

Benefits That Require Pre-Authorization

Referred Care

Your primary care physician or provider contacts the Patient Care Management team and provides information to support the request for services. The Patient Care Management (PCM) team, made up of physicians and nurses, evaluates the proposed plan of care for payment of benefits. The PCM team notifies the physician/provider whether services are approved for coverage. If the PCM team does not have sufficient information or the information evaluated does not support coverage, the physician/provider and member are notified verbally and in writing of the decision. Members, providers or other individuals acting on behalf of the member, with the member's consent, may appeal the decision. At any time during the evaluation process or the appeal, the provider or member or designee may provide additional information to support the request.

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

- All Non-Emergency Hospital Admissions (excluding Maternity)
- All Same Day Surgery/Short Procedure Unit Admissions
- Outpatient Therapies: Physical, Occupational, Speech, Cardiac, Pulmonary, Respiratory, Home Infusion
- Other Facility Services: Skilled Nursing, Home Health, Hospice, Birthing Center
- Rental/Purchase of Durable Medical Equipment and Prosthesis (purchase over \$100.00 and all rentals)
- Non-Emergency Ambulance Services
- Spinal Manipulation Services
- Inpatient Psychiatric Care
- Inpatient Alcohol and Substance Abuse Treatment
- Some Medications That Have Specific Uses and are Administered in Outpatient Settings or Physician Offices

Members are not responsible for payment of services if the provider does not obtain preauthorization of services.

Self-Referred Care

When an APOS member seeks self-referred benefits the member is required to pre-authorize the following:

- All Non-Emergency Hospital Admissions (excluding Maternity)
- Private Duty Nursing
- Rental/Purchase of Durable Medical Equipment and prosthesis (purchase over \$1,500)

To maximize your benefits, you must remember to pre-authorize these services. If you do not pre-authorize these services, you will be responsible for higher out-of-pocket costs. You may obtain pre-authorization for self-referred services by calling 1-800-227-3116. You will be asked to provide the patient's name, identification number, physician's name, facility name, diagnosis and procedure or indication for services. If you are seeing an out-of-network OB/GYN for maternity care, please contact AmeriHealth's Patient Care Management Team to notify them of your upcoming admission. A penalty will not be applied if you fail to notify Patient Care Management.

Inpatient Hospital Stays

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

Continuity of Care

Terminated Providers

AmeriHealth offers members continuation of an ongoing course of treatment with a terminated provider (for reasons other than for cause) from the date that AmeriHealth notified the member of the provider termination in the following situations:

- For up to 4 months, if services by your provider are medically necessary.
- In cases of pregnancy, and this is your OB/GYN, you may continue receiving treatment from the provider for up to six (6) weeks after your delivery.
- Medically necessary postoperative care may continue with your provider for a period not to exceed six (6) months.
- Medically necessary oncological and psychiatric treatment may continue with your provider for a period not to exceed one (1) year.

All authorized health care services provided during this period of continuation 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 can contact our Members Services department.

New Point-of-Service (POS) Members

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

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

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

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

Emergency Services

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

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

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

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

Emergency Services (Continued)

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.

A Word About Confidentiality

Protection of Privacy in All Settings

We are taking steps to see that the personal Identifiable health information of our members is kept confidential and to prevent the unauthorized release of, or access to, this data. All AmeriHealth employees are asked to sign confidentiality statements annually.

Access to Medical Records

Upon a member's written request, we will provide the member with a summary of any of his or her personally identifiable health information maintained by us. At any time, any member may request that we modify, correct, change or update his or her personally identifiable health information that we maintain by contacting us by postal mail, e-mail, or telephone.

Inclusion in Routine Authorization

It may be necessary for us to maintain and release a member's records, claims-related information, or health related information to third parties for purposes of treatment, payment or healthcare operations. By enrolling with us, each member gives his or her authorization to us to maintain and release the member's records to see that health care is provided to the member or is paid for, to perform our contractual obligations to the member or to assist us in doing so, or to fulfill a legal mandate. If a member is unable to provide such authorization, AmeriHealth will obtain authorization, when necessary from the individual with appropriate legal authority to make decisions on behalf of the member.

Right to Approve Release of Information

In certain circumstances, where required by law to release unique member health information, AmeriHealth HMO will first ask for your consent before releasing the information. There could be other circumstances, however, such as a subpoena issued by a court or regulatory agency where your consent is not required before AmeriHealth HMO would release such information. If you give consent for us to release the information, the member has the right - at any time - to revoke your consent (except to the extent we relied on the consent while it was in effect).

Use of Measurement Data

At times we may utilize membership data to develop or enhance our health benefits. Patient identity will be kept anonymous wherever possible.

Appeals

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