Notice of Privacy Practices

AmeriHealth New Jersey is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures. al records. You should contact your doctor or other health care provider for copies of your medical records.

The Notice of Privacy Practices describes how AmeriHealth New Jersey may use and disclose a member's personal health information and how a member of an AmeriHealth New Jersey health plan can get access to this information. For details on our practices, available privacy forms, and HIPAA requirements, please visit **amerihealthnj.com/privacy**. You can also call to request a copy of the Notice of Privacy Practices by contacting Customer Service at the number on the back of your ID card.

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Maintaining your privacy

Gramm-Leach-Bliley Notice of Privacy Practices

At AmeriHealth New Jersey, we value you as a member, and the protection of your personal information is very important to us. To effectively administer the array of health plans offered to our members, AmeriHealth New Jersey may collect and share "nonpublic personal information" about you in accordance with applicable laws and regulations. This notice is provided as required by the Gramm-Leach-Bliley Act, a federal law, and applicable state regulations. This notice informs you how we collect, share, and protect your personal information.

Nonpublic personal information

What AmeriHealth New Jersey collects

AmeriHealth New Jersey collects nonpublic personal information about you when you apply for health care coverage with AmeriHealth New Jersey or when AmeriHealth New Jersey administers your benefits. For example, AmeriHealth New Jersey may collect personal information such as your name, address, phone number, cell phone number, Social Security number, and account information, which may not otherwise be publicly available.

AmeriHealth New Jersey receives this information from:

- You, your employer, or benefits plan sponsor on applications and other forms
- Your transactions with AmeriHealth New Jersey, our affiliates, or others
- Consumer reporting agencies
- Electronic sources when you access our website, including data that is obtained with an information-collection device known as a "cookie"

What AmeriHealth New Jersey discloses and to whom

AmeriHealth New Jersey does not disclose nonpublic personal information about our members or former members to anyone, except as otherwise permitted by law. For example, AmeriHealth New Jersey may disclose nonpublic personal information to affiliates and nonaffiliated third parties to perform services on our behalf or as necessary for everyday business purposes, such as to process your transactions, maintain your account, respond to court orders, or report to credit bureaus.

Our security procedures

AmeriHealth New Jersey restricts access to nonpublic personal information about you to individuals or entities involved in providing services to you. AmeriHealth New Jersey maintains safeguards to protect nonpublic personal information from unauthorized access and use.

Please call **1-888-YOUR-AH1 (1-888-968-7241, TTY: 711)** or go to **amerihealthnj.com/privacy** if you have any questions about this notice.

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AmeriHealth NEW JERSEY

Protecting your privacy and health information

At AmeriHealth New Jersey, 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 — PHI is individually identifiable information about you; it may be in oral, written or electronic form.

We may obtain or create your PHI as part of our business, which is to provide 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.

To learn more

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 at **amerihealthnj.com** and selecting Privacy Policy at the bottom of the page or by going to **amerihealthnj.com/privacy**. You can also call Customer Service to request a copy.

Releasing protected health information

We do not use or share your PHI without your permission unless permitted by law. You may wish to have certain individuals view or receive part or all of your PHI. For instance, you may have an adult son or daughter to whom you turn for assistance with coordinating your medical care or paying your medical expenses. You can authorize us to share your PHI with any person or organization you choose by completing an *Authorization for Disclosure of Health Information* form and returning it to us for our records. The form is available on our website at **amerihealthnj.com/privacy**. Select the *HIPAA Privacy Practices and Forms* link, and then click on *Authorization Form*. You may also request us to send this form to you by calling Customer Service at **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)**.

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 New Jersey by contacting Customer Service. Please remember that we typically do not have copies of your medical records. You should contact your doctor or other health care provider for copies of your medical records.

AmeriHealth New Jersey is an Equal Opportunity Employer (EOE). Qualified applicants are considered for employment without regard to age, race, color, religion, sex, national origin, sexual orientation, disability, or veteran status.

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AmeriHealth NEW JERSEY

Member rights and responsibilities

AmeriHealth New Jersey would like to take this opportunity to thank you for being an AmeriHealth New Jersey 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 New Jersey member:

Member rights

- You have the right to receive information about your health plan, its benefits, services included or excluded from your coverage, policies and procedures, participating practitioners/providers, and member rights and responsibilities. Written and Web-based information will be readable and easily understood.
- You have the right to obtain upon request a current directory of participating practitioners in the AmeriHealth New Jersey network. The directory includes addresses, telephone numbers, and a listing of providers who accept members who speak languages other than English.
- You have the right to file a complaint or appeal about your health plan or care provided with AmeriHealth New Jersey or the Department of Banking and Insurance. You also have the right to receive an answer to those complaints within a reasonable period of time and to be notified of the disposition of an appeal or complaint and further appeal, as appropriate.
- You have the right to appeal a decision to deny or limit coverage, first within AmeriHealth New Jersey and then through an independent organization, for a filing fee. You also have the right to know that your doctor cannot be penalized for filing a complaint or appeal on your behalf.
- You have the right to choose practitioners within the limits of covered benefits, availability, and participation within the plan network. You have the right to refuse care from specific practitioners.
- You have the right to have a choice of specialists among participating network providers following an authorized referral, subject to their availability to accept new patients.
- For members with chronic disabilities, you have the right to obtain assistance from and referrals to providers who are experienced in treating your disabilities.
- You have the right to participate with providers in decision making regarding your health care.
- You have the right to candid discussions of appropriate or medically necessary treatment options for your condition, regardless of cost or benefits coverage, in terms that you understand — including an explanation of your medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If you are unable to easily understand this information, you have the right to have an explanation provided to your next of kin or guardian and documented in your medical record. AmeriHealth New Jersey does not direct practitioners to restrict information about treatment options.
- You have the right to be treated with courtesy and consideration and with respect and recognition of your dignity and right to privacy.
- You have the right to the confidential treatment of your personally identifiable health information and to have access to your medical records in accordance with applicable federal and state laws.
- You have the right to have available and accessible services when medically necessary, including availability of care 24 hours a day, 7 days a week, for urgent and emergency conditions.
- You have the right to call 911 in a potentially life-threatening situation without prior approval from AmeriHealth New Jersey and the right to have AmeriHealth New Jersey pay for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.

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Member rights and responsibilities (continued)

- You have the right to continue receiving services from a provider who has been terminated from the AmeriHealth New Jersey network (without cause) for up to four months if medically necessary. If you are pregnant, coverage extends to the postpartum evaluation, up to six weeks after delivery. If you are receiving postoperative care, coverage extends for up to six months, if medically necessary. If you are receiving oncological or psychiatric care, treatment will be extended for up to one year, if medically necessary. This continuation of care does not apply if the provider is terminated for reasons that would endanger you, endanger public health or safety, or constitute a breach of contract or fraud.
- 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 other unlawful basis including, without limitation, the filing by such member of any complaint, grievance, appeal or legal action against a Professional Provider, a Group Practice Provider (if applicable), or AmeriHealth New Jersey.
- You have the right to formulate an advance directive and to have the directive implemented. The Plan will provide information concerning advance directives to members and participating providers.
- You have rights afforded to you by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- You have the right to be free from balance billing by providers for medically necessary services that are authorized or covered by AmeriHealth New Jersey, except as permitted for copayments, coinsurance, and deductibles by contract.
- You have the right to prompt notification of terminations or changes in benefits, services, or provider network.
- You have the right to make recommendations regarding the AmeriHealth New Jersey Member Rights and Responsibilities Policy by contacting Customer Service in writing.

Commercial Member responsibilities

- You have the responsibility to review all benefits and membership materials carefully and to follow the regulations pertaining to your health plan.
- You have the responsibility to communicate, to the extent possible, information that AmeriHealth New Jersey and participating practitioners and providers need in order to provide care.
- You have the responsibility to understand your health care problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- You have the responsibility to follow plans and instructions for care that you and your practitioners have agreed upon, including the consideration of the possible consequences of failure to comply with recommended treatment.
- 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 you expect for yourself.
- You have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation.
- You have the responsibility to pay deductibles, coinsurance, or copayments, as appropriate, according to your contract.
- You have the responsibility to pay for charges incurred that are not covered under or authorized under your benefits policy or contract.
- You have the responsibility to pay for charges that exceed what AmeriHealth New Jersey determines are customary and reasonable (usual and customary or usual, customary, and reasonable, as appropriate) for services that are covered under the out-of-network component of your contract with respect to point-of-service contracts.

Note: Magellan Healthcare, Inc. provides similar rights and responsibilities. Magellan manages mental health and substance use disorder benefits for most members.

* When used in specific statements of rights and responsibilities, AmeriHealth New Jersey has adopted the definition of "provider" used by the New Jersey Department of Health and Human Services in regulations at N.J.A.C. 8:38-1.2 and 8:38A-1.2, as follows: "Provider" means any physician or other health care professional, hospital, facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

Understanding mastectomy-related benefits

If you had a mastectomy or expect to have one, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). WHCRA is a federal law that requires group health plans and a health insurance issuer providing health insurance coverage in connection with a group health plan to cover breast reconstruction after a mastectomy. If you are receiving mastectomy-related benefits, you'll have coverage — provided in a manner determined in consultation between you and your attending physician — for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits are subject to the same deductibles, coinsurance, and/or copayments applicable to other medical and surgical benefits provided under your group health plan.

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Physician review, utilization management, and language line services

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

Only physicians can make denials of coverage of health care services and supplies based on 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 Customer Service by telephone, email message, or fax. Our Customer Service representatives will provide assistance with understanding the utilization process or transfer you to the Utilization Management Department to address 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 **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)**.

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Finding a network provider

Our *Find a Doctor* tool offers a wealth of information about network providers. Log in at **amerihealthnj.com** to find detailed listings of doctors and hospitals — information you can use to make informed decisions about your healthcare. The following tools can help you locate network providers and hospitals that will suit your health needs:

With the *Find a Doctor* tool, you can:

- **Search for a participating doctor or hospital.*** Search by name, location, specialty, or medical procedure to find the right physicians, hospital, or treatment center. The listings for each provider include valuable information, such as the provider's gender, 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 experiences of others members. When you log in at **amerihealthnj.com** to use the *Find a Doctor* tool, you can also post your own ratings.
- **Compare the cost of basic procedures.** The *Find a Doctor* tool gives you a range for nearly 150 health care procedures.

Go online

Log in at **amerihealthnj.com** to use this valuable resource. If you do not have Internet access, call Customer Service at **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)** to obtain a copy of the Provider Directory for your coverage (HMO, POS, or PPO/EPO).

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

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Estimate cost of care

Estimate costs before you go to the doctor

With the Care Cost Estimator* tool, you can estimate your out-of-pocket costs before you schedule a doctor's appointment or medical procedure. All estimates are based on your specific health plan. Knowing your share of medical costs in advance can help you plan your budget for treatment.

The Care Cost Estimator helps you find the lowest estimated price of services when comparing doctors in your network. Compare costs for office visits, surgeries, tests, vaccines, and more.

Try the Care Cost Estimator today! Here's how you can access it:

- Log in at **amerihealthnj.com**.
- Click on the *My Care* tab.
- Select *Estimate Cost of Care*.

You can also use it with the AHNJ On the Go mobile app for Apple iOS and Android devices.

Please note: The estimated costs are not a guarantee of your liability. Payment of claims and member liability are based on the terms of your health benefit plan, eligibility at the time the services are provided, copayments and coinsurance, and the actual services submitted for payment by your provider.

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How to plan for your doctor visit

Make your next trip to the doctor as quick and smooth as possible with these helpful tips:

- **Check to make sure you have your current plan ID card with you** before leaving for your appointment.
- **Ask if you can pay your copayment when you arrive for your appointment.** Your office visit copayment amount is located on the front of your ID card. Using some of your waiting room time for the business part of your visit lets you move on to the rest of your day as soon as you are finished seeing the doctor.
- **Keep your medical records current.** If your address, phone number, or ID number has changed since your last visit, be sure to tell the doctor's office staff.
- **Bring a list of all prescription medications, over-the-counter medications, and herbal remedies that you are taking** to identify any possible drug interactions. Also take the names of doctors currently treating you and details about any recent hospitalizations. This will help the doctor know how to treat you and coordinate your care.

For HMO members

If you have an appointment with a specialist, your primary care physician should have submitted a referral through the electronic submission process. If you want a hard copy of the referral, you can view and print copies by logging in at **amerihealthnj.com**. Select *View Open Referrals* located under the *My Care* tab.

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AmeriHealth NEW JERSEY

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

When you need medical care, seeing a doctor should be fast and easy. AmeriHealth New Jersey 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, 7 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 within one hour of the crisis call or be directed to your nearest emergency room.
- In a situation that is not life-threatening, you should be seen within six hours of the crisis call.
- For an urgent situation, you should be offered an appointment within 48 hours.
- For a routine visit, you should be offered an appointment within 10 business days.

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

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

† An emergency is defined as a medical condition manifesting itself in acute symptoms of sufficient severity that the absence of immediate medical attention could result in serious medical consequences or place one's health in serious jeopardy. If you are experiencing symptoms that might reasonably indicate such a condition (such as severe chest pain or a broken arm), you may need emergency care and should go immediately to the emergency department of the closest hospital. Health concerns of a pregnant woman may also extend to her unborn child. If you believe your situation is an emergency, you should call 911.

Please note that "emergency services" are covered benefits in accordance with your contract. Your benefits description materials contain a complete and more detailed definition of "emergency" with which you should become familiar. It is this definition that determines whether your condition, injury, or illness will be covered as an emergency service.

‡Magellan Healthcare, Inc. manages mental health and substance use disorder benefits for most members.

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

For HMO members

- **Primary care.** AmeriHealth New Jersey members choose a primary care physician (PCP) on enrollment. To select a participating PCP or change PCPs, log in at **amerihealthnj.com** or use the AHNJ On the Go mobile app. You can also call the Customer Service numbers on the back of your card.

- **Specialty care.** To have specialist visits covered, you must request a referral from your PCP. This helps avoid unnecessary or duplicate tests. Your PCP will submit an electronic referral to the specialist indicating the services authorized. Your referral is valid for 90 days from the issue date as long as you are an AmeriHealth New Jersey 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. You can view and print copies of referrals issued to you by logging in at **amerihealthnj.com**.

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

For PPO, EPO, POS+, and HMO+ members

AmeriHealth New Jersey PPO, EPO, POS+, and HMO+ members do not need referrals for most specialty care services.

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Working with your primary care physician and health care providers to maintain your health

AmeriHealth New Jersey encourages all members to routinely visit their primary care physician (PCP) and/or other health care providers. Routine visits allow for monitoring of your health, including, but not limited to:

- Blood pressure and heart rate
- Body Mass Index (BMI) – a measurement comparing your weight and height that assesses if you are normal weight, underweight, overweight, or obese
- Review of medications
- Routine blood/lab work
- Nutrition
- Immunizations
- Preventive health screenings
- Chronic health conditions like diabetes or heart disease
- Assessment for depression, anxiety, or other behavioral health conditions

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

Also, please remember that your PCP/health care provider is prepared to see only the member for whom an appointment is made. Please do not ask your doctor to see other family members as part of your appointment.

Seeing a specialist

AmeriHealth New Jersey encourages you to discuss specialty care with your PCP. You can also find specialty care providers in our *Find a Doctor* tool when you log in at **amerihealthnj.com**.

For HMO/POS/Select EPO members

A PCP is required for members enrolled in HMO, POS, and Select EPO plans. To schedule an appointment with your PCP, call the PCP's office and identify yourself as an AmeriHealth New Jersey member who has selected the office as your PCP. Whenever possible, contact the office in advance of the day you want the appointment. If you are injured or have an urgent medical problem that cannot wait, be sure to contact your PCP, who will advise you about what to do.

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Hospital care procedures

If you are an HMO member and need outpatient surgery or hospitalization, your primary care physician (PCP) will provide any referrals that your AmeriHealth New Jersey 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 precertification (approval in advance), if needed, with AmeriHealth New Jersey.

If you are an HMO Plus, EPO, PPO, or POS+ member and need outpatient surgery or hospitalization, you do 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 New Jersey. PPO 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.

For more information, refer to your benefits information or call **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)**.

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

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Differences between emergency and urgent care

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

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

If you believe that 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), 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.

An urgent care center 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.

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 PCP. He or she knows you and your medical history and can best assess your condition. Based on your symptoms, your PCP may send you to a hospital emergency room. Your PCP may also arrange to see you for an evaluation and treatment in the office or suggest another option.

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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.

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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 technology for medical and behavioral health conditions. In accordance with accepted principles of technology assessment, we routinely evaluate the available evidence based on the following criteria:

- **The technology must have final approval from the appropriate government regulatory bodies.**
  This applies when organizations like the U.S. Food and Drug Administration (FDA) regulate the lawful use of a product. It is important to remember that the evidence required for FDA approval varies depending on the type of product being reviewed.
- **The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.**
  The evidence should consist of well-designed and well-conducted investigations. These studies should be published in peer-reviewed journals. The quality and the consistency of the results are considered crucial in evaluating the evidence. There should be evidence that the technology positively affects health outcomes. "Health outcomes" refers to the measurable physiologic responses of a medical nature.
- **The technology must improve the net health outcome.**
  That means that the advantages outweigh the disadvantages. The technology must be as beneficial as any established alternatives. The technology should improve the net health outcome as much as, or more than, established alternatives. Direct comparison of the technology with established standard treatments for the medical condition provides the best evidence.
- **The improvement must be attainable outside investigative settings.**
  Participating professional providers with direct experience in the practice of the service help us evaluate the evidence. Their assessment helps us decide if the service is an acceptable medical practice that should be available to members in our plans and networks.

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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 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 for our members based on their medical and behavioral health care needs
- Promote **efficient** care and reduce health care waste
- Promote health **equity** by identifying and addressing the needs of our members
- Assess and improve 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 **Member Services 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 **Member Services number listed on the back of your member ID card.**

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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 **amerihealthnj.com** to view your benefits handbook.
- **Find a Doctor.** Use our *Find a Doctor* tool at **amerihealthnj.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 **1-888-YOUR-AH1 (1-888-968-7241) (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.**

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Communication between your health care providers can improve your health

You are a whole person, not a collection of heart, lung, and brain! That's why it is so important for all your doctors to cooperate in your care.

Poor communication between doctors may lead to gaps in your care or duplication of services. To make sure you are getting the best quality care, talk with your doctors and other health care providers about all your health care visits and treatments. If you see multiple doctors, 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 healthcare experience.

You can help open the lines of communication!

Between primary and specialty care

Here are some suggestions to improve communication between your primary doctor and specialists:

1. Ask your specialist to send updates to your primary care doctor and anyone else involved with your care.
2. If your doctor uses computer documentation, ask them if they also have access to your records from other doctors. Doctors that are part of the same health system can often see information from other offices in the system.
3. Whenever you have a test or study, ask for your results to be sent to your primary care physician as well as the specialist that ordered it. Also, ask the specialist if the test or study impacts any of your other care. If the answer is yes, ask them to send the results to your other specialists.

Between medical and behavioral or mental health care

Your mental health is an important part of your health as a whole person. Many people experience depression, anxiety, substance use disorder, and other mental health conditions. These may 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 doctor. He/she will discuss your symptoms and offer treatment options, which could include referral* to a specialist for behavioral health counseling and support.

If you receive treatment or support from a counselor or psychiatrist, it is important that they communicate together and with your primary doctor about your care and treatment plan so that you can get the best care.

Ask your primary care doctor and your behavioral health providers to communicate. You may need to sign a form allowing them to release records to each other and specifying what records they can share. When your medical and behavioral health providers work together, they can:

- Review medications to reduce potential interactions or side effects
- Make sure you receive required testing to monitor medication effects
- Discuss how your medical and behavioral health symptoms are affecting your health
- Work together to develop a coordinated plan for your care

*Note: You do not need a referral for behavioral health. You can also find behavioral health counseling and support by calling **the number on the back of your ID card.**

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Prescription drug guidelines

Our prescription drug plans are administered by FutureScripts®, a pharmacy benefits management 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.

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
- Quantity limits 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 FutureScripts

Formulary

The formulary is a list of drugs covered by your prescription drug plan. If you're not yet a member, you can visit **amerihealthnj.com/rx** to view the formulary guides or searchable tools. You can also call **1-888-678-7012** to find out if a drug is included in your plan's formulary. As a member, you can register for member access on **amerihealthnj.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 amerihealthnj.com to:

- 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 **amerihealthnj.com/rx**. You can also call FutureScripts at the number on **the back of your ID card** if you want to find out whether a drug is included in your formulary.

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

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Prior Authorization

Prior authorization means that your doctor must obtain approval from your health plan for coverage of, or payment for, your medication. AmeriHealth New Jersey 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.

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 ages 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 **amerihealthnj.com/rx** or call FutureScripts at **the 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 level limits that are explained in detail on the next page. 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.

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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 computer system 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 the 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 narcotics. 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 tablets per 1 day
  - Maximum quantity allowed without prior authorization = 30 tablets (6 tablets per day for 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 (MME) limits. AmeriHealth New Jersey 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, and tramadol.

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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	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	72mg/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 **amerihealthnj.com/rx** or call FutureScripts® at **the phone number on the back of your member ID card.**

96-hour Temporary Supply Program

A one-time 96-hour Temporary Supply Program is available for certain drugs that require prior authorization or for certain non-formulary drugs.

If your doctor writes a prescription for a drug that requires prior authorization, and prior authorization/preapproval has not been obtained by the doctor, the following steps will occur:

1. The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to you with either no out-of-pocket copay or the appropriate percentage cost-sharing as defined by your benefit.
2. By the next business day, FutureScripts will contact your doctor to request that he or she submit the necessary documentation of medical necessity or medical appropriateness for review.
3. Once the completed medical documentation is received by FutureScripts, the review will be completed and the medication will be approved or denied.
4. If approved, the remainder of the prescription order will be filled and the appropriate prescription drug out-of-pocket cost-sharing will be applied.
5. If denied, notification will be sent to you and your doctor.

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Obtaining a 96-hour temporary supply does not guarantee that the prior authorization/preapproval request will be approved. This program limits a one-time release of 96-hour supply per drug. Some medications are not eligible for the 96-hour temporary supply program due to packaging or other limitations, such as Retin-A® (tube).

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 FutureScripts® by fax at **1-888-671-5285.** The forms are available online at **futurescripts.com/prior-authorization1**. The form must be completed and submitted by your doctor.

- FutureScripts 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.
- You may call **the Customer Service phone number on 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 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 provider payment information
FutureScripts administers our prescription drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. FutureScripts 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 New Jersey 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.

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Opioid use and abuse

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 **amerihealthnj.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 is taking opioids, talk to your doctor or pharmacist to learn more about naloxone and whether it is appropriate to have on hand. AmeriHealth New Jersey offers the opioid-reversal drug at no cost and without a prescription to members who have prescription drug benefits through AmeriHealth New Jersey.
- **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 **amerihealthnj.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.**

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Using coverage when traveling

AmeriHealth New Jersey HMO, POS, and PPO/EPO members have access to only emergency and urgent care services when traveling outside the AmeriHealth New Jersey service area. Always be sure to travel with your AmeriHealth New Jersey 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 **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).**

HMO and POS members do not require a referral for treatment from their primary care physician (PCP); however, all members should notify their PCP or personal physician 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, such as severe ear pain, that requires treatment prior to your return to the AmeriHealth New Jersey service area. For information about benefits restrictions that apply to services obtained outside the service area, call Customer Service at **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).**

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 **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)** within 48 hours of receiving the care or as soon as reasonably possible, as determined by AmeriHealth New Jersey. If the services received outside of the service area are determined not to require urgent care, you will be responsible for the cost of the services.

Member responsibilities

It is the member's responsibility to forward to AmeriHealth New Jersey 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 New Jersey or, if applicable, to Magellan Healthcare, Inc.* Be sure to include your full name, address, and your member ID number that 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 **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).** POS members will need to submit a claim for self-referred services received outside the AmeriHealth New Jersey network. Self-referred POS claim forms are available by logging in at **amerihealthnj.com**, clicking the down arrow next to your name at the top, and selecting *Resource Center*.

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

*Magellan manages mental health and substance use disorder benefits for most members.

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Embrace Well-being

Embrace Well-being is our holistic wellness program featuring incentives, discounts, and a variety of member resources that can help you on your journey to well-being in a way that's fun and rewarding. Every AmeriHealth New Jersey plan features access to Embrace Well-being. As a member, you'll benefit from incentives and tools to help you get well and resources to help you stay well. They are designed to help you stay motivated on your well-being journey.

Log in to **amerihealthnj.com**, complete your Well-being Profile, and get started!

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Improving health with your Well-being Profile

Are you looking for ways to improve your health but aren't sure where to begin? Our interactive online Well-being Profile can help. The profile:

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

To access your Well-being Profile, log in at **amerihealthnj.com** and select *Health & Well-being* at the top of the page. Then select *Complete my Well-being Profile*.

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.

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

Note: The Embrace Well-being program is available to most members. Please call **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)** to find out if you are eligible.

To learn more

Discover how our Embrace Well-being program can help you reach your Well-being Profile goals. Embrace Well-being provides incentives to encourage you to make healthy changes. Information is available at **amerihealthnj.com** or by calling **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).**

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AmeriHealth NEW JERSEY

Reaching a Registered Nurse Health Coach with our 24/7 Health Information Line

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

Health Coaches are registered nurses who are available to you via our Health Information Line 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, your Health Coach is there to help you meet your health goals.

Call **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)** to speak with a Health Coach. When prompted, state the information requested and then say "health coach" as your call reason.

Translation services are available through the CyraCom. There is no additional cost to you for using the Health Information Line.

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AmeriHealth NEW JERSEY

Registered Nurse Health Coaches give support for condition management, case management, maternity, and general health concerns

Living with a chronic condition or coordinating care after a hospital stay can be overwhelming, but you don't have to do it alone. AmeriHealth New Jersey provides members with access to Health Coaches — registered nurses who are available to help you manage your care and make informed health decisions — at no additional cost. Health Coaches are available 24 hours a day, 7 days a week, 365 days a year by calling **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).**

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 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 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 program, a Health Coach 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

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

- Telephonic support from an experienced Registered Nurse Health Coach, which may include periodic health assessments over the phone
- 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 that are enrolled for digital messaging

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
- Review your plan and goals and communicate with your doctor as necessary

Speaking with a Health Coach is voluntary. You can talk to a Health Coach just once or establish a relationship and set up follow-up calls — whatever works best for you.

To contact a Health Coach, call **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)**. When prompted, state the information requested, and then say "Health Coach" for your call reason. Translation services are available through CyraCom. There is no additional cost to you for speaking with a Health Coach. You have the right to opt-in or opt-out of health coach services at any time by simply advising your health coach of your wishes. You may also call **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711)** and request that you not be contacted by a health coach in the future.*

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

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AmeriHealth NEW JERSEY

Improve your well-being with Embrace Well-being

Embrace Well-being is our holistic wellness program featuring incentives, discounts, and a variety of member resources that can help you on your journey to well-being in a way that's fun and rewarding.

Every AmeriHealth New Jersey plan features access to Embrace Well-being. As a member, you'll benefit from incentives and tools to help you get well and resources to help you stay well.

Embrace Well-being: Online tools
Our online wellness tools are available to all members. They are designed to help you stay motivated on your well-being journey. Earn tokens and badges for every small step you take to reach your well-being goals. It's simple! Log in to **amerihealthnj.com**, complete your Well-being Profile and get started!

Embrace Well-being: Discounts
Shop smarter, healthier and get active. All AmeriHealth New Jersey members over the age of 18 have access to these discount programs by logging in to **amerihealthnj.com**.

- **Discounted gym memberships,** fitness wearables, education programs, at home fitness equipment and so much more are available through GlobalFit's Gym Network 360.
- **Access to a variety of workouts** ranging from cycling and yoga to bootcamps and personal training through GlobalFit Anywhere.
- **Livewellamerihealthnj.com:** score deals on everything from cleaning supplies to nutritious foods or find your new favorite healthy recipe — check in with Live Well regularly for updated coupons, articles, and recipes.
- **AmeriHealth Insider:** save up to 60% on tickets, travel, and shopping for a wide range of businesses, from local to national attractions and events.

Embrace Well-being: Programs and resources
As an AmeriHealth New Jersey member you have access to a variety of innovative support programs: helping you get the care you need, when you need it.

- **Condition and Case Management** programs provide 24/7 support from our Registered Nurse Health Coaches for members managing chronic conditions or a complex health situation, such as asthma, diabetes, hypertension, cancer or stroke, and many more.[1]
- **Health Coaching** is available 24/7 from our Registered Nurse Health Coaches and offers extra support to help you navigate your health journey.
- **Baby FootSteps®** provides prenatal resources and information. Sign up for Baby FootSteps by calling 1-800-598-BABY.
- **On To Better Health** can help you better manage life's daily pressures and balance your physical and emotional well-being through online access to self-help tools and resources proven to help people get better and feel better.

Log in to **amerihealthnj.com** for more information on our Embrace Well-being program!

[1] 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.

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AmeriHealth NEW JERSEY

Accessing benefit and claims information online

As an AmeriHealth New Jersey member, you can use our secure, password-protected, self-service member website, when you log in at **amerihealthnj.com**. One of the many features available 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.

Logging in at **amerihealthnj.com**, 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* tab, then *My Claims Overview*. Here you will be able to view the status of the claim, the date it was paid, and any amount that you are responsible to pay.

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

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Reaching multilingual Customer Service

If you or a member you know has difficulty communicating because of an inability to speak or understand English and needs language assistance, call Customer Service at **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).** Follow the prompts or wait to speak with a Customer Service representative.

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

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AmeriHealth NEW JERSEY

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 New Jersey POS member who self-refers to providers or an AmeriHealth New Jersey PPO member using an out-of-network provider, you may be required to submit a claim form for services received. Here's what to do:

AmeriHealth New Jersey POS*and POS+ members
You are only required to submit a claim for self-referred services. Use the POS claim form available when you log in at **amerihealthnj.com**.†

AmeriHealth New Jersey 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 **amerihealthnj.com**.†

Step-by-step instructions
Claim submission instructions are located on the back of the AmeriHealth New Jersey POS and PPO claim forms. Remember to always keep a copy of the completed claim form and the itemized bills for your records.

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

†Additional claim forms are available by calling Customer Service at **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).**

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Making an appeal or complaint

Informal member complaint process

AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively, AmeriHealth New Jersey) will make every attempt to address questions or concerns related to benefits or services. To discuss a concern or obtain the address to send a letter, call Customer Service at **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).** 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 NJ 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.

Member appeals

There are two types of member appeals — medical necessity (utilization management) appeals and administrative appeals — and they are further classified as "preservice" or "postservice." A preservice appeal is for services that are covered if preapproved by AmeriHealth New Jersey before medical care is obtained. A postservice appeal is for claims where AmeriHealth New Jersey preapproval is not required and medical care has already been obtained. Expedited review is also available for appeals that involve "urgent care" — any appeal for medical care or treatment with respect to which the application of the time periods for making nonurgent determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot adequately be managed without the care or treatment that is the subject of the appeal. The member appeal process 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; however, external review is not available for administrative issues.

The following time frames apply for AmeriHealth New Jersey to complete internal appeals and issue decision letters containing further appeal rights:

- **Standard appeals: Medical Necessity**
  - From receipt of first-level internal appeal request: 10 calendar days for preservice or postservice appeals
  - From receipt of second-level internal appeal request: 20 business days for preservice or postservice appeals
- **Standard appeals: Administrative Appeals.** From receipt of first- or second-level internal appeal request: 15 calendar days for preservice appeals; 30 calendar days for postservice appeals
- **Expedited appeals:** From receipt of a qualified urgent care appeal request: 72 hours

Members with urgent 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 **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).**

AmeriHealth New Jersey will provide the member, free of charge, with new or additional evidence considered, relied upon, or generated by AmeriHealth New Jersey 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.

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Appeal panels

Each appeal panel consists of one or more persons designated by AmeriHealth New Jersey to act as decision-maker. The decision-makers may not have participated in the previous decision to deny coverage and are not subordinates to whomever made that 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 New Jersey 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 180 calendar days after receipt of the initial adverse benefits determination. The stage 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 matched specialist. A matched specialist, or "same or similar specialty physician," is a licensed physician or psychologist who is in the same or similar specialty as typically manages the care under review.

Standard Stage 2* internal appeals must be filed within 180 calendar days after receipt of the related Stage 1 determination. The Stage 2 internal appeal will be reviewed by a three-person panel of physicians and/or other health care professionals selected by AmeriHealth New Jersey. If requested by you or your designee, AmeriHealth New Jersey will arrange for a consultant practitioner — a matched specialist with no prior involvement in the case — to be available to participate in the review. AmeriHealth New Jersey 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 New Jersey to have a staff member who is not involved 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, rescission of coverage (except for failure to pay premiums or coverage contributions), and/or the operations or management policies of AmeriHealth New Jersey.

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 who is a member of the plan's senior 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 New Jersey management personnel. The committee will schedule and convene a meeting within the time frames previously outlined. AmeriHealth New Jersey 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 New Jersey 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.

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External 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 New Jersey letter that provides notice of the decision on the final level of the internal appeal review.

If not satisfied with the outcome of the Stage 2 internal appeal, the member or member designee may initiate an external appeal with the New Jersey Department of Banking and Insurance (DOBI). For most health plans, external review is conducted by an independent utilization review organization (IURO) consistent with processes mandated by New Jersey state laws.

For plans subject to New Jersey state-mandated requirements, the member or member designee may initiate the external review within four months of receipt of the final internal adverse benefit determination to the DOBI 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 days of receiving all necessary documentation to complete the external review. A member or member designee may appeal directly to the IURO if AmeriHealth New Jersey waives its right to conduct an internal appeal or fails to meet the time frames for completing Stage 1 or Stage 2 of the internal appeal process. The external review decision is binding on AmeriHealth New Jersey and the member.

To request an external review, follow the instructions in the decision letter for the AmeriHealth New Jersey Stage 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-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
P.O. 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 DOBI'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 **1-888-YOUR-AH1 (1-888-968-7241) (TTY: 711).**

*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.

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