the applicable group master contract.

If the new member is in her second or third trimester of pregnancy at the time of the effective date of enrollment, the transitional period of authorization shall extend through post-partum care related to the delivery.

The non-participating provider must agree that all authorized health care services provided during this transitional period shall be covered by AmeriHealth under the same terms and conditions applicable for participating health care providers.

Non-participating health care providers (whose services are covered during the transitional period) must agree to be bound by the same terms and conditions as participating providers. The plan is NOT required to provide health care services that are not covered benefits.

Emergency Services

An emergency is defined as the sudden and unexpected onset of a medical or psychiatric condition and/or symptoms of substance abuse manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the member's health or in the case of a pregnant member, the health of the unborn child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency exists where: There is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency care includes covered services provided to a member in an emergency, including emergency transportation and related emergency services provided by a licensed ambulance service.

In the event of an emergency, the member should go to the nearest appropriate medical facility. Emergency admissions must be certified within (2) business days after admission.

Appeals

You have a right to appeal any adverse decision through the Appeals Process. Instructions for the appeal will be described in the denial notifications and in the Benefits Booklet.