AmeriHealth POS

AmeriHealth

Continuity of Care for Referred Care

Terminated Providers

AmeriHealth HMO, Inc. offers members continuation of an ongoing course of treatment with a terminated provider (for reasons other than cause) for up to 90 days from the date that AmeriHealth notified the member of the provider termination. AmeriHealth will cover such continuing treatment under the same terms and conditions as if the treatment was being received from participating providers.

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

All authorized health care services provided during this transitional period shall be covered by AmeriHealth under the same terms and conditions applicable for participating health care providers.

New APOS Members

New APOS members may continue an ongoing course of treatment with a non-participating health care provider for a transitional period of up to 90 days from the effective date of enrollment into the plan subject to the requirements set forth herein and in the applicable group master contract.

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

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

In order to initiate continuity of care, members must complete a Continuity of Care form and submit it to AmeriHealth's Care Management and Coordination department. The form will be in the enrollment materials and available through Member Services.

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

Utilization Review

To assist AmeriHealth in making coverage determinations regarding the medical necessity and appropriateness of requested services, AmeriHealth uses medical guidelines based on clinically credible evidence. This is called utilization review. Utilization review can be done before a service is performed (precertification/ preservice); during a hospital stay (concurrent review) or after services have been performed (retrospective/ post service review). AmeriHealth follows applicable state/federal standards pertaining to how and when these reviews are performed.

Inpatient Hospital Stays

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

Emergency Services

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

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

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

In the event of an emergency, the member should go to the nearest appropriate medical facility. The Primary Care Physician should be contacted as soon as reasonably possible in the event of any emergency occurring either within AmeriHealth's service area or outside of the service area.

Complaints and Grievances

You have a right to appeal any adverse decision through the Complaint and Grievance Process. Instructions for the appeal will be described in the denial notifications and in the Member Handbook.

This summary represents only a partial listing of benefits and exclusions of the AmeriHealth program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all your health care expenses. Read your HMO group contract/member handbook and self-referred group health benefits booklet/certificate carefully to determine which health care services are covered. If you need more information, please call 866-681-7372.

www.amerihealth.com

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