Dental coverage reminder for HMO members

If you, or an eligible dependent, have dental coverage under your group HMO contract, you must select a primary dental office when you enroll. You may change your selection as often as once a month.

For assistance finding a network dentist near you, call Customer Service at the number on the back of your ID card.

Check your benefits description materials or ask your employer’s benefits administrator for additional information. Benefits may vary.
How to access your claims and benefit information

As an AmeriHealth member, you can use our secure, password-protected, self-service member website, amerihealthexpress.com. One of the many features available is the ability to view personalized information about the benefits and services included in your coverage. To do so, select My Benefits. There you will find information about benefits and services not covered under your health plan, as well as copayments and other charges for which you may be responsible.

Using amerihealthexpress.com, you also have the ability to view personalized information about the status of claims submitted for services provided for you by any provider in the network. By selecting My Claims, you will be able to view the status of the claim, the date that the claim was paid, and any amount that you are responsible to pay.

If you have questions or need information about your claims or benefits coverage, or if you do not have Internet access, call Customer Service at the number on the back of your ID card.
Important changes to your privacy notice

The Department of Health and Human Services Office for Civil Rights published the final rule implementing modifications to the privacy and security regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA Final Rule).

The HIPAA Final Rule also implements the amendments under the Health Information Technology for Economic and Clinical Health Act, the Genetic Information Nondiscrimination Act of 2008, and the Breach Notification Rule. The HIPAA Final Rule is effective March 26, 2013, and compliance by Covered Entities is required no later than September 23, 2013.

As a Covered Entity, we are required to revise our Notice of Privacy Practices to include the changes related to the HIPAA Final Rule that affect you. Listed below is a summary of the major changes:

- We are required to limit the use and disclosure of protected health information (PHI) for marketing purposes, and prohibit the sale of PHI without your authorization.
- We will prohibit the use and disclosure of genetic information for underwriting purposes.
- You have the right to receive electronic copies of your protected health information in certain situations.
- You have the right to be notified following a breach of your unsecured PHI or if a security breach occurs involving your PHI.

Note: “Protected health information,” or “PHI,” is information about you, including information that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for that care.

Please review our Notice of Privacy Practices for more detailed information about your privacy rights and how we may use and share your PHI. You may view or print a copy of our notice from our website at www.amerihealth.com/privacy.

You may also call Customer Service at the telephone number on the back of your ID card to request that a copy of the notice be mailed to you.
Your privacy and protected health information

At AmeriHealth, protecting your privacy is very important. That’s why we have implemented measures to keep our members’ protected health information (PHI) confidential. PHI is individually identifiable health information about you — specifically, your medical or mental history, the health care you receive, or the payment for that care. PHI may be in oral, written, or electronic form.

We may obtain or create your PHI as part of our business: providing you with health care benefits.

One of the ways we protect your privacy is by limiting who may view your PHI. Our policies and business procedures cover the collection, use, and disclosure of PHI. We continually review these policies and procedures to make sure that your information is protected and at the same time available as needed to provide your health benefits. For example, procedures are in place to help us verify the identity of someone requesting PHI and to place limits on which staff members can access your PHI. We share only the minimum amount of information necessary when PHI must be disclosed. We also protect any PHI that is electronically transmitted outside our organization by using only secure networks and encryption technology.

We do not use or share your PHI without your permission unless permitted by law. Examples of business situations in which we are permitted to use or disclose your PHI include:

• Paying your claims
• Coordinating the delivery of health care services
• Monitoring the performance of network providers regarding health care outcomes

In certain other circumstances, we may also share your PHI with health care oversight and government agencies for legally authorized activities, such as audits and investigations, or when we are required to do so by law. We may also share certain information with the sponsor of your group health plan for administration purposes.

The laws that protect your privacy also give you certain rights regarding your PHI. For example, you may request a copy of your PHI on file at AmeriHealth by contacting Customer Service. Please remember that we typically do not have copies of your medical records. You should contact your doctor or other health care provider for copies of your medical records.

Releasing protected health information

You may wish to have certain individuals view or receive part or all of your PHI. For instance, you may have an adult son or daughter to whom you turn for assistance with coordinating your medical care or paying your medical expenses. You can authorize us to share your PHI with any person or organization you choose by completing an Authorization for Disclosure of Health Information form and returning it to us for our records. The form is available on our website at www.amerihealth.com/privacy. Select the HIPAA Privacy and Practices Forms link, and then click on Authorization Form. You may also request us to send this form to you by calling Customer Service at 1-800-275-2583.

Please review our Notice of Privacy Practices for more detailed information about your privacy rights and how we may use and share your PHI. You may view or print a copy by logging on to www.amerihealthexpress.com and selecting Privacy Policy at the bottom of the page or by going to amerihealth.com/privacy. You can also call Customer Service to request a copy.
Tips for planning for your next doctor visit

Here are a few things to keep in mind that will help make your visit go as quickly and smoothly as possible:

• Check to make sure you have your current plan ID card with you before leaving for your appointment.

• Ask whether you can pay your copayment when you arrive for your appointment. Your office visit copayment amount is located on the front of your ID card. Using some of your waiting room time for the business part of your visit lets you move on to the rest of your day as soon as you are finished seeing the doctor.

• Keep your medical records current. If your address, phone number, or ID number has changed since your last visit, be sure to tell the doctor’s office staff.

• Take along a list of all prescription medications, over-the-counter medications, and herbal remedies that you are taking to identify any possible drug interactions. Also take the names of doctors currently treating you and details about any recent hospitalizations. This will help the doctor know how to treat you and coordinate your care.

• Log on to www.amerihealthexpress.com and select Symptom Checker under WebMD®. As you use the tool, you will see a link called Preparing for Your Appointment under Topic Contents. There you will find specific questions to ask your doctor and things your doctor will need to know about your particular condition.

For AmeriHealth HMO members

If you have an appointment with a specialist, your primary care physician should have submitted a referral through the electronic submission process. If you want a hard copy of the referral, you can view and print copies of any referrals that were issued to you by logging on to www.amerihealthexpress.com. Select View Open Referrals located under the My Benefits tab.

Use your Personal Health Profile

An easy way to share important health information with your doctor is to bring a printed copy of your Personal Health Profile to appointments. To get your copy, log on to www.amerihealthexpress.com and select the WebMD tab.
Our utilization review policy

It is the policy of AmeriHealth HMO, Inc. and its affiliates ("Plans") that all utilization review decisions are based on the benefits available under the member’s coverage and the medical necessity of health care services and supplies in accordance with the Plans’ definition of medical necessity.

Only physicians can make denials of coverage of health care services and supplies based on lack of medical necessity. The nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services for the Plans are not compensated or given incentives based on their coverage review decisions. Medical directors and nurses are salaried, and contracted external physicians and other professional consultants are compensated on a per-case-reviewed basis, regardless of the coverage determination.

The Plans do not provide financial incentives for issuing denials of coverage or utilization review decisions that result in underutilization.

If you have questions about the utilization decision process or a determination you have received, you can call Customer Service at the telephone number on the back of your insurance card. Customer Service will provide assistance with understanding the process or transfer you to the Utilization Management Department to discuss your concerns.

Utilization Management is available Monday through Friday, 8 a.m. to 4:30 p.m. For urgent issues relating to utilization management after business hours, call 1-800-275-2583.
Hospital care procedures for HMO members

If you need outpatient services, surgery, or hospitalization, your primary care physician (PCP) will provide any referrals that your AmeriHealth plan might require.

If your PCP refers you to a specialist who then determines that you need outpatient services, surgery, or hospitalization, the specialist will coordinate the prior authorization (approval in advance) with AmeriHealth.

Prior authorization is not needed if you require emergency admission. Once you are discharged from the hospital, we highly recommend that you follow up with your PCP to review your medications, especially if there has been a change during a hospital admission.
Objectives of our Quality Management Program

The AmeriHealth Quality Management Program monitors and objectively evaluates standards and quality of care for our members. The goals and objectives of the QM Program include the following:

- To improve the quality of medical and behavioral health care and service provided to members
- To maintain current preventive health and clinical practice guidelines
- To identify, develop, and/or enhance activities that promote member safety
- To comply with all regulatory requirements, and to achieve and maintain accreditation and necessary certification

For more information on our Quality Management Program, visit www.amerihealthexpress.com and select Quality Management under the Member tab. You can also receive a printed copy of the Quality Management goals and objectives by calling the Customer Service number on the back of your ID card.
Understanding the difference between emergency and urgent care

There is a difference between emergency care and urgent care. Understanding this important difference helps you know when to go to a hospital emergency room and when to seek care from your physician or other health care provider, such as an urgent care center or retail clinic.

If you need to go to a hospital emergency room, remember that emergency rooms must prioritize patients' needs. The most seriously hurt or ill patients are treated first. If you are not in that category, you may wait a long time before receiving care.

What is an emergency?

A medical emergency is typically thought of as a medical or psychiatric condition in which symptoms are so severe that the absence of immediate medical attention could place one's health in serious jeopardy.

A medical emergency could include severe chest pain. If you are experiencing symptoms that may indicate an emergency condition, you should go immediately to the emergency room of the closest hospital.

If you believe your situation is life-threatening, you should call 911 or go immediately to the emergency room of the nearest hospital. With an emergency condition, you can directly access medical care that does not require prior approval.

If you had emergency care, be sure to notify your primary care physician (PCP) or personal physician, even if follow-up treatment is not needed.

What is urgent care?

Urgent care is necessary treatment for a non-life-threatening, unexpected illness or accidental injury that requires prompt medical attention when your doctor is unavailable. Examples include sore throat, fever, sinus infection, ear ache, cuts, rashes, sprains, and broken bones.

You may visit an urgent care center, which offers a convenient, safe, and affordable treatment alternative to emergency room care, when you can't get an appointment with your own doctor. Many urgent conditions require follow-up care that is best provided or coordinated by your PCP or personal physician.

What if my PCP is not available?

When you are unable to get an appointment with your PCP, and you have an urgent-care benefit, urgent care centers and retail health clinics are an easy, safe, and less costly option to the emergency room. Urgent care centers have board-certified doctors who can give you care for an illness or injury that needs medical attention right away but is not life-threatening.

Retail health clinics have certified nurse practitioners who can treat simple illnesses and injuries. If you are seen at an urgent care facility or retail health clinic, notify your PCP. You may also need to schedule a follow-up appointment with your PCP, not the urgent care center or retail health clinic where you were treated.

When in doubt, call your physician

If you are unsure whether your condition is an emergency or an urgent condition, call your physician. He or she knows you and your medical history and can best assess...
your condition. Based on your symptoms, your physician may send you to a hospital emergency room. Your physician may also arrange to see you for an evaluation and treatment in the office or suggest another option.
Understanding advance directives

Do you have a living will or advance directive — a document that spells out how you want to be cared for in the event that you cannot articulate your wishes?

Many of us do not think about such issues until we are admitted to a hospital. That is when, in accordance with federal law, we are asked if we have signed any such documents.

Of course, that is probably the worst time to make such decisions, particularly in an emergency, when you may not be able to think clearly. It may be best to discuss these matters with your family, your physician, and anyone else involved in your care before a medical emergency occurs. If you have a lawyer, he or she may be able to help you write up your wishes in a formal document.

Advance directives can take various forms

- **Living will.** This document expresses your wishes should you become terminally ill or be in a persistent vegetative state. You state whether you would want to be kept alive through such measures as tube feeding, artificial respiration, or heart resuscitation. For a living will to be valid, it must be in writing and signed, dated, and witnessed by two adults.

- **Health care agent.** This is someone you appoint to make decisions about your health care in the event that you are unable to make decisions yourself. You may specify to your agent what procedures you do or do not want, but this is not necessary. You can identify your health care agent in your living will or ask your lawyer to draft an official document needed to appoint a health care agent.

- **Durable power of attorney for health care.** This document allows you to designate a health care surrogate to make decisions for you even if you are temporarily unable to express your wishes. This can be part of a general durable power of attorney, which allows your surrogate to make decisions on your behalf in virtually all matters — legal, personal, and financial. This document must be drafted by a lawyer.

Share information with others

Whatever advance directives you select, give copies to your family and other caregivers, lawyer, physician, and other health care providers, and ask that they be made part of your permanent medical record.

If you have any questions about advance directives, speak with your lawyer.
How to reach multilingual Customer Service

If you or a member you know has difficulty communicating because of an inability to speak or understand English and needs language assistance, call Customer Service at 1-800-275-2583 (for the hearing impaired: 711). Follow the prompts or wait to speak with a Customer Service representative.

AmeriHealth has multilingual staff, telephone language-line services, and TTY for the deaf or hearing impaired. Our Customer Service representatives can answer questions or provide information about your claims or benefits coverage. They can also assist you in finding a participating provider who speaks your language.

Through an AmeriHealth partnership with WebMD®, amerihealthexpress.com takes you to a whole new level of information about your health. With just one easy log-in, you can choose to learn about symptoms of certain conditions, complete your Personal Health Profile, or use many other features that are available in English or Spanish.
Preventive wellness can help you stay healthy

Health experts agree — and statistics have shown — that one way to help reduce your risk for illness is to follow recommended wellness and preventive care practices such as these:

• Visit your health care provider for well-care visits and recommended health screenings.

• Ensure that immunizations (including flu, pneumonia, and whooping cough vaccinations) are up to date for you and your whole family.

• Know your family’s medical history and discuss it with your health care provider.

You can find more information on well checkups and recommended health screenings in the Member Wellness Guidelines brochure at www.amerihealthexpress.com, then selecting Health & Wellness under the Member tab. You can also obtain a printed copy of the Member Wellness Guidelines by calling the Health Resource Center at 1-800-275-2583. Remember to check your benefits coverage to learn more about which health screenings are covered and any costs involved.

Note: Your health care provider may suggest alternative tests/screenings to those listed. Wellness guidelines are constantly changing, and these guidelines were current at the time of publishing. Please discuss your individual needs relating to the recommended guidelines with your health care provider.
How to find a network provider

Our online provider directory offers a wealth of information about network providers. You’ll find easy-to-follow, up-to-date, detailed listings of doctors and hospitals — information you can use to make informed decisions about your health care.

The following tools can help you locate network providers and hospitals that will suit your health needs:

• Provider Finder. Find a participating health care provider who matches your location, situation, and preferences. Learn valuable information, such as the provider’s gender, hospital admitting privileges, and languages spoken at the practice. You can also review and compare the qualifications and experience of network physicians.

• Hospital Finder. Research and compare hospitals based on procedure, diagnosis, and location, as well as hospital quality and safety information. You can customize the way the results are displayed according to which measures (number of patients, complication and mortality rates, length of stay, and cost) are most important to you. Therefore, the results are unique to each member.

Go online

Go to www.amerihealth.com/providerfinder or www.amerihealthexpress.com to use these valuable resources. If you do not have Internet access, call Customer Service at 1-800-275-2583 to obtain a copy of the Provider Directory for your coverage (HMO, POS, or PPO).
Getting support from a Health Coach is just a phone call away

When you have a chronic condition or a serious health concern, you may find it confusing or difficult to manage — juggling new medications, scheduling visits to doctors and specialists, and keeping information straight. That’s when an AmeriHealth Health Coach can help.

Health Coaches are registered nurses who are available to you 24 hours a day, 7 days a week, to help you with your health needs and questions. Once you speak with a Health Coach, he or she becomes your personal health resource for all your health-related issues. From information on chronic conditions to coordinating care and everything in between, your Health Coach is there to help you meet your health goals.

Call 1-800-275-2583 (for hearing impaired: 711) to speak with a Health Coach. Translation services are available through the AT&T Language Line. There is no additional cost to you for using the Health Information Line.
Registered Nurse Health Coaches offer comprehensive health support

Living with a chronic condition or coordinating care after a hospital stay can be overwhelming, but you don’t have to do it alone. AmeriHealth provides members with access to Health Coaches — registered nurses who are available 24/7 to help you manage your care and make informed health decisions — at no additional cost to you. Health Coaches are available 24 hours a day, 7 days a week, 365 days per year by calling 1-800-275-2583.

Our Health Coaches support members with chronic conditions through our condition management program* and also members who require more intensive case management and coordination of care. Health Coaches have access to health information that may help identify members as being eligible for one of our programs. These members may receive a telephone call from a Health Coach offering support for their condition.

In addition, Health Coaches can address general health questions and concerns you may have. Once you speak with a Health Coach, he or she is dedicated to you. Whatever your health concern, your personal Health Coach works with you to set goals and develop a plan to manage your health care through telephone calls and/or educational materials and health reminders mailed to your home.

Together, you and your Health Coach will:

- Assess your current health status and history
- Confirm your needs
- Develop a care plan designed to meet your needs that could include home care, education, and coaching
- Review your plan and goals and communicate with your doctor as necessary

Speaking with a Health Coach is voluntary. You can talk with a Health Coach just once or establish a relationship and set up follow-up calls — whatever works best for you. If at any time you wish to stop your relationship with your Health Coach, simply call 1-800-275-2583 and ask that you not be contacted by a Health Coach in the future.

*Condition management is available to most members. Please call Customer Service at the telephone number on your ID card to find out if you are eligible.
What you should know about your prescription drug benefits

When you need prescription drugs, an AmeriHealth prescription drug program can help you make the best choice.

Our safe-prescribing procedures

AmeriHealth uses safe-prescribing procedures to give you access to the drugs you need while keeping you safe. These procedures include additional requirements or limits on coverage that help ensure that you and your doctor find safe, appropriate drugs and keep costs down.

Our safe-prescribing procedures include:

- **Prior authorization.** Certain prescription drugs require your physician to receive approval to prescribe a specific medication for you before that medication is covered. Usually, prior authorization applies if a drug is often taken in the wrong way, should be used only for certain conditions, or often costs more than other drugs that are just as effective. When we review prior authorization requests, a clinical pharmacist checks that there is no duplication in drug therapies or potentially harmful interactions with other drugs, and that the drug is prescribed according to our criteria and the U.S. Food and Drug Administration (FDA) guidelines.

- **Quantity-level limits.** Some drugs have a limit on how many doses you can receive per month. Quantity-level limits ensure that a drug is not taken in the wrong way and that you don’t take more than the FDA-approved maximum daily dose and the length of therapy.

- **Age and gender limits.** Certain drugs may be appropriate for specific age groups or gender. An age or gender limit may be placed on a drug if there are safety concerns or inappropriate issues for a particular age group or gender. For example, prenatal vitamins are prescribed for women only.

You can find out more about our safe prescribing procedures by logging on to www.amerihealthexpress.com and viewing your benefits information, or by calling Customer Service at 1-800-275-2583.

Our prescription drug list

Our list of covered prescription drugs – known as a “formulary” – is available online. You can use the formulary to find information about prescription drugs. For example, the list will show you if your drug is available in a generic version and if additional requirements and limits apply, such as prior authorization and quantity-level limits.

Our formulary changes as the Pharmacy and Therapeutics Committee, an established group of medical directors and practicing area physicians and pharmacists, reviews the list to ensure its continued effectiveness. Changes to the standard AmeriHealth prescription drug program and the Select Drug® program may include:

- Generic and/or brand-name drugs added to the formulary
- Additional drugs that require prior authorization or quantity-level limits
- Drugs that are still available, but at a different level of cost-sharing

If you take a drug affected by a change, we notify you of the changes directly by mail. For a list of the most recent changes, log on to www.amerihealthexpress.com.

Note: Please check your benefits description materials to determine if prescription drug coverage is available to you.
Improve your health with your
Personal Health Profile

Are you looking for ways to improve your health but aren’t sure where to begin? Our interactive online Personal Health Profile (PHP) can help. The profile:

- Helps you identify and learn about possible health risks
- Identifies opportunities for improving your overall well-being
- Connects you to other resources

Log on to www.amerihealthexpress.com and select the WebMD® tab to access your PHP. Then select Personal Health Profile in the menu on the left.

Results provide action plan for better health

Once you complete your PHP, you will receive an overall health score plus a summary report. The summary report shows your risks and what changes you can make to increase your PHP score.

You will also receive risk reports, condition reports, and a Physician Summary. Risk reports provide a more in-depth look at some of your modifiable risk factors, such as nutrition, blood pressure, blood sugar, and emotional health. Condition reports show your personal risk for cancer, heart disease, stroke, and other diseases. The condition reports include information on early detection, next steps, and action plans.

Want to review your results with your doctor? Print out the Physician Summary and take it to your next office visit. Your doctor can offer additional suggestions for ways to improve your health.

Nationally accepted guidelines and recommendations can change. To provide you with the most current health information available, content is regularly updated. We encourage you to complete your PHP annually or as often as you wish.

To learn more

Discover how our AmeriHealth Healthy Lifestyles™ Solutions programs can help you reach your PHP goals. AmeriHealth Healthy Lifestyles Solutions provides reimbursements, discounts, and more to encourage you to make healthy changes.

Information on the AmeriHealth Healthy Lifestyles Solutions programs is available by logging on to www.amerihealthexpress.com or by calling the Health Resource Center at 1-800-275-2583.

Note: The AmeriHealth Healthy Lifestyles Solutions programs are available to most members. Please call 1-800-275-2583 to find out if you are eligible.
Obtaining care when traveling outside the AmeriHealth service area

AmeriHealth HMO, POS, and PPO members have access to emergency and urgent care services when traveling outside the AmeriHealth service area. Always be sure to travel with your AmeriHealth ID card in the event that you need emergency or urgent care services.

Emergency services

Emergency services are covered. Examples of a medical emergency include severe chest pain, a broken arm, or a medical condition that is quickly getting worse. In an emergency, go directly to the nearest hospital. If you are admitted, call Customer Service at 1-800-275-2583.

HMO and POS members do not require a referral for treatment from their primary care physician (PCP); however, all members should notify their PCPs or personal physicians to coordinate follow-up care. Medically necessary care by a provider other than your personal physician or PCP will be covered until you can be transferred, without medically harmful consequences, to the care of your PCP, personal physician, or a referred specialist.

Urgent care services

Urgent care benefits cover medically necessary treatment for any unforeseen illness or injury that requires treatment prior to your return to the AmeriHealth service area, such as severe ear pain. For information about benefits restrictions that apply to services obtained outside of the service area, call Customer Service at 1-800-275-2583.

The provider may collect the appropriate copayment and/or coinsurance for the visit/service, or you may be asked to pay the cost for the visit/service when provided. To facilitate the processing of claims for your out-of-area urgent care, call Customer Service at 1-800-275-2583 within 48 hours of receiving the care or as soon as reasonably possible, as determined by AmeriHealth. If the services received outside of the service area are determined not to be urgent care, you will be responsible for the cost of the services.

Member responsibilities

It is the member’s responsibility to forward to AmeriHealth any bill received for emergency or urgent care services provided outside of the service area by a nonparticipating provider. Members should submit their bills for reimbursement to AmeriHealth or, if applicable, to Magellan Behavioral Health, Inc. * Be sure to include your full name and address, and your member ID number, which appears on your ID card. No claim form is required.

Note: This is not a statement of benefits. Please refer to your benefits description materials for complete details of the terms, limitations, and exclusions of your health care coverage.

*Magellan Behavioral Health, Inc., manages mental health and substance abuse benefits for most members.
Keeping abreast of emerging technologies

Newer does not always mean better when it comes to health care technology

Every day, new technology is developed to fight disease. Many of these new products and procedures turn out to be highly effective, while some need further investigation. Many, however, fall short of their original intentions, and a few turn out to be unsafe or even harmful.

In an effort to provide coverage for safe and effective treatments, we evaluate new and emerging technology for medical and behavioral health conditions. In accordance with accepted principles of technology assessment, we routinely evaluate the available evidence based on the following criteria:

The technology must have final approval from the appropriate government regulatory bodies. This applies when organizations like the U.S. Food and Drug Administration (FDA) regulate the lawful use of a product. It is important to remember that the evidence required for FDA approval varies depending on the type of product being reviewed.

The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations. These studies should be published in peer-reviewed journals. The quality and the consistency of the results are considered crucial in evaluating the evidence. There should be evidence that the technology positively affects health outcomes. “Health outcomes” refers to the measurable physiologic responses of a medical nature.

The technology must improve the net health outcome. That means that the advantages outweigh the disadvantages.

The technology must be as beneficial as any established alternatives. The technology should improve the net health outcome as much as, or more than, established alternatives. Direct comparison of the technology with established standard treatments for the medical condition provides the best evidence.

The improvement must be attainable outside the investigative settings. Participating professional providers with direct experience in the practice of the service help us evaluate the evidence. Their assessment helps us decide if the service is an acceptable medical practice that should be available to members in our plans and networks.
When and how to submit a claim

When you use a network provider, there’s no need for you to submit a claim. Your provider does that for you. However, if you are an AmeriHealth POS or Direct POS* member who self-refers to providers or an AmeriHealth PPO member using an out-of-network provider, you may be required to submit a claim form for services received. Here’s what to do:

**AmeriHealth POS or Direct POS† members**

You are required to submit a claim only for self-referred services. Use the POS claim form available when you log on to amerihealthexpress.com.‡

**AmeriHealth PPO members**

You may have to pay the full charges and then submit a claim for reimbursement if you use doctors or hospitals that are not in the PPO network. Out-of-network claim forms are available on amerihealthexpress.com.‡

**Step-by-step instructions**

Claim submission instructions are located on the backs of the AmeriHealth POS, Direct POS, and PPO forms. Remember to always keep a copy of the completed claim form and the itemized bills for your records.

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*AmeriHealth Direct POS is available only to members in Pennsylvania.

†AmeriHealth POS and Direct POS members who use out-of-network doctors and hospitals may have to pay the full charges and then submit a claim form for reimbursement.

‡Additional claim forms are available by calling Customer Service at 1-800-275-2583.
Appointment scheduling, wait times, and other standards

When you need medical care, seeing a doctor should be fast and easy. AmeriHealth has put these standards in place to get you the service you need when you need it.

Appointment availability

In conjunction with the doctors in our network, we have set standards for the scheduling of patients’ appointments:

• In a medically urgent situation, you should receive an appointment within 24 hours.*
• For a routine visit, you should be able to schedule an appointment with your doctor within two weeks.
• For a routine physical, you should be able to schedule an appointment with your doctor within four weeks.

In an emergency, you should get medical help as soon as possible.†

Wait times

No one likes to be kept waiting. We have asked our network doctors to set a goal of seeing you within 30 minutes of your scheduled appointment time. Of course, unforeseen events may prevent your doctor from achieving that goal all the time. You may experience an occasional delay. However, the objective is to ensure that you consistently have access to medical care within an acceptable waiting period.

Access after normal business hours

Urgent or emergency medical advice should be available 24 hours a day, seven days a week. If an urgent issue arises after normal business hours, call your doctor’s office for instructions on how to reach your doctor or a covering physician. A physician should call you within 30 minutes.

Your access to behavioral health care‡

To access behavioral health services (including mental health and substance abuse services), members may call the telephone number on their ID card. We have established the following standards for scheduling behavioral health services:

• In the case of a life-threatening emergency, you should be seen within one hour of the crisis call or be directed to your nearest emergency room.
• In a situation that is not life-threatening, you should be seen within six hours of the crisis call.
• For an urgent situation, you should be offered an appointment within 48 hours.
• For a routine visit, you should be offered an appointment within 10 business days.

For HMO members

• **Primary care.** AmeriHealth members choose a primary care physician (PCP) on enrollment. In order to find out if your PCP is a participating provider, or to find a participating provider, log on to [www.amerihealth.com/find_a_provider](http://www.amerihealth.com/find_a_provider). To change PCPs, log on to [www.amerihealthexpress.com](http://www.amerihealthexpress.com) and choose *Change Your Primary Care Physician (PCP)* under the *My Self-Service Tools* section, or call the Customer Service number on the back of your card.

• **Specialty care.** In order to have specialist visits covered, you must request a referral from your PCP. This helps your PCP coordinate your treatment and any medication and helps avoid unnecessary or duplicate tests. Your PCP will submit an electronic referral to the specialist indicating the services authorized. Your referral is valid for 90 days from the issue date as long as you are an AmeriHealth member.
Make sure the specialist or facility has received the referral before the services are performed. Only services authorized on the referral are eligible for coverage. If the referred specialist recommends additional medically necessary care after the initial 90-day window has expired, another electronic referral from your PCP will be required. If you would like a copy of the referral form, you can view and print copies of referrals issued to you at www.amerihealthexpress.com.

- Obstetrical/gynecological care. Members may seek care from an AmeriHealth-participating obstetrician or gynecologist for all gynecological care without a referral.

Note: Not all HMO plans require referrals. Please check your benefits description materials to verify if referrals are required for you.

* Urgent care is medical attention you need right away for an unanticipated illness or injury, such as severe ear pain or a sprain.

†An emergency is defined as a medical condition manifesting itself in acute symptoms of sufficient severity that the absence of immediate medical attention could result in serious medical consequences or place one’s health in serious jeopardy. If you are experiencing symptoms that might reasonably indicate such a condition (such as severe chest pain or a broken arm), you may need emergency care and should go immediately to the emergency department of the closest hospital. Health concerns of a pregnant woman may also extend to her unborn child. If you believe your situation is an emergency, you should call 911. Please note that “emergency services” are covered benefits in accordance with your contract. Your benefits description materials contain a complete and more detailed definition of “emergency” with which you should become familiar. It is this definition that determines whether your condition, injury, or illness will be covered as an emergency service.

‡Magellan Behavioral Health, Inc. manages mental health and substance abuse benefits for most members.
HMO members: Making an appointment with your PCP

To schedule an appointment with your primary care physician (PCP), call the PCP’s office and identify yourself as an AmeriHealth member who has selected the office as your PCP. Whenever possible, make the call in advance of the day you want the appointment. If you are injured or have an urgent medical problem that cannot wait, be sure to contact your PCP. You will be advised about what to do.

When you arrive for your appointment, please show your AmeriHealth ID card, which you should carry with you at all times. If, for some reason, you cannot keep your appointment, be sure to call the office to cancel it so that your scheduled time can be used by someone else.

Also, please remember that your PCP is prepared to see only the member for whom an appointment is made. Please do not ask your doctor to see other family members as part of your appointment.
Your rights and responsibilities

AmeriHealth would like to take this opportunity to thank you for being our member. We are dedicated to keeping our members healthy and informed. We not only respect your rights, but we also encourage you to exercise your responsibilities. The following are your rights and responsibilities as an AmeriHealth HMO, POS, or PPO member:

Member rights

- You have the right to be provided with information concerning the managed care organization, its policies and procedures regarding products, its services and benefits, participating providers, grievance/appeal procedures, and other information about the organization, the care provided, and member rights and responsibilities. Written information provided to you will be readable and easily understood.

- You have the right to be treated with courtesy, consideration, respect, and recognition of your dignity and your right to privacy.

- You have the right to participate with providers in decision-making regarding your health care. This includes candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefits coverage.

- You have the right to file or voice complaints or appeals with or about the managed care organization or care provided and to receive a timely response.

- Upon exhaustion of the internal member appeal process, you may have the right to file for external review by state regulatory authorities or an independent review organization. Your external appeal rights vary and will depend on whether:
  - you are enrolled in an HMO, POS, or PPO plan;
  - your health plan is fully insured or self-insured;
  - your appeal is about a medical necessity issue or an administrative issue.

For more information, see the appeal instructions in the decision letter for your final level of internal member appeal review.

- You have the right to choose providers within the limits of the covered benefits and plan network, including the right to refuse the care of specific providers.

- You have the right to confidential treatment of medical information. You have the right to have access to your medical records in accordance with applicable federal and state laws.

- You have the right to reasonable access to medical services, including availability of care 24 hours a day, 7 days a week, for urgent or emergency conditions.

- You have the right to receive health care services without discrimination based on race, color, ethnicity, age, mental or physical disability, religion, gender, genetic information, national origin, or source of payment.

- You have the right to formulate advance directives. The plan will provide information to members and providers concerning advance directives and will support members through its medical record-keeping policies.

- You have the right to make recommendations regarding your health plan’s policy on member rights and responsibilities. To make any recommendations, please call Customer Service at 1-800-275-2583.

Member responsibilities

- You have the responsibility to communicate, to the extent possible, information that the managed care organization and participating providers in our network require in order to care for you.
• You have the responsibility to ask questions to make sure that you understand the explanations given to you regarding your health problems and to follow the plans and instructions for the care and treatment goals that you agreed on with your providers. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.

• You have the responsibility to review all benefits and membership materials carefully and to follow the regulations pertaining to your health plan.

• You have the responsibility to treat your health care providers with the same respect and courtesy you expect for yourself.

• You have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation.

Note: Magellan Behavioral Health, Inc. provides similar rights and responsibilities. Magellan manages mental health and substance abuse benefits for most members.
What to do if you have a concern about your coverage

Informal member complaint process

AmeriHealth HMO, Inc. (AmeriHealth) will make every attempt to address questions or concerns related to benefits or services. To discuss a concern or obtain the address to send a letter, call Customer Service at 1-800-275-2583. Most member concerns are resolved informally at this stage. If we cannot immediately resolve your concern, we will investigate the issue and respond to you within 30 days. If you do not wish to wait for the response, you can file a formal complaint as outlined below.

Special appeal rules apply to self-insured plans. These rules are not described here. Enrollees of self-insured plans should consult their benefits description materials for details.

Member appeals

The two types of member appeals — complaints and grievances — are classified as “preservice” or “postservice.” A preservice appeal is for services that are covered only if preapproved by AmeriHealth before medical care is obtained. A postservice appeal is for other claims when AmeriHealth preapproval is not required and medical care has already been obtained. Also, expedited review is available for appeals that involve “urgent care” — any appeal for medical care or treatment with respect to which the application of the time periods for making nonurgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot adequately be managed without the care or treatment that is the subject of the appeal.

The member appeal process for complaints and grievances consists of up to two levels of internal appeal for group plans (only one level of internal appeal for nongroup plans) and one level of external appeal. AmeriHealth completes the internal review and issues decision letters with further appeal rights within the following time frames:

- **Standard appeals:**
  - **Group plans:** from receipt of first- or second-level appeal request —
    - 15 days for preservice; 30 days for postservice
  - **Individual plans:** from receipt of first-level, appeal request —
    - 30 days for preservice; 60 days for postservice

- **Expedited appeals:** from receipt of a qualified urgent care appeal request —
  - 48 hours

Claimants with urgent care conditions or who are currently receiving ongoing treatment may file an external expedited review at the same time they file an internal expedited review by calling Customer Service at 1-800-275-2583.

AmeriHealth will provide to the member, free of charge, new or additional evidence considered, relied upon, or generated by AmeriHealth in connection with the appeal sufficiently in advance of notice of the internal adverse determination to give the member reasonable opportunity to respond.

To file a member complaint or grievance appeal, write as directed in the AmeriHealth notice or call Customer Service at 1-800-275-2583. With your valid consent, your provider or another authorized representative may appeal on your behalf.

Appeal committees

Each appeal committee consists of one or more persons designated by AmeriHealth to act as decision-maker. The decision-makers may not have participated in the
previous decision to deny coverage and are not subordinates of whomever made that determination. Each committee reviews all information for the appeal provided by the member or other sources. For grievances, the first-level decision-maker is a plan medical director who is a matched specialist or the decision-maker receives input from a consultant who is a matched specialist. A matched specialist, or “same or similar specialty physician,” is a licensed physician or psychologist who is in the same or similar specialty as typically manages the care under review.

Internal review process for member complaint appeals

A member complaint appeal focuses on an unresolved dispute or objection regarding coverage related to contract exclusions/limitations, noncovered services, cost-sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions), or the operations or management policies of AmeriHealth. First-level complaint appeals must be filed within 180 days after receipt of the notice that you dispute or completion of the informal complaint process.

A committee consisting of one AmeriHealth staff person decides first-level complaints within the applicable period. For group plans, second-level complaint appeals are to be filed within 60 days after receipt of the first-level appeal decision letter. A three-person committee consisting of two staff persons familiar with managed care and one nonemployee decides second-level complaint appeals.

Internal review process for member grievance appeals based on medical necessity decisions

A member grievance appeal focuses on an AmeriHealth decision to deny, reduce, or limit coverage that is based on an evaluation of the medical necessity or appropriateness of the coverage request. First-level member grievance appeals must be filed within 180 days after receipt of the adverse benefit determination.

A plan medical director decides the standard first-level grievances within the applicable period. For group plans, standard second-level grievance appeals are to be filed within 60 days after receipt of the related first-level decision letter. However, an expedited grievance appeal has only one level of internal review, which is to be completed within 48 hours after receipt of a qualified appeal request for urgent care. A three-person committee, consisting of a medical director and another staff person familiar with managed care and one nonemployee, decides expedited grievance appeals and standard second-level grievance appeals.

External member appeal process

After an internal appeal review is completed, the external appeal process available for complaints and grievances varies from plan to plan. To file an external complaint or grievance appeal, follow the directions stated in the AmeriHealth letter that provides notice of the decision on the final level of the internal appeal review.

If your health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following your appeal, you may have the right to bring civil action under Section 502(a) of the act. For questions about your rights, this notice, or for assistance, you can call the Employee Benefits Security Administration at 1-866-444-EBSA. In addition, if you have an insured business, a consumer assistance program may be able to assist you at:

Pennsylvania Department of Insurance
1325 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388
www.insurance.pa.gov
Effective January 1, 2012, if your plan fails to “strictly adhere” to the internal appeal process, you may initiate an external review or file appropriate legal action under state law or ERISA unless the violation:

- was *de minimis* (minimal);
- did not cause (or was not likely to cause) prejudice or harm to the claimant;
- was for good cause or due to matters beyond the control of the insurer/plan;
- was in the context of a good faith exchange of information with the claimant;
- was not part of a pattern or practice of violations.

Note: The procedures summarized here vary by plan type and may change due to changes in applicable state and federal laws, to satisfy standards of certain recognized accrediting agencies, or to improve the member appeal process. For additional information, call Customer Service at 1-800-275-2583.