

Members' rights and responsibilities

AmeriHealth HMO, Inc. and its affiliates (AmeriHealth) are committed to treating enrolled members in a manner that not only respects their rights, but also encourages them to exercise their personal responsibilities.

Commercial (HMO/POS) Member rights

A Commercial Member has the *right* to:

- Receive information about the health plan, its benefits, services included or excluded from coverage, policies, appeals procedures, Participating Providers¹ and Members' rights and responsibilities. Written and Web-based information that is provided to the Member will be readable and easily understood.
- Obtain a current directory of Participating Practitioners in the network, upon request. The directory includes addresses, telephone numbers, and a listing of providers who accept members who speak languages other than English.
- File a complaint or appeal about the health plan or care provided with AmeriHealth or the Department of Banking and Insurance and to receive an answer to those complaints within a reasonable period of time. To be notified of the disposition of an appeal or complaint and further appeal, as appropriate.
- Appeal a decision to deny or limit coverage, first within AmeriHealth and then through an independent organization for a filing fee. The Member also has the right to know that his or her doctor cannot be penalized for filing a complaint or appeal on the Member's behalf.
- Choose a primary care provider, within the limits of covered benefits and availability, within the plan network. The Member also has the right to refuse care from specific practitioners.
- Have a choice of specialists among Participating Network Providers following an authorized Referral, subject to their availability to accept new patients.
- For Members with chronic disabilities, the right to obtain assistance and Referrals to providers who are experienced in treating their disabilities.
- Participate with providers in decision making regarding his or her health care.
- Candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage, in terms the Member understands, including an explanation of his or her medical condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives. If the member is unable to easily understand this information, he or she has the right to have an explanation provided to his or her next of kin or guardian and documented in his or her medical record. AmeriHealth does not direct practitioners to restrict information regarding treatment options.
- Be treated with courtesy and consideration and with respect and recognition of his or her dignity and right to privacy.
- Have confidential treatment of personally identifiable health/medical information and to have access to his or her medical records in accordance with applicable federal and state laws.
- Have available and accessible services when Medically Necessary, including availability of care 24 hours a day, seven days a week for urgent and Emergency conditions.
- Call 911 in a potentially life threatening situation without prior approval from AmeriHealth; the right to have AmeriHealth pay for a medical screening evaluation in the emergency room to determine whether an Emergency medical condition exists.
- Continue to receive services from a provider who has been terminated from the AmeriHealth network (without cause) for up to four months if Medically Necessary. If the Member is pregnant, coverage extends to the postpartum evaluation, up to six weeks after delivery. If the Member is receiving postoperative care, coverage extends for up to six months, if Medically Necessary. If they are receiving oncological or psychiatric care, treatment will be extended for up to one year if Medically Necessary. This continuation of care does not apply if the provider is terminated for reasons that would endanger the Member, public health or safety, or constitute breach of contract, or fraud.

- Receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin or source of payment.
- Formulate an advance directive and to have the directive implemented. The Plan will provide information concerning advance directives to Members and Participating Providers.
- Those rights be afforded to them by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language understood by him or her.
- Be free from balance billing by providers for Medically Necessary services that are authorized or covered by AmeriHealth except as permitted for copayments, coinsurance, and deductibles, by contract.
- Prompt notification of terminations or changes in benefits, services, or provider network.
- Make recommendations regarding the AmeriHealth Member Rights and Responsibilities Policy by contacting Customer Services in writing.

¹When used in specific statements of Commercial and PPO Members' rights and responsibilities, the Plan has adopted the definition of "provider" used by the New Jersey Department of Banking and Insurance in regulations at N.J.A.C 11:24-1.2 as follows: a provider is a physician, or other health care professional, hospital, facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

Commercial (HMO/POS) Member responsibilities

A Commercial Member has the *responsibility* to:

- Review all benefits and membership materials carefully and to follow the regulations pertaining to the health plan.
- Communicate, to the extent possible, information that AmeriHealth and Participating Practitioners and Providers need in order to provide care.
- Understand his or her health care problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Follow plans and instructions for care that he or she has agreed upon with his or her practitioners. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Ask questions to assure understanding of the explanations and instructions given.
- Treat others with respect and courtesy.
- Keep scheduled appointments or to give adequate notice of delay or cancellation.
- Pay deductibles, coinsurance, or copayments, as appropriate, according to the Member's contract.
- Pay for charges incurred that are not covered under or authorized under the Member's benefits policy or contract.
- Pay for charges that exceed what AmeriHealth determines are customary and reasonable (usual and customary, or usual, customary, and reasonable, as appropriate) for services that are covered under the out-of-network component of the Member's benefits contract with respect to point-of-service contracts.

PPO Member rights

A PPO Member has the *right* to:

- Receive information about the health plan, its benefits and services, policies, appeals procedures, Participating Providers, and Members' rights and responsibilities.
- Be treated with respect and recognition of his or her dignity and right to privacy.
- Participate with providers in decision-making regarding his or her health care.
- Candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage, in terms he or she understands, including an explanation of his or her medical condition, recommended treatment, risks of treatment, expected results, and reasonable

medical alternatives. AmeriHealth does not direct practitioners to restrict information regarding treatment options. If the Member is unable to easily understand this information, an explanation shall be provided to the next of kin or guardian and documented in the medical record.

- Voice appeals or complaints about the health plan or care provided with AmeriHealth or the Departments of Banking and Insurance and to receive an answer to those complaints within a reasonable period of time. This includes the right to be notified of the disposition of the appeal or complaint and further appeal, as appropriate.
- Receive reasonable access to medical services and payment of appropriate benefits, when Medically Necessary, consistent with Member's benefits plan. This includes the right to have access to care 24 hours a day, 365 days a year for urgent or Emergency services.
- Call 911 in a potentially life-threatening situation without prior approval from AmeriHealth; the right to have AmeriHealth pay for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, or source of payment.
- Receive prompt notification of terminations or changes in benefits, services, or provider network.
- Make recommendations regarding the AmeriHealth Member Rights and Responsibilities policy.

PPO Member responsibilities

A PPO Member has the *responsibility* to:

- Communicate, to the extent possible, information that AmeriHealth and its providers need in order to provide care.
- Follow plans and instructions for care that he or she and his or her provider have agreed on, including consideration of the possible consequences of failure to comply with recommended treatment.
- Understand his or her health care problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Pay deductibles, coinsurance, or copayments, as appropriate, according to his or her contract. Also, the responsibility to pay for charges incurred that are not covered under or authorized under the Member's benefits policy or contract.
- Pay for charges that exceed what AmeriHealth determines are customary and reasonable (usual and customary, or usually, customary, and reasonable, as appropriate) for services that are covered under the out-of-network component of the Member's benefits contract with respect to point-of-service contracts.

Medicare Advantage HMO Member rights

A Medicare Advantage HMO member has the *right* to:

- Get information about AmeriHealth 65[®], its services included or excluded from coverage, its practitioners and providers, and Member's rights and responsibilities.
- Be treated with fairness, respect, and recognition of his or her dignity.
- Have privacy of medical records and personally identifiable health/medical information and access to his or her medical records in accordance with applicable federal and state laws.
- See network providers and obtain Covered Services within a reasonable period of time.
- Choose providers, within the limits of covered benefits and availability within the AmeriHealth 65 network and the right to refuse care from specific providers.
- Have a choice of specialists among Participating Network Providers following an authorized Referral, subject to their availability to accept new patients.
- Know treatment choices and participate with providers in decisions about his or her health care.
- Participate with providers in decision-making regarding his or her health care. The right to a candid discussion of appropriate or Medically Necessary treatment options for his or her medical conditions, regardless of cost or

benefits coverage. AmeriHealth does not direct practitioners to restrict information regarding treatment options.

- Use advance directives (such as a living will or a power of attorney).
- Voice complaints or appeals about AmeriHealth 65 or the care it provides and to receive an answer to those complaints within a reasonable period of time. This includes the right to be notified of the disposition of an appeal or complaint and further appeal, as appropriate.
- Receive information about health care coverage and costs.
- Receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, or source of payment.
- Obtain information about the AmeriHealth 65 HMO in other formats.
- Make recommendations regarding AmeriHealth 65 Member Rights and Responsibilities Policy by contacting Customer Service in writing.

Medicare Advantage member rights

A Medicare Advantage HMO Member has the *responsibility* to:

- Notify providers that he or she is enrolled in AmeriHealth 65 when seeking care (unless it is an Emergency).
- Give AmeriHealth 65 and providers the information they need to provide care (to the extent possible) and to follow agreed upon the treatment plans and instructions.
- Act in a way that supports the care provided to others and helps smooth the running of providers' offices and facilities.
- Pay premiums and any cost shares he or she may owe for Covered Services and meet other financial responsibilities as described in the *Evidence of Coverage*.
- Understand his or her health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Advise AmeriHealth 65 of any questions, concerns, problems, or suggestions.
- Notify AmeriHealth 65 if he or she has additional health insurance.
- Notify AmeriHealth 65 if he or she moves out of the service area.