Protecting your privacy and 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; it may be in oral, written, or electronic form.

The Authorization to Release Information form can be downloaded at **amerihealth.com** or requested from Customer Service at **1-800-275-2583 (TTY: 711)**

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

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.

Releasing protected health information

We do not use or share your PHI without your permission unless permitted by law. You can authorize us to share your PHI with someone you choose. You may wish to have certain individuals view or receive part or all of your PHI, if necessary. For instance, you may have an adult son or daughter to whom you turn for assistance coordinating your medical care or paying your medical expenses. We can disclose your PHI to any person or organization you choose, provided you complete an *Authorization for Disclosure of Health Information form* and return it to us for our records.

To do so, print a copy of our *Authorization for Disclosure of Health Information form* from our website at amerihealth.com. Log in and select the *Resource Center* tab, then the *Authorizations* button from the menu on the left. Or request a copy by calling Customer Service at **the number on the back of your ID card**.

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 health care provider for copies of your medical records.

To learn more about your privacy rights

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 in to amerihealth.com and selecting *Privacy Policy* at the bottom of the page. You also can call Customer Service to request a copy.

AmeriHealth

Member rights and responsibilities

AmeriHealth would like to take this opportunity to thank you for being an AmeriHealth health plan 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 member.

Commercial member rights

- You have the right to receive information about AmeriHealth, its benefits, services included or excluded from coverage, policies and procedures, participating practitioners/providers, and member rights and responsibilities. Information provided will be in a manner and format that is easily understood and readily accessible.
- You have the right to be treated with courtesy, consideration, and respect and to be recognized for your dignity and right to privacy.
- You have the right to participate with practitioners in making decisions about your health care.
- You have the right to make recommendations regarding our member rights and responsibilities policy by contacting Customer Service.
- You have the right to choose practitioners within the limits of covered benefits, availability, and participation within the AmeriHealth network.
- You have the right to confidential treatment of personally identifiable health/medical information. You also have the right to access your medical record and ask that it be amended or corrected, in accordance with applicable federal and state laws.
- You have the right to reasonable access to medical services.
- You have the right to receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, health status, genetic information, color, religion, gender, sexual orientation, national origin, source of payment, utilization of medical or mental health services or supplies, or the filing by such member of any complaint, grievance, appeal or legal action against Professional Provider, a Group Practice Provider (if applicable), or AmeriHealth.
- You have the right to formulate and have advance directives implemented.
- You have the right to obtain a current directory of participating providers in the plan's network upon request. The directory includes addresses, telephone numbers, and a listing of providers who speak languages other than English.
- You have the right to voice and file complaints or appeals about AmeriHealth or the care it provides and receive a timely response about the disposition of the appeal/complaint, and you have the right to further appeal through an independent organization for a filing fee or the applicable regulatory agency, as appropriate. A doctor cannot be penalized for filing a complaint or appeal on a member's behalf.
- For members with chronic disabilities, you have the right to obtain assistance and referrals to providers with experience in treatment of your disabilities.
- You have the right to candid discussions of appropriate or medically necessary treatment options and alternatives for your conditions, regardless of cost or benefit coverage, in terms that you understand, including an explanation of your complete medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If you are not capable of understanding this information, an explanation shall be provided to your next of kin or guardian and documented in your medical record.
- You have the right to available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week for urgent and emergent conditions.

Commercial member rights (continued)

- You have the right to call 911 in a potentially life-threatening situation without prior approval and have AmeriHealth pay per contract for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- You have the right to continue receiving services from a provider who has been terminated from the AmeriHealth network (without cause) in the timeframes defined by the applicable state requirements of your benefit plan. This does not apply if the provider is terminated for reasons that would endanger you, public health or safety, breach of contract, or fraud.
- You have the rights afforded to members 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 a language you understand.
- You have the right to be free from balance billing by providers for medically necessary services that were authorized or covered, except as permitted for copayments, coinsurance, and deductibles by contract.
- You have the right to be free from lifetime or yearly dollar limits on coverage of essential health benefits.
- You have the right to be free from unreasonable rate increases and to receive an explanation of rate increases of 15% or more before your premium is raised.
- You have the right to prompt notification of terminations or changes in benefits, services, or provider network.
- You have the right to a choice of specialists among participating providers following an authorized referral, as applicable, subject to their availability to accept new patients.
- You have the right to choose an individual On-Exchange health plan rather than the one offered by an employer and to be protected from employer retaliation.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Commercial member responsibilities

- You have the responsibility to communicate, to the extent possible, information AmeriHealth and participating providers need in order to provide care.
- You have the responsibility to follow plans and instructions for care agreed to with your practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment.
- You have the responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- You have the responsibility to review benefits and member materials carefully and to follow the policies and procedures of the health plan.
- You have the responsibility to ask questions to assure understanding of the explanations and instructions given.
- You have the responsibility to treat others with the same respect and courtesy expected for oneself.
- You have the responsibility to keep scheduled appointments or give adequate notice of delay or cancellation.
- You have the responsibility to pay deductibles, coinsurance, or copayments, as appropriate, according to the member's contract.
- You have the responsibility to pay for charges incurred that are not covered under, or authorized under, the member's benefit policy or contract.
- For point-of-service contracts, you have the responsibility to pay for charges that exceed what the plan determines as 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 benefit contract.

Physician review, utilization management, and language services

It is the policy of AmeriHealth 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 a 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 contact the Customer Service Department by telephone, by sending an email message, or by sending a fax. The Customer Service Representatives will provide assistance with understanding the utilization process or transfer you to the Utilization Management Department to discuss your concerns. Utilization Management is available Monday through Friday, 8 a.m. to 5 p.m. For urgent issues relating to utilization management after business hours, call **the number on the back of your ID card**.

Our Customer Service representatives also provide the following services at no cost for the member: multilingual staff, translation services, separate phone number for receiving TTY/TDD messages, State/711Relay Services for the deaf or hearing impaired, finding a provider that speaks your language, and information about your claims or benefit coverage. Call Customer Service at **the number on the back of your ID card.** Follow the prompts or wait to speak with a Customer Service representative.

Utilization Management is available Monday through Friday, 8 a.m. to 5 p.m. For urgent issues relating to utilization management after business hours, call **the number on the back of your ID card.**

Finding a network provider

Our *Find a Doctor* tool makes it easy to search our broad network for a doctor, hospital, or other health care provider. Log in at **amerihealth.com** to find detailed listings of doctors and hospitals — information you can use to make informed decisions about your health care.

With Find a Doctor, you can:

- **Search for a participating doctor or hospital.*** You can search by name, location, specialty, or medical procedure to find the right physicians, hospital, or treatment center. You can also access valuable information, such as the provider's gender, race, ethnicity, medical school attendance, residency completion, board certification status, hospital admitting privileges, and languages spoken at the practice.
- **Review and compare providers.** You can also review and compare the qualifications and experience of network physicians. Or research and compare hospitals based on procedure, diagnosis, and location, as well as hospital quality and safety information. You can also 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.
- **Read and post reviews.** Learn from the experience of others. If you're registered on amerihealth.com, you can also post your own ratings.
- **Compare the cost of basic procedures.** *Find a Doctor* gives you a range for most health care procedures.

Go online

Log in to amerihealth.com to use these valuable resources.

If you do not have Internet access, call Customer Service at **the number on the back of your ID card** to obtain a copy of the Provider Directory for your coverage.

*The *Find a Doctor* tool includes information on all physicians, hospitals, and ancillary providers who participate in our managed care plans.

Working and communicating with your health care providers

AmeriHealth encourages all members to routinely visit their primary care physician (PCP) and/or other health care providers. Routine visits allow providers to monitor your:

- Blood pressure and heart rate
- Weight and height
- Medications, including prescriptions, over-the-counter drugs, and herbal remedies
- Routine blood/lab work
- Lifestyle, including diet, exercise, smoking, etc.
- Preventive health needs like immunizations or screenings
- Chronic health conditions like diabetes or heart disease
- Behavioral health conditions like depression or anxiety

Communication with and between your health care providers can improve your health

You are a whole person, not a collection of heart, lungs, and brain! That's why it is so important for all your providers to work together in your care. Lack of communication between providers may lead to gaps in your care or duplication of services.

To make sure you are getting the best quality care, talk with your health care providers about all your medical conditions, health care visits and treatments, recent hospitalizations, and other providers you have seen or are currently seeing. If you see multiple providers, ask them to communicate with each other about your care and plans for your treatment. When doctors collaborate, it can reduce the number of office visits you need and improve your health care experience.

Seeing and coordinating care with a specialist

AmeriHealth encourages you to discuss specialty care with your PCP. You can also find specialty care providers using our *Find a Doctor* tool at amerihealth.com.

If you have an appointment with a specialist and your plan requires a referral, your primary care physician should have submitted a referral through the electronic submission process. You can view and print copies of your referrals through the member portal at amerihealth.com. Select *View Open Referrals* located under the *My Care* tab.

To improve communication and coordination between your PCP and specialists:

- Ask specialists to send updates to your PCP and anyone else involved with your care.
- If your provider uses computer documentation, ask if they have access to your records from other providers. Providers who are part of the same health system can often see information from other offices in the system.
- Whenever you have a test or study, ask for your results to be sent to your PCP and the specialist who ordered it. Also, ask the specialist if the test or study impacts any other care you're receiving. If the answer is yes, ask them to send the results to your other specialists.

Working and communicating with your health care providers (continued)

Seeing and coordinating care with a behavioral health care specialist

Your behavioral health is an important part of your overall health. Many people experience depression, anxiety, substance use disorder, and other mental health conditions — these conditions can develop after a traumatic event or slowly develop over time. The good news is that these conditions can be treated with medication, talk therapy, or both.

If you experience symptoms of mood, emotions, or behavior that you find disturbing, please talk with your PCP. Your PCP will discuss your symptoms with you and offer treatment options, which could include recommending a specialist for behavioral health counseling and support. (Note: A referral is not required to see a behavioral health provider.) You can find behavioral health counseling and support providers by calling **the number on the back of your ID card**.

If you receive treatment or support from a counselor or psychiatrist, it is important that they communicate together and with your PCP about your care and treatment plan so you get the best care. You may need to sign a form that allows them to release records to each other and specifies what records they can share.

Sharing your current medical information

An easy way to share important health information with your providers is to bring a printed copy of your *Well-being Profile* to appointments. If you haven't done so already, complete your *Well-being Profile* by logging in at **amerihealth.com** and selecting *Complete my Well-being Profile* under the *Health & Well-Being* tab. View and print a physician summary report by clicking on the link at the bottom of the page.

Your Personal Health Record is another way to share your health information. Select the *Personal Health Record* button under the *My Care* tab to view or print.

Current health plan and personal information

When visiting any health care provider, it is important to make sure the provider has your current member ID card information. This will help ensure that you are charged the appropriate copay. Your office visit copayment amount is located on the front of your ID card. You can also access or re-order an ID card via the member portal at **amerihealth.com**.

You should also make sure the provider has your current contact information, such as address, phone number, and email. Many providers now use text messaging for patients to confirm, cancel, and reschedule appointments. If your provider offers this service, make sure your contact information includes your cell phone number.

Standards for doctor appointments, wait times, hours, and access

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.
- For an obstetrics/gynecology routine examination, you should be able to schedule an appointment with your doctor within two months.

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 use disorder 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 immediately or be directed to your nearest emergency department.
- If the emergency is not life-threatening, you should be seen within six hours of your 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.

*Urgent care is medical attention you need right away for an unanticipated illness or injury.

†An emergency is defined as a medical cond tion manifesting itself in acute symptoms of sufficient seve ity 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.

Standards for doctor appointments, wait times, hours, and access, continued

For HMO members

- **Primary care.** AmeriHealth members choose a primary care physician (PCP) on enrollment. To select a participating PCP or change PCPs, log in at **amerihealth.com**. You can also call the Customer Service number **on the back of your ID card**.
- **Specialty care.** 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 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 any referrals that have been issued to you by logging in at amerihealth.com and selecting *View Open Referrals* from the *My Care* tab.
- **Obstetrical/gynecological care.** Members may seek care from an AmeriHealth-participating obstetrician or gynecologist without a referral for all gynecological care.

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

Hospital care procedures

If you are an **HMO member** and need outpatient services, surgery, or hospitalization, your primary care physician (PCP) will provide any referrals that your health plan requires. If your PCP refers you to a specialist who then determines that you need outpatient services, surgery, or hospitalization, the specialist will coordinate the preauthorization (approval in advance), if needed, with AmeriHealth. Preauthorization is not needed if you require emergency admission.

If you are an HMO Plus, EPO, PPO, POS, or POS+ member and need outpatient surgery or hospitalization, you may not need a referral. If you are receiving care from a participating PCP or specialist who then determines that you need outpatient services, surgery, or hospitalization, the specialist will coordinate the precertification, if needed, with AmeriHealth. PPO, POS+, and POS members utilizing out-of-network physicians and/or facilities are responsible for obtaining the precertification.

Precertification 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.

If you have questions, call Customer Service at the number **on the back of your member ID card.**

You can also learn about how and when to obtain referrals and preauthorizations at **amerihealth.com**.

Differences between emergency care 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.

If you believe you have an emergent or life-threatening condition or illness, you should always go to the ER for immediate evaluation and treatment.

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 alternative 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.

Evaluating new and emerging technologies

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 technologies 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 investigative settings. Participating professional providers with direct experience in the practice of the service help us evaluate the evidence. Their assessment helps us decide whether the service is an acceptable medical practice that should be available to members in our plans and networks.

Our Quality Management program

Our Quality Management program is focused on keeping our members healthy and happy with their health care. Our program is wide-ranging and supports other areas of our organization in supplying quality care and service to our members. We have set goals to focus on the health and experience of our members.

- Assess and improve the **safety** of health care and services our members receive
- Assess the ability of our members to access **timely** and appropriate care
- Ensure the most current and **effective** health care and services are provided to members for their medical and behavioral health conditions
- Promote **efficient** care and reduce health care waste
- Promote health **equity** by identifying and addressing the needs of our members
- Assess the satisfaction of our members and support **patient-centered** system improvements

Our activities seek to improve member safety, meet member health needs, and ensure a quality network of providers. Our program works with delegates, provider credentialing, and clinical services compliance. We also maintain organization-wide policies that make sure we meet all regulations and standards of practice.

If you want to learn more about our program, a yearly description or report on progress is available. To request this information or ask a question, call **the Customer Service number listed on the back of your member ID card.**

We want to know if you have a concern or complaint about the quality of care or service that you received from a provider. To file a concern or complaint, call **the Customer Service number listed on the back of your member ID card.**

Care transitions

Care transitions occur when you move from one health care provider or setting to another as your situation or condition changes. Examples include transitioning from pediatric to adult care, from a hospital to a nursing facility, or from one provider to another; when a covered benefit is exhausted; or when your coverage ends.

If you are preparing to transition care for yourself or a covered dependent, consider the following resources to help with the process:

- **Benefits Handbook.** Check your benefits handbook for information about transitioning care. Log in at amerihealth.com to view your benefits handbook.
- **Find a Doctor.** Use our *Find a Doctor* tool at amerihealth.com to search for participating health care providers. You can search by name, location, or specialty. You will have access to provider addresses, telephone numbers, and professional qualifications such as medical school attendance, residency completion, and board certification status.
- **Health Coach.** Health Coaches are available 24/7, year-round, and can help with health-related questions, condition management support, finding alternatives for continuing care, obtaining care, and accessing resources. To reach a Health Coach, call 1-800-275-2584 (TTY/TDD: 711).

Transitioning from pediatric to adult care

Pediatricians can treat people until the age of 21, but not all adolescents or teenagers will want to be seen by a pediatrician. Parents or guardians can help navigate this transition. If your adolescent or teenager is being seen by a pediatrician, you can ask when they want to switch to an adult primary care provider. You can also ask if they have any concerns or preferences, like if they want to see a female or male provider or how to see specialists like a gynecologist.

For more information

If you have questions about your benefits, how to find a doctor, or how to access a Health Coach, call Customer Service at **the number on the back of your member ID card.**

Prescription drug guidelines

Our prescription drug plans are administered by an independent pharmacy benefits management (PBM company that is responsible for providing a network of participating pharmacies, administering benefits, conducting prior authorization reviews, and providing customer service.

When using your prescription drug plan, it's important to know how to find out what's covered by your plan and whether there are any guidelines that apply to those drugs. Our prescription drug plans are designed to provide you with safe and affordable access to covered medications. This document will explain the prior authorization process, age and quantity limits, and a number of other ways we support the safe prescribing practice of covered medications.

Please note that this document is applicable to the *Standard Formulary, Select Drug Formulary,* and *Value Formulary*.

Formulary

The formulary is a list of drugs covered by your prescription drug plan. If you're not yet a member, you can visit **amerihealth.com/rx** to view the formulary guides or searchable tools. You can also call **1-888-671-5285** to find out if a drug is included in your plan's formulary. As a member, you can log in at **amerihealth.com** to find drugs on the formulary and view and manage your prescription drug plan. The pharmacy tools and services available will help you to better understand your prescription drug coverage so you can take full advantage of the cost-saving options available to you.

Log in at amerihealth.com:

- Review your prescription records — what you spent, and when and where your prescriptions were filled
- Locate a network retail pharmacy near you
- Review your coverage and cost-sharing information
- Price a specific drug and compare savings with a generic equivalent
- Access formulary information
- Check on drug-to-drug interactions

To see the formulary status of a drug, or to find out if the drug requires prior authorization, please refer to the formulary guide or searchable tool which can be found at **amerihealth.com/rx**. You can also call **the pharmacy benefits phone number on the back of your ID card** if you want to find out whether a drug is included in your formulary.

Prior authorization

Prior authorization means that your doctor must obtain approval from your health plan for coverage of, or payment for, your medication. AmeriHealth requires prior authorization of certain covered drugs to confirm that the drug prescribed is medically necessary, clinically appropriate, and is being prescribed according to FDA approved labeled or medically accepted use. Some examples of drugs that require prior authorization are drugs to treat conditions like hemophilia, cancer, and hepatitis C. The approval criteria were developed and approved by the Pharmacy and Therapeutics Committee, a group of doctors and pharmacists from the area.

What you need to know

- How to find out what prescription drugs are covered by your plan
- You may need additional approval from your health plan before you receive prescription drugs
- Age limits apply to some prescription drugs
- Safety edits apply to some prescription drugs
- Your doctor may request coverage for medications that are not on your prescription drug formulary
- You have a right to appeal a coverage decision you disagree with
- How we work with the PB

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by your prescribing doctor, and your available prescription drug therapy history. Their evaluation may include a review of potential drug-drug interactions or contraindications, appropriate dosing and length of therapy, and utilization of other drug therapies, if necessary.

Without prior authorization, your prescription will not be covered at the retail or mail-order pharmacy. The prior authorization process may take up to two business days once complete information from the prescribing doctor has been received. Incomplete information will result in a delayed decision.

Prior authorization and Formulary Exception are approved for up to 2 years, the expiration date will be given at the time the approval is made. If the doctor wants you to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approval in order for coverage to continue.

Age limits

Some drugs such as zafirlukast are approved by the FDA only for individuals age 5 and older. If the member's prescription falls outside of the FDA guidelines, it may not be covered until prior authorization is obtained. In addition, an age limit may be applied when certain drugs are more likely to be used in certain age groups. For example, drugs to treat Alzheimer's disease may require prior authorization for use in young adults. The provider may request coverage for drugs outside of the age limit when medically necessary. The approval criteria for this review were developed and approved by the Pharmacy and Therapeutics Committee. The member should contact the provider to initiate the prior authorization process. To determine if a covered prescription drug prescribed for you has an age limit, visit **amerihealth.com/rx** or call the **pharmacy benefitshphone number on the back of your ID card**.

Quantity limits

Quantity limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses, standard dosing, and/or length of therapy. We have several different types of quantity limits that are explained in detail below. The purpose of these limits is to ensure safe and appropriate utilization. If you require more than the limit, your doctor will need to submit a prior authorization request. Note: If applicable, quantity limits will apply if a formulary exception is approved allowing coverage of a non-formulary drug.

Quantity over time. This quantity limit is based on dosing guidelines over a rolling time period. For example, if a drug has a quantity limit over a 30-day time period and you went to the pharmacy on January 1 for one of these medications, the plan would have looked back 30 days to December 2 to see how much medication was dispensed. The purpose of these limits is to prevent the dispensing of excessive quantities. Examples of quantity limits over time are:

- Ibandronate 150 mg (generic for Boniva®) = 1 tablet per 30 days
- Naratriptan (generic for Amerge®) = nine 2.5 mg tablets per 30 days
- Sumatriptan (generic for Imitrex®) = eighteen 50 mg tablets per 30 days
- Diabetic supplies such as blood glucose test strips = 200 strips per 30 days and lancets = 200 lancets per 30 days

Maximum daily dose. This quantity limit defines the maximum number of units of the drug allowed per day. This limit is based on the maximum daily dose approved by the FDA, the formulation, and/or availability of multiple strengths of the drug where a dose can be achieved with another available strength. Examples of maximum daily dose quantity limits are:

- Zolpidem (Ambien®) = 1 tablet per day
- Oral opioid drugs, such as oxycodone/acetaminophen (generic for Percocet®) 5/325 mg = 12 tablets per day
- Guanfacine ER 24 hour = 1 tablet per day

Refill too soon. This limit is in place to encourage appropriate utilization and minimize stockpiling of prescription medications. Based on this limit, you are able to receive a refill of a prescription after 75% utilization. Additional refills will pay once 75% of the supply has been consumed. The following examples illustrate how refill-too-soon limit works:

- A 30-day supply of a prescription filled on January 1 will be refillable again on or after January 24
- A 90-day supply of a prescription filled on July 1 will be refillable again on or after September 7

Day supply limit. This limit is based on the day supply and not the quantity. However, quantity limits may apply as well. Day supply limits apply to some classes of drugs, such as opioids. If a quantity limit applies, you will be limited to the maximum daily dose for that drug. The following are examples of drugs that have a day supply and a quantity limit:

- Butalbital-containing headache agents such as butalbital/aspirin, or opioids, such as oxycodone tablets
  - Day supply limit = 5-day supply per 30 days, for adults age 18 or older
  - Quantity limit = 6 per 1 day
  - Maximum quantity allowed without prior authorization = 30 (6 per day x 5 days)
- Opioid-containing cough and cold products, such as hydrocodone/homatropine
  - Day supply limit = 5-day supply per 30 days, for adults age 18 or older
  - Quantity limit = 30 ml per 1 day
  - Maximum quantity allowed without prior authorization = 150 ml (30 ml per day x 5 days)

Morphine Milligram Equivalent limits. AmeriHealth applies additional safety measures to opioid products by limiting the total daily dose. This limit accounts for various opioid products through a measurement called the Morphine Milligram Equivalent (MME) dose. The MME is a number that is used to determine and compare the potency of opioid medications. It helps to identify when additional caution is needed. The daily limit is calculated based on the number of opioid drugs, their potencies, and the total daily usage. Prior authorization is required for an opioid dose that exceeds 90 MME per day. The MME limit applies to opioid products containing the following active ingredients: benzhydrocodone, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, tapentadol, or tramadol.

Cumulative stimulant limit

Central Nervous System (CNS) stimulants such as amphetamine and methylphenidate, when used in high doses, are associated with increased risk for cardiac-related adverse events such as hypertension and new or worsening psychosis, including manic behavior. The cumulative stimulant limit is a safety measure designed to ensure that the provider has assessed the member for alternative medication and advised the member about the risks associated with stimulant use. The cumulative stimulant limit works by calculating the total daily stimulant dose by the drug's active ingredient. Stimulant prescriptions that exceed the limit outlined below would require prior authorization.

Active ingredient	Medications impacted (brands and generics)	High cumulative daily dose
Amphetamine	Adzenys ER[ODT], Dyanavel, Evekeo [ODT]	60mg/day
Amphetamine-Dextroamphetamine	Adderall [IR/XR], Mydayis	60mg/day
Dextroamphetamine	Dexedrine, Zenzedi, ProCentra, Xelstrym	60mg/day
Lisdexamfetamine	Vyvanse	70mg/day
Methamphetamine	Desoxyn	60 mg/day
Dexmethylphenidate	Focalin [IR/XR]	40mg/day
Methylphenidate	Ritalin [IR/LA], Daytrana, Cotempla, Metadate [ER/CD], Methylin, Quillivant XR, Concerta, Aptensio XR, QuilliChew ER, Jornay PM, Adhansia XR, Relexxii	72mg/day
Serdexmethylphenidate	Azstarys	52.3mg/day

Note: Prior authorization and other safety edits including quantity limit and age limit continue to apply.

Concurrent Drug Utilization Review (cDUR). cDURs are built into the pharmacy claim adjudication system to review a member's prescription history for possible drug-related problems, including drug-drug interactions and drug therapy duplications. Drugs may be rejected at the point of sale and/or generate a message to the dispensing pharmacist when there is a safety concern. The dispensing pharmacist can review the issue with the provider and override the rejection if appropriate in most cases. Examples of cDURs are:

- **Drug-drug interaction:** Sildenafil (Viagra®/Revatio®) and nitroglycerin in combination may lead to potentially fatal hypotension.
- **Drug therapy duplication:** Simvastatin and atorvastatin in combination will trigger a message in the claim adjudication system to alert the dispensing pharmacist that there is a duplication of statin therapy.

To determine if a covered prescription drug prescribed for you has a prior authorization requirement, age limit, quantity limit, MME limit, or cumulative stimulant limit, visit **amerihealth.com/rx** or call the **pharmacy benefits phone number on the back of your member ID card.**

Requesting a prior authorization/preapproval:

- The provider prescribing the drug can access electronic prior authorization (ePA) platforms such as CoverMyMeds® and SureScripts™ to submit a prior authorization request. Alternatively, the provider can complete a prior authorization fax form or write a letter of medical necessity and submit it to the PBM by fax at 1-888-671-5285.
- The PBM will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review the document.
- A decision is made regarding the request.
- If approved, the prescribing doctor will be notified of approval via fax or telephone, and the claims system will be coded with the approval. Note: ePA approval can occur in real time, which means you can be approved for the drug prior to leaving the provider's office with a prescription.
- You can call **the Customer Service number on the back of your ID card** to determine if the prescription is approved.
- If denied, the prescribing doctor will be notified via letter, fax, or telephone.
- You are also notified of all denied requests via letter.
- The appeals process will be detailed on the denial letters sent to you and your doctor.

Coverage for medications not on the formulary (specific to Value Formulary members only)

Doctors may request formulary coverage of a non-formulary medication when there has been a trial of at least three formulary alternatives or there are contraindications to using the formulary alternatives. Your doctor should complete a non-formulary exception request form providing details to support use of the non-formulary medication and should fax the request to 1-888-671-5285. If the non-formulary request is approved, the drug will be paid at the highest applicable non-specialty cost share. Safety measures like quantity limits, age limits, and MME limits will still apply. If the request is denied, you and your doctor will receive a denial letter with the appropriate appeals language.

Appealing a decision

If a request for prior authorization/preapproval or exception results in a denial, you, or your doctor on your behalf (with your consent), may file an appeal. Both you and your doctor will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. To assist in the appeals process, it is recommended that you keep your doctor involved to provide any additional information on the basis of the appeal.

Prescription Drug Program information

The PBM administers our prescription drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. AmeriHealth may incorporate certain savings resulting from rebates into reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a member cost-share.

Opioid use and substance use disorder

Pain management can be complex. You or a covered dependent might need to manage pain due to an injury, a procedure or surgery, arthritis, or a medical condition. Discuss your pain management goals and options with your health care provider so you can decide together how best to meet your pain management needs. Depending upon your situation, your provider may recommend one or more of the following:

- Opioid pain medicines (for example, Percocet or Vicodin)
- Non-opioid pain medicines, including:
  - Nonsteroidal anti-inflammatory drugs (for example, aspirin or Aleve)
  - Anticonvulsants (for example, Neurontin)
  - Serotonin and norepinephrine reuptake inhibitors (for example, Cymbalta)
- Procedural interventions (for example, corticosteroid injections)
- Complementary medicine, like acupuncture or massage
- Exercise or physical therapy
- Behavioral support, like cognitive-behavioral therapy

Opioids are commonly prescribed, but have not been shown to improve pain more than non-opioid medicines, and can cause serious risks. Risks include sedation, addiction, and difficulty breathing that can cause an overdose death. Taking opioids with other medications or alcohol, taking higher doses, or taking opioids for longer than a few days increases these risks. Talk with your doctor or pharmacist about your pain management strategies and the medications you are taking so they can advise you about safety concerns.

Log in at **amerihealth.com** to learn more about your benefits for pain management therapies or to use our *Find a Doctor* tool to find participating providers.

Precautions you can take when using opioids

- **Opioid-reversal drugs.** Medication is available for opioid overdose rescue. Opioid-reversal drugs, such as Narcan® (generic name naloxone), block opioid effects and can reverse an overdose if administered in time. If you or someone in your home are taking opioids, talk to your doctor or pharmacist to learn more about naloxone and whether it is appropriate to have on hand. AmeriHealth offers the opioid-reversal drug at no cost and without a prescription to members who have prescription drug benefits through AmeriHealth.
- **Safely storing and disposing of drugs.** Medications can be dangerous if they are used by someone other than the person for whom they were prescribed, especially addictive medications like opioids. Do not share your prescription medications with others, even family members. Store medications safely and securely while you need them and dispose of them safely when you are no longer taking them. If you need to dispose of leftover medication, many pharmacies have safe medication take-back disposal kiosks available. Talk to your local pharmacy to learn more about available medication take-back programs.

Help is available

- **Medication-Assisted Treatment (MAT). Opioid addiction can be successfully treated.** MAT is the use of medications with counseling and behavioral therapies to treat dependence on addictive substances like opioids. MAT is the most effective treatment for substance use disorders and opioid overdose prevention. To find a participating provider in your community with a focus on MAT, log in to **amerihealth.com** and use our *Find a Doctor* tool to search for "Medication-Assisted Treatment."
- **Behavioral health specialists.** There are resources and support available to help you cope with pain, stress, addiction, or concerns about your or someone else's substance use. To find a behavioral health care provider or learn more about your mental health and substance use disorder benefits, including opioid use resources or support, call **the number on the back of your member ID card** under "Mental Health/Substance Use Disorder."

For more information

If you have questions or concerns about pain management, opioid abuse, your benefits, how to access available resources, or the quality of care you've received from a provider, call Customer Service at **the number on the back of your member ID card.**

For Pennsylvania-based employer group members only

Choose a primary dentist (HMO dental coverage only)

If you, or an eligible dependent, have dental coverage under our group HMO, you must select a Primary Dental Office (PDO) from the Plan's dental HMO network when you enroll.

The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage. You may change your PDO as often as once a month, and each covered member may select a different PDO.

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.

Using coverage when traveling

AmeriHealth HMO, POS, EPO, and PPO members have access to only 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. 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.

For information on how to submit the claim, refer to your benefits description materials or call Customer Service at **1-800-275-2583**. POS members will need to submit a claim for self-referred services received outside the AmeriHealth network. Self-referred POS claim forms are available by logging on to **amerihealth.com** and selecting *Claims* under the *Resource Center* tab.

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.

For Pennsylvania-based employer group members only

Achieve Well-being with AmeriHealth

Our personalized online tools and resources, called Achieve Well-being, help you achieve what's important to you in a way that's simple, easy, and fun.

Here's how it works:

- Complete the Well-being Profile, which provides an overall summary of your health and individual risk factors.
- Start a program.
- Develop your action plan to:
  - Get fit
  - Eat right
  - Sleep better
  - Manage stress
- Sync your devices to track your progress.
- Stay motivated with tokens and badges for achievements.
- Look for reminders, encouraging emails, and text messages.

To access your Well-being Profile, log in at **amerihealth.com/login**, select *Achieve Well-being* from the *Health & Well-being* menu, and then click on the *Well-being Profile* tab.

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 the Well-being Profile annually or as often as you wish to evaluate your progress.

Results provide an action plan for better health

Once you complete your profile, 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 score.

You will also have access to several other reports:

- **Risk report.** This report provides an in-depth look at some of your modifiable risk factors, such as diet, blood pressure, blood sugar, and emotional health.
- **Condition report.** This report shows your personal risk for cancer, heart disease, stroke, and other diseases. It will also include information on early detection and taking action.
- **Physician summary.** Have questions about your results? Print out the Physician Summary and take it to your next appointment. Your doctor can offer additional suggestions for ways to improve your health.

You can get additional support and information by contacting our Registered Nurse Health Coaches. Health Coaches are available to you 24 hours a day, 7 days a week via the Health Information Line to help you address general health questions and concerns (see **the number on the back of your ID card**). They can also work with you to help you improve your health or better manage your condition through our case management and condition management programs.*

* Case Management is available to all members. Condition Management is available at no cost to most members. Please refer to your member materials for the terms, limitations, and exclusions of your health care coverage, or call Customer Service at **the number on the back of your medical ID card** to find out if you are eligible.

Please note: The Well-being Profile is provided through New Ocean Health Solutions, a National Committee for Quality Assurance (NCQA) accredited vendor. Information may be disseminated to New Ocean vendors for the purpose of assisting in your care. Please see consent form at the beginning of the Well-being Profile for more information.

For consumer and New Jersey-based employer group members only

Embrace Well-being with AmeriHealth

Our personalized online tools and resources, called Embrace Well-being, help you achieve what's important to you in a way that's simple, easy, and fun.

Here's how it works:

- Complete the Well-being Profile, which provides an overall summary of your health and individual risk factors.
- Start a program.
- Develop your action plan to:
  - Get fit
  - Eat right
  - Sleep better
  - Manage stress
- Sync your devices to track your progress.
- Stay motivated with tokens and badges for achievements.
- Look for reminders, encouraging emails, and text messages.

To access your Well-being Profile, log in at **amerihealth.com/login**, select *Embrace Well-being* from the *Health & Well-being* menu, and then click on the *Well-being Profile* tab.

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 the Well-being Profile annually or as often as you wish to evaluate your progress.

Results provide an action plan for better health

Once you complete your profile, 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 score.

You will also have access to several other reports:

- **Risk report.** This report provides an in-depth look at some of your modifiable risk factors, such as diet, blood pressure, blood sugar, and emotional health.
- **Condition report.** This report shows your personal risk for cancer, heart disease, stroke, and other diseases. It will also include information on early detection and taking action.
- **Physician summary.** Have questions about your results? Print out the Physician Summary and take it to your next appointment. Your doctor can offer additional suggestions for ways to improve your health.

You can get additional support and information by contacting our Registered Nurse Health Coaches. Health Coaches are available to you 24 hours a day, 7 days a week via the Health Information Line to help you address general health questions and concerns (see **the number on the back of your ID card**). They can also work with you to help you improve your health or better manage your condition through our case management and condition management programs.*

* Case Management is available to all members. Condition Management is available at no cost to most members. Please refer to your member materials for the terms, limitations, and exclusions of your health care coverage, or call Customer Service at **the number on the back of your medical ID card** to find out if you are eligible.

Please note: The Well-being Profile is provided through New Ocean Health Solutions, a National Committee for Quality Assurance (NCQA) accredited vendor. Information may be disseminated to New Ocean vendors for the purpose of assisting in your care. Please see consent form at the beginning of the Well-being Profile for more information.

24/7 Support from a Registered Nurse, Behavioral Health Clinician, or Health Information Line

When you have a question about health concerns such as medications or scheduling visits with doctors or specialists, need assistance with making health decisions, or want help keeping information straight, AmeriHealth has Health Coaches and Behavioral Health Case Managers who can help.

Health Coaches and Behavioral Health Case Managers are registered nurses, licensed social workers, and licensed professional counselors who are available to you 24 hours a day, 7 days a week, to help you with your health needs and questions. From information on chronic conditions to coordinating care, to your emotional wellness, a Health Coach or Behavioral Health Case Manager is there to support you with your comprehensive health care needs.

Call **the number on the back of your ID card** to speak with a Health Coach or Behavioral Health Case Manager. Translation services are available through CyraCom. There is no additional cost to you for speaking with a Health Coach or a Behavioral Health Clinician.

Support for condition management, case management, behavioral health, maternity, and general health concerns

Living with a chronic condition, managing a complex health situation, or coordinating care after a hospital stay can be overwhelming, but you don't have to do it alone. That's when an AmeriHealth Registered Nurse Health Coach or Behavioral Health Case Manager who are specialized Registered Nurses and Licensed Social Workers can help. Access to Health Coaches and Behavioral Health Case Managers are available to you at no additional cost 24 hours a day, 7 days a week, 365 days a year by calling **the number on the back of your ID card**.

Health Coaches and Behavioral Health Case Managers also have access to health information that helps them identify members who are eligible for and may benefit from one of our programs. These members may receive a phone call offering support for their condition. Health Coaches and Case Managers may also refer members to an AmeriHealth Social Worker for assistance with community resources.

Condition Management Program

Our condition management program* provides health coaching and educational resources to support members coping with chronic conditions such as asthma, diabetes, hypertension, and upper gastrointestinal disease, as well as members facing treatment decisions. Our program is designed to encourage members to engage in shared decision-making with their physicians. The focus is on education for prevention of flare-ups and complications, with the goal of improving overall health and quality of life.

Case Management Program

Case management is a free, confidential program offered to all our members who are in need of more intensive support and/or coordination of care. Health Coaches, Behavioral Health Case Managers, and Social Workers pair their occupational expertise with knowledge of benefits to offer you support and guidance in dealing with complex health concerns.

For either condition management or case management, our health care professionals can help you to:

- Understand your condition and current health status
- Learn skills to help you stay as healthy as possible
- Learn about your medications
- Transition between the hospital and home
- Cope with the emotional impact of your illness or condition

Behavioral Health Case Management Program

Available to all members at no additional cost, Behavioral Health Case Management provides you with extra support for your emotional well-being needs. Behavioral Health Case Managers specialize in a variety of areas including mental health and substance use . The goal of Behavioral Health Case Management is to help you set goals and connect you with resources to support your comprehensive healthcare needs so that you can feel good about your emotional health and well-being.

You may access Behavioral Health Case Management services 24/7 by calling **the number on the back of your ID card** under Mental Health/Substance Abuse.

Support for condition management, case management, behavioral health, maternity, and general health concerns, (continued)

Maternity Program

Health Coaches also support pregnant members through our free Baby FootSteps® maternity program, which offers:

- Telephonic support from an experienced Registered Nurse Health Coach
- Prenatal resources and information that guide expectant mothers through each stage of pregnancy
- Monthly emails or texts with helpful tips and information about pregnancy and delivery for members who are enrolled for digital messaging

***Note:** Condition management is available to most members. Please call Customer Service at **the number on the back of your ID card** to find out if you are eligible.

General Health

Additionally, 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 phone 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 (in accordance with your health plan benefits)
- Review your plan and goals and communicate with your doctor, as necessary

Speaking with a Health Coach or Behavioral Health Case Manager is voluntary. You can talk to them just once or establish a relationship and set up follow-up calls — whatever works best for you. To contact a Health Coach or Case Manager, call the number on the back of your ID card. When prompted, state the information requested and then say "Health Coach" to be connected with the next available Health Coach or Case Manager. Translation services are available through CyraCom. There is no additional cost to you for speaking with a Health Coach or Case Manager.

You have the right to opt-in or opt-out of these services at any time by simply advising your Health Coach or Case Manager of your wishes. You may also call **the number on the back of your ID card** and request that you not be contacted by a Health Coach or Case Manager in the future.

For Pennsylvania-based employer group members only

Discounts and savings for members

As an AmeriHealth member, you can take advantage of savings and discount programs for local, regional, and national businesses and attractions.*

Discounts on entertainment and events

AmeriHealth Insider^{SM} offers great deals on family-themed activities like movie and theater tickets, sporting events, museums, zoos, and travel. You can also save on online shopping and merchant gift certificates.

Discounted gym membership

The GlobalFit Gym Network 360 provides membership discounts to 8,000 gyms, fitness centers, and studios nationwide. You can also take advantage of discounts on virtual fitness classes, home exercise equipment, and healthy eating programs. Plus, you and your family will get free access to a library of fitness and nutrition resources, training spotlight videos, and GlobalFit's health and wellness blog.

Free nutrition counseling

Schedule up to six visits a year with a participating registered dietitian, your doctor, or another network provider — at no cost to you.[†]

Check out all of the exciting member perks at amerihealth.com/discounts.

* These are value-added programs and services. They are not benefi s under the health care plans that you purchased and are, therefore, subject to change without notice.

† Not all members have nutrition counseling visits as part of their benefi s plans. Please contact Customer Service or your benefi s administrator to determine if this benefit app ies to your coverage.

Accessing benefit and claims information online

As a member of an AmeriHealth health plan, you have access to our secure, password-protected, self-service member website. Log in at amerihealth.com.

One of the many features of this member website on amerihealth.com is the ability to view personalized information about the benefits and services included in, and excluded from, your coverage. To do so, select the *Benefits* tab, then *My Benefits Overview*. Select the *Summary of Benefit & Coverage* link to understand your share of charges for which you may be responsible.

You can also view personalized information about the status of medical and pharmacy claims submitted for services provided for you by any provider in the network. To do so, select the *Claims & Spending* tab, then *My Claims Overview*. Here you will be able to view the status of a claim, the date it was paid, and any amount that you are responsible for paying.

If you have questions 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.**

Learn more about your benefits

As an AmeriHealth member, you may have questions about your coverage and benefits. Our article database can provide answers. You can find the database at **amerihealth.com/healtharticles**.

Reaching multilingual Customer Service

If you or a member you know needs language assistance, call Customer Service at **1-800-275-2583 (TTY: 711).** Follow the prompts or wait to speak with a Customer Service representative.

AmeriHealth has multilingual staff, telephone language-line services, and TTY/TDD 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.

Submitting a claim

When you use an in-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 member who self-refers to providers, you may be required to submit a claim form for services received. Here's what to do:

AmeriHealth POS and POS+ members

You are required to submit a claim only for self-referred services. Use the POS claim form available when you log in at **amerihealth.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 when you log in at **amerihealth.com**.

Step-by-step instructions

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

*Additional claim forms are available by calling Customer Service at **the number on the back of your ID card.**

For consumer and New Jersey-based employer group members only

Making an appeal or complaint

Informal member complaint process

AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively, 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 **the number on the back of your member ID card.** 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 calendar days. If you do not wish to wait for the response, you can file an internal appeal as outlined below. To initiate an internal appeal, you or your designee may call or write as directed in the original denial letter or call Customer Service. You or your designee may also mail or fax a written appeal to:

AmeriHealth Appeals Unit
259 Prospect Plains Road, Building M
Cranbury, NJ 08512
Fax: 609-622-2480

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.

Making an appeal or complaint (continued)

Member appeals

There are two types of member appeals — medical necessity (utilization management) appeals and administrative appeals — and they are further classified as "pre-service" or "post-service." A pre-service appeal is for services that are covered if pre-approved by AmeriHealth before medical care is obtained. A post-service appeal is for services where AmeriHealth preapproval is not required. Expedited review is also available for appeals that involve "urgent/emergent care" — any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent 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 consists of up to two levels of internal appeal for members with group coverage and only one level of internal appeal for members with individual coverage. Both group and individual coverage have one level of external review. The following time frames apply for AmeriHealth to complete internal appeals and issue decision letters containing further appeal rights:

- Standard appeals: Medical Necessity
  - From receipt of a Stage 1 internal appeal request: ten (10) calendar days for pre-service or post-service appeals
  - From receipt of a Stage 2 internal appeal request: fifteen (15) calendar days for a pre-service request and twenty (20) business days for a post-service request.
  - From receipt of a non-formulary exception request: seventy-two (72 hours)
- Standard appeals: Administrative Appeals. From receipt of first- or second-level internal appeal request: fifteen (15) calendar days for pre-service appeals; thirty (30) calendar days for post-service appeals
- Expedited appeals:
  - From receipt of a qualified urgent care appeal request: seventy-two (72) hours.
  - From receipt of a non-formulary expedited request: twenty-four (24) hours.

Members with urgent/emergent care conditions or who are currently receiving ongoing treatment may file an expedited external review at the same time they file an expedited internal appeal by calling Customer Service **at the number on the back of your member ID card.**

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

Making an appeal or complaint (continued)

Appeal panels Each appeal panel consists of one or more persons designated by AmeriHealth to act as a decision maker/makers. The decision maker/makers may not have participated in the previous decision to deny coverage and are not subordinates to whomever made a prior determination.

Each committee reviews all information provided by the member or other sources for the internal appeal. For expedited and second-level internal appeals, the member or an authorized representative may make a brief presentation to the panel.

Internal appeal process for member appeals based on medical necessity decisions. A member medical necessity 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.

Stage 1 member internal appeals must be filed within one hundred and eighty (180) calendar days after receipt of the initial adverse benefits determination. The stage 1 decision maker is a plan medical director who is a same or similar specialist, or the decision maker receives input from a consultant who is a same or similar specialist. A same or similar specialist is a licensed physician or psychologist who is in the same or similar specialty as typically manages the care under review.

Standard Stage 2* internal appeals must be filed within one hundred and eighty (180) calendar days after receipt of the related Stage 1 determination. The Stage 2 internal appeal will be reviewed by a panel including a physician and/or other applicable health care professionals selected by AmeriHealth. If requested by you or your designee, AmeriHealth will arrange for a consultant practitioner — a same or similar specialist with no prior involvement in the case — to be available to participate in the review. AmeriHealth will notify you of the meeting date, meeting procedures, and your rights at the hearing. You or your designee has the right to present information about your appeal before the panel. You also have the right to ask AmeriHealth to have a staff member who has no prior involvement with the case represent you.

Internal appeal process for administrative appeals. A member administrative appeal focuses on an unresolved dispute or objection regarding coverage, including participating or nonparticipating health care provider status, coverage related to contract exclusions/limitations, noncovered services, cost-sharing requirements, certain surprise medical bills received by a member from an out of network provider, rescission of coverage (except for failure to pay premiums or coverage contributions), and/or the operations or management policies of AmeriHealth.

First-level internal appeals must be filed within one hundred and eighty (180) calendar days after the initial adverse benefits determination. The Level 1 Administrative Appeals Committee is staffed by a single decision maker who is a plan employee familiar with AmeriHealth managed care operations and benefits, who has had no previous involvement in the decision at issue and is not a subordinate of such individuals.

Second-level internal appeals* must be filed within sixty (60) calendar days after receipt of the first-level internal appeal decision letter. The second-level administrative appeal will be reviewed by a three-person committee of AmeriHealth personnel. The committee will schedule and convene a meeting within the time frames previously outlined. AmeriHealth will notify you of the meeting date, meeting procedures, and your rights at the hearing. You or your designee has the right to present information about your appeal to the panel. You also have the right to ask AmeriHealth to have a staff member who is not involved with the case represent you. The second-level determination is final. External review is not available for administrative issues, with the exception of certain surprise medical bills received by the member from an out-of-network provider, or recissions of coverage (unless the recission is due to non-payment of premiums or coverage contributions).

Making an appeal or complaint (continued)

External review process for Medical Necessity Issues

For plans subject to New Jersey state-mandated requirements, the Covered Person or authorized representative may initiate the External Review within four (4) months of receipt of the Stage 1 determination for individual plans and Stage 2 determinations for group plans to Maximus. If Maximus accepts the External Review, it will issue a decision within forty-five (45) calendar days of receiving all necessary documentation to complete the standard review or within forty-eight (48) hours for an Expedited Appeal.
For non-formulary exceptions, Maximus makes a decision on a standard case within seventy-two (72) hours for a standard request and within twenty-four (24) hours of receipt of an expedited request.

A decision reached by Maximus is binding on the Carrier. A Covered Person or authorized representative may appeal directly to Maximus if the Carrier waives its right to an Internal Appeal or fails to meet the timeframes for completing Stage 1 or Stage 2 of the Internal Appeals process.

To request a Standard or Expedited External Review, the Covered Person or the Provider should electronically file the request to **https://njihcap.maximus.com** or mail it to the following address:

Maximus Federal-NJ IHCAP
3750 Monroe Avenue, 705
Pittsford, New York 14534
Fax: 585-425- 5296

Questions about the application process can be directed to Maximus Federal by calling **888-866-6205** or **emailing stateappealseast@maximus.com**.

External Appeals for issues pertaining to certain surprise medical bills received by a Covered Person from an out-of-network Provider or for recissions of coverage (except for failure to pay premiums or contributions) Based on federal requirements, Covered Persons or the Covered Person's designee may request an external administrative review for issues pertaining to certain surprise medical bills received by the Covered Person from an out-of-network Provider, and/or rescissions of coverage (except for failure to pay premiums or coverage contributions), that have not been resolved by the Carrier, via the Federal Independent Review Organization (IRO) Process. All requests for external review must be made by the Covered Person or the Covered Person's designee within four (4) months of receipt of the final internal administrative appeal decision. The IRO makes its decision within forty-five (45) calendar days of receipt of the request for a standard appeal type.
To file an appeal of the final internal appeal determination, call, write, or fax a request to:

AmeriHealth Appeals Unit
259 Prospect Plains Road, Building. M
Cranbury, NJ 08512
Phone: 1-877-585-5731 prompt #2
Fax: 609-662-2480

Making an appeal or complaint (continued)

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 and this notice, or for assistance, you can call the Employee Benefits Security Administration at **1-866-444-EBSA**. In addition, a consumer assistance program may be able to assist you at:

New Jersey Department of Banking and Insurance Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329
1-800-446-7467 | 1-888-393-1062 (appeals)
state.nj.us/dobi/consumer.htm
ombudsman@dobi.state.nj.us

You may also submit complaints online using the New Jersey Department of Banking and Insurance's online complaint form at state.nj.us/dobi.

If your health 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 **the number on the back of your member ID card.**

*Members with group coverage have two stages/levels of internal appeal, while members with individual coverage have one stage/level of internal appeal. Both have a member external review process.

For Pennsylvania-based employer group members only

Making an appeal or complaint

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 Plan address to send a letter, call Customer Service at the number on the back of your ID card. Most covered person 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 calendar days. If you do not wish to wait for the response, you may file a formal appeal as outlined below.

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

Covered person appeals

The two types of covered person appeals — administrative and medical necessity — are classified as "pre-service" or "post-service." A pre-service appeal is for services that are covered only if precertified by the Plan before medical care is obtained. A post-service appeal is for claims when medical care has already been rendered. Also, an expedited appeal process is available for appeals that involve "urgent/emergent care" — any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or that would, in the opinion of a physician with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot adequately be managed without the care or treatment that is the subject of the appeal.

The covered person appeal process consists of up to two levels of internal appeal for covered persons with group coverage and only one level of internal appeal for covered persons with individual coverage. Both group and individual coverage have one level of external review for reasons of medical necessity or rescission of coverage (except for non-payment of premiums). The Plan completes the internal review and issues decision letters stating any further appeal rights within the following time frames:

- Standard appeals:
  - Group plans: From receipt of first- or second-level appeal request — 15 calendar days for pre-service; 30 calendar days for post-service
  - Individual plans: From receipt of first-level administrative appeal request or second-level administrative appeal — 15 calendar days for each level for pre-service; 30 calendar days for each level for post-service. For medical necessity, there is only one level of internal appeal, for which there are 30 calendar days for a pre-service appeal and 60 calendar days for post-service appeals.
- Expedited appeals:
  From receipt of a qualified urgent/emergent care appeal request — 72 hours.
  For non-formulary appeals, a decision will be twenty-four (24) hours from the receipt.

Covered Persons or their authorized representatives with urgent/emergent 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 **the number on the back of your ID card.**

To file a covered person appeal on an administrative or medical necessity issue, write as directed in the Plan notice or call Customer Service at **the number on the back of your ID card.** With your valid consent, your provider or another authorized representative may appeal on your behalf.

Making an appeal or complaint (continued)

Appeal committees

Each appeal committee consists of one or more persons designated to act as decision-makers. The decision-makers have not participated in the previous decision to deny coverage, and they are not subordinates of whoever made that determination.
Each committee reviews all information provided by the covered person or other sources. For first-level medical necessity appeals, the decision-maker is a plan medical director in the same or similar specialty as the subject of the appeal or who has received a review from an external consultant same or similar specialty reviewer who is a licensed physician or psychologist who typically manages the care under review.

Internal appeal process for covered person administrative appeals

A covered person administrative appeal focuses on an unresolved dispute or objection regarding coverage, including participating or nonparticipating health care provider status, coverage related to contract exclusions/limitations, noncovered services, cost-sharing requirements, rescission of coverage (except for failure to pay premiums or coverage contributions), certain surprise medical bills received by a covered person from an out of network provider, and/or the operations or management policies of AmeriHealth.

First-level internal appeals must be filed within 180 calendar days after the initial adverse benefits determination. The Level 1 Administrative Appeals Committee is staffed by a single decision-maker, familiar with managed care operations, who is a member of the plans' management, or a designee who has had no previous involvement in the decision at issue and is not a subordinate of such individuals.

Second-level internal appeals are to be filed within 60 calendar days after receipt of the first-level internal appeal decision letter. The second-level administrative appeal will be reviewed by a three-person committee of AmeriHealth management personnel.

The committee will schedule and convene a meeting within the time frames previously outlined. AmeriHealth will notify you of the meeting date, meeting procedures, and your rights at the hearing. You or your authorized representative has the right to present to the panel information about your appeal. You also have the right to ask AmeriHealth to have a staff member who is not involved with the case represent you. Second-level determination is final. External review is not available for administrative issues, except for rescission of coverage (except for failure to pay premiums or coverage contributions) and certain surprise medical bills received by a covered person from an out-of-network provider.

Internal appeal process for a covered person medical necessity appeals

Level 1 medical necessity internal appeal must be filed within 180 calendar days after receipt of the initial adverse benefits determination. The Level 1 decision-maker is a plan medical director who is a matched specialist, or the decision-maker receives input from a consultant who is a same or similar specialist. A "same or similar specialist" is a licensed physician or psychologist who is in the same or similar specialty and typically manages the care under review.

Standard Level 2 internal appeals must be filed within sixty (60) calendar days after receipt of the related Level 1 determination. The Level 2 internal appeal will be reviewed by a three-person panel of physicians and/or other health care professionals selected by AmeriHealth.

If requested by you or your authorized representative, AmeriHealth can arrange for a consultant practitioner – a same or similar specialist with no prior involvement in the case — to be available to participate in the review. AmeriHealth will notify you of the meeting date, meeting procedures, and your rights at the hearing. You or your authorized representative has the right to present information about your appeal before the panel. You also have the right to ask AmeriHealth to have a staff member who is not involved in the case represent you.

Making an appeal or complaint (continued)

External covered person review process

After an internal appeal is completed, the external review is available for any final internal adverse benefits determination that involves medical necessity review. To file an external review, follow the directions stated in the AmeriHealth letter that provides notice of the decision on the final level of the internal appeal review.

If you are not satisfied with the outcome of the Level 2 internal appeal, the covered person or authorized representative may initiate an external appeal with the Pennsylvania Insurance Department (PID).

For most health plans, external review is conducted by an independent utilization review organization (IURO) consistent with processes mandated by Pennsylvania state laws.

For plans subject to Pennsylvania-mandated requirements, the covered person or authorized representative may initiate the external review within four months of receipt of the final internal adverse benefit determination to the PID with a filing fee. Please note that the fee may be waived upon determination of financial hardship. If the IURO accepts the appeal, it will issue a decision within 45 calendar days of receiving all necessary documentation to complete the external review. A covered person or authorized representative may appeal direction to the IURO if AmeriHealth waives its right to conduct an internal appeal or fails to meet the time frames for completing Level 1 or Level 2 of the internal appeals process. The external review decision is binding on AmeriHealth and the covered person.

To request an external review, follow the instructions on the decision letter for the AmeriHealth Level 2 appeal.

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 and this notice, or for assistance, you can call the Employee Benefits Security Administration at **1-866-444-ESBA**. In addition, a consumer assistance program may be able to assist you at:

Pennsylvania Department of Insurance
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
FAX: 717-787-8585
insurance.pa.gov