

UTILIZATION MANAGEMENT PROGRAM

AmeriHealth Administrators has been authorized by your group health plan sponsor to provide medical management and medical necessity review services for your self-funded group health plan.

AmeriHealth Administrators' utilization management program uses evidence-based, decision support criteria to help ensure plan members receive medically appropriate care for their conditions.* The goal is to help improve the quality and cost effectiveness of a plan member's care.

Utilization review decisions are based on the medical necessity of the health care services and the benefits available under your health plan. Medical directors, nurses, contracted physicians, and other professional consultants perform the reviews. Medical directors and nurses receive salaries. External, contracted physicians and other professional consultants are paid per-case-reviewed, regardless of the decision. AmeriHealth Administrators does not reward or provide financial incentives for issuing coverage denials or decisions that result in under-utilization.

If you have questions about this process or a determination you received, please call our Customer Experience team at the service number on your ID card (TTY: 711). The Customer Experience team can help you understand the process or direct your question to the Clinical Services team for further information.

You can speak with a Medical Management Representative from 8:30 a.m. to 5 p.m. ET (or 8 a.m. to 5 p.m. CT), Monday through Friday, excluding public holidays. If you have an urgent issue, you can leave a message 24/7/365 and an on-call nurse will call you back.

*Care is recommended based on covered services under your health plan. Your plan may not cover all care, even if it is considered medically appropriate.



REACHING MULTILINGUAL AND TTY PLAN MEMBER SERVICES

AmeriHealth Administrators has been authorized by your group health plan sponsor to provide medical management and medical necessity review services for your self-funded group health plan.

If you or a plan member you know has difficulty speaking or understanding English and needs language assistance, call the Customer Experience team at the service number on your ID card (for hearing impaired – TTY: 711). Follow the prompts to speak with a Customer Experience representative. Telephone language-line services and TTY/TDD services for the deaf or hearing impaired are available.

Customer Experience representatives can answer questions or provide information about your claims or benefits coverage. They can also assist you in finding a network health care provider who speaks your preferred language.

If you are calling from Minnesota, Customer Experience representatives are available by phone Monday through Thursday 8 a.m. to 6 p.m. CT, and Friday 9 a.m. to 6 p.m. CT.

For all other plan members, Customer Experience representatives are available by phone Monday through Friday, from 8 a.m. to 8 p.m. CT.



This article may not be reproduced in any way without the express written permission of AmeriHealth Administrators.

GET HELP MANAGING A SERIOUS OR COMPLEX MEDICAL CONDITION

AmeriHealth Administrators has been authorized by your group health plan sponsor to provide medical management and medical necessity review services for your self-funded group health plan.

Case management program

Our case management program offers friendly staff and attentive nurses who may be able to help support you during a time of need. Our case managers can help you get the most out of your health care coverage by helping to coordinate your care based on your coverage, network access, and your doctor's recommendations.

A plan tailored to your needs

You may be eligible for a case manager at no cost to you. You can contact a case manager to see if you're eligible or you may be contacted if you demonstrate a need based on precertification, your claims, or a referral from your health care provider.

Once you're enrolled, a case manager will consult with you or your caregiver and doctor to help develop an evidence-based, tailored plan of care to meet your needs. The case manager will review this plan with you and your doctors throughout your time in the program.

Your plan of care may include services such as:

- Assistance and personal support for you and your caregiver
- Monitoring inpatient care and helping to set up necessary covered medical services
- Identifying resources for covered services
- Determining alternative care options
- Helping you obtain necessary covered equipment and services

Getting started is easy

To see if you're eligible for case management services or to learn more about the program, please contact our Clinical Services department at the number on your ID card, TTY/TDD: 711.

You have the right to opt-in or opt-out of case management services at any time by simply advising your case manager of your wishes. You may also call and request that you not be contacted by a case manager in the future.



This article may not be reproduced in any way without the express written permission of AmeriHealth Administrators.

MAKING AN APPEAL OR COMPLAINT

AmeriHealth Administrators has been authorized by your group health plan sponsor to provide medical management and medical necessity review services for your self-funded group health plan.

Informal plan member complaint process

Your health plan's claims administrator will make every effort to address questions or concerns about benefits or services. To discuss a concern or to obtain the plan address to send a letter, call the Customer Experience Department at the service number on your ID card.

Most concerns or complaints can be resolved during the Customer Experience inquiry process. If the Customer Experience team cannot resolve your concern, or if you are dissatisfied with the resolution, you may file a formal appeal as described below.

At any time during the process, you can ask for access to, or copies of, all relevant documents and records, including any additional information the decisionmakers received and reviewed. There is no charge for this information.

Plan member appeals

If you disagree with a decision about your claim or about a request to pre-certify treatment or a hospital stay, you can appeal the decision.

If you want information on how to appeal a decision, call the service number on your ID card.

A representative will tell you the suggested types of documentation to include if you appeal a decision.

We may change these appeal processes from time to time to comply with state or federal regulations, or to meet accreditation standards, or to improve the appeal processes.

To submit an appeal and the supporting documentation:

- Fax to 215-761-0956; or
- Write to the following address:
 - If you have an AmeriHealth Administrators ID card:
AmeriHealth Administrators, P.O. Box 21545, Eagan, MN 55121
 - If you have a BlueLink TPA ID card:
BlueLink TPA, c/o Processing Center, P.O. Box 21974, Eagan, MN 55121



There are two types of appeals: administrative appeals and medical necessity appeals.

Administrative appeals

Administrative appeals focus on resolving disputes or objections regarding decisions about coverage terms such as exclusions, services, or items your group health plan does not cover; exhausted benefits; and claims payment issues. If all or part of a claim is denied, and you think it may be eligible for coverage, you can have us review your claim. In your letter, explain why you think the claim may be eligible. Include any documentation or data that may relate to the claim.

There are two timeframes for internal administrative appeal reviews:

- **Level 1 appeals** – You have 180 calendar days after you receive the decision to file an appeal. We review the appeal within 30 days of when we receive the appeal request.
- **Level 2 appeals** – You have 60 calendar days after you receive the Level 1 decision to file a Level 2 appeal. We review the appeal within 30 days of when we receive the appeal request.

If your claim is related to certain surprise medical bills or a rescission of coverage, you may be eligible for an external review after the first two levels of appeal.

Medical necessity appeals

Medical necessity appeals focus on medical necessity and requests to change a decision to deny or limit the benefits provided for a covered service.

A **pre-service appeal** concerns benefits for medical care that you must have pre-certified before you obtain it, under the terms of your plan.

A **post-service appeal** concerns claims for services you already obtained and does not qualify for expedited or urgent appeals (explained below).

You have 180 days from the initial denial date to file an appeal.

Internal appeals

The first step is the internal appeal, performed by AmeriHealth Administrators.

There are two timeframes for internal appeal reviews: standard and expedited.

1. **Standard appeals** consist of one internal review and a second, external review – if your plan allows. We must complete the evaluation and decision within the following timeframes:
 - **Standard internal pre-service appeal** – within 30 days of the date we receive the appeal request
 - **Standard internal post-service appeal** – within 60 days of the date we receive the appeal request
2. **Expedited appeals** are for pre-service requests related to urgent care. They involve a serious medical condition that you believe may jeopardize your life, health, or ability to regain maximum function, or that would subject you to severe pain that cannot be adequately managed while you wait for a standard appeal decision.



The evaluation and decision for an expedited pre-service appeal must be completed within 72 hours of the date we are notified of your appeal request.

The initial appeal decision is final with respect to your right to appeal through our internal appeal process.

We will send written notice of the appeal decision within the timeframes stated above. If your appeal is denied, the decision notice will:

- State the specific reason it was denied
- Refer to the plan provision and guidelines on which the decision is made
- Tell you about the relevant information that is available free of charge
- Describe external appeal rights or other dispute resolution options that may be available to you

External appeals. If external appeals are available under your group health benefits plan and you request one, we send the external appeal to an independent review organization (IRO). At the IRO, the evaluation and determination are performed by a health care provider of the same – or similar – specialty as providers who typically manage the care being reviewed. The external review process is described below.

Full and fair review. If the decisionmakers uphold the original decision, we provide you with the rationale and any new or additional evidence they considered or relied upon regarding the appeal, to give you a reasonable opportunity to respond before the final decision.

Right to pursue civil action. If your group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of the Act, after completing the internal appeal processes described in this document.

Matched specialist's reports. We get input from a matched specialist for certain medical necessity appeals. Matched specialists are licensed health care providers who are in the same or similar specialty as the providers who typically manage the care being reviewed. They cannot be the same person who made the initial adverse decision, and they cannot report to any person who completed any previous reviews.

Decisionmakers. We designate representatives who did not make the initial decision to act as decisionmakers on the appeal. They review all relevant information that you provide. If the additional information shows that the care met your group health plan's guidelines, the decisionmakers may overturn the decision. To avoid conflict of interest and comply with regulatory and accreditation requirements, we also use peer medical reviewers, including contracted independent review organizations.



External reviews

Some group health plans that are **grandfathered** as allowed by the Patient Protection and Affordable Care Act (ACA) may not offer an external appeal option. If you're not sure if your plan is grandfathered and excludes external appeals, please see your benefit book or ask your plan sponsor (for example, your employer).

An external review of certain surprise medical bills is available, if you were covered under the plan at the time of service, regardless of the grandfathered status of the plan.

After an internal review, if allowed by your group health plan, you may ask for an external review up to four months after you receive our notice of an adverse decision that involves:

- Your coverage being rescinded; or
- Medical judgment including: medical necessity; appropriateness; the setting or level of care; effectiveness of a treatment your group health plan covers; or determination that a treatment is experimental or investigational; or
- Certain surprise medical bills received by you after receiving in-network services.

Call the number on your ID card for information on how to request an external review. You may be responsible for a small fee to cover the administrative duties performed to process the external review.

Responsibility for performing external reviews. This description of external reviews and the external review process apply to you if AmeriHealth Administrators performs external reviews for your group health plan.

Your employer or plan sponsor may choose to handle external reviews or assign another party – other than AmeriHealth Administrators – to perform them. In that case: (1) we will provide all pertinent information from the internal review to the appropriate party to help facilitate the external review; (2) your plan sponsor (for example, your employer) can give you more information and instructions on their external review process. If you're not sure if AmeriHealth Administrators handles external reviews for your plan, please ask your plan sponsor.

Timeframe. Within five business days, we complete a preliminary review to determine if the request is eligible for external review. Within one business day after that, we send you a written notice stating if the appeal is eligible. The notice includes explanations, contact information, and instructions.

Independent Review Organization (IRO). We send eligible external review requests to a contracted, accredited IRO. We send the IRO all necessary documents and information we considered in making the adverse decision. If, during the external review process, we reconsider the adverse decision, we will call to notify you and send you written notice within 48 hours.

The IRO makes final external review decisions within 45 days and notifies you and us in writing. We are bound by the external decision.



Expedited (urgent) external review process. If you want to initiate an urgent claim review during the external review process, call the service number on your ID card. You may request an expedited external review if:

- You have a medical condition that would seriously jeopardize your life or health or your ability to regain maximum function during the standard timeframe; or
- If the matter concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

You may ask for an expedited external review in writing or call the service number on your ID card.

As soon as we receive your request, we will determine if it is eligible for an expedited external review and notify you. If it is eligible for expedited external review, we will assign an IRO.

The IRO completes the review as quickly as the medical condition or circumstances require, but always within 72 hours after they receive the expedited request. They provide prompt notice of the final external review decision and send written notice within 48 hours of their decision.

We are bound by the external decision. If the external decision reverses the adverse decision, we will immediately authorize to provide the coverage or payment for the claim.



PRESCRIPTION DRUG GUIDELINES

For plan members in a prescription drug benefit program managed through AmeriHealth Administrators

When using your prescription drug plan, it's important to know how to find out what your plan covers and whether any guidelines apply to those drugs. This document describes what generic alternatives and therapeutic alternatives are, and it explains the prior authorization process*, age and quantity limits, and other ways the prescription drug program supports the safe prescription of covered drugs.

Generic alternative drugs

Generic prescription drugs are a money-saving, effective alternative to brand-name prescription drugs. A generic drug is similar in composition to its brand-name counterpart and is used to treat the identical health condition.

Facts about generic drugs:

- They are safe and effective.
- They can cost up to 70 percent less than brand-name drugs.
- They have the same active ingredients as their brand-name equivalents.
- They treat the same health conditions as their brand-name equivalents.
- They meet the same rigorous health and safety standards set by the U.S. Food and Drug Administration.

You can usually save money when you use a generic drug because prescription plans typically include a lower copayment or cost sharing for generic drugs than for brand-name drugs. If there is no generic equivalent for your brand-name drug, you still may be able to save money with a therapeutic alternative drug.

Therapeutic alternative drugs

Patents typically protect brand-name drugs for 17 to 20 years. Generic equivalents cannot be developed during that time. For brand-name drugs that have no generic equivalent, generic therapeutic alternatives may be available.

Although they are not the exact chemical equivalents of the brand-name drugs they replace, generic therapeutic alternatives treat medical conditions in a similar way.

Talk to your doctor to find out if a generic therapeutic alternative could be right for you.



Formulary

The formulary is a list of drugs covered by your prescription drug plan. The Pharmacy and Therapeutics Committee, a group of doctors and pharmacists, develop and approve the formulary and the approval criteria for the provisions and requirements described here.

You can view a PDF of the current prescription drug formulary online.

- If your plan uses the **Select Drug Formulary or the Premium Formulary**, please visit your plan member website at the address on your ID card.

If you want to speak with a representative, or you're not sure which formulary your plan uses, or you want to request a printed copy of the formulary – call the pharmacy benefits phone number on your ID card.

You can also log on to your plan member website at the address on your ID card.

Click *Benefits* at the top of the screen for tools and services that can help you understand your prescription drug plan. You can:

- Review what you spent, and when and where you filled prescriptions
- Find a network retail pharmacy near you
- Price a specific drug and compare savings with a generic equivalent
- Access formulary information
- Check on drug-to-drug interactions

Prior authorization*

The prior authorization program requires that your doctors obtain approval from your health plan for coverage of, or payment for, certain medications. **Without prior authorization, your plan will not cover these prescriptions at either the retail or mail order/home delivery pharmacy.**

Prior authorization helps confirm that the drug is medically necessary and appropriate and is prescribed according to Food and Drug Administration (FDA) approved label or medically accepted use.

Therapy history may include a trial of at least three formulary alternatives (step therapy) or contraindications to using the formulary alternatives. The evaluation may include: a review of potential drug-to-drug interactions; contraindications; appropriate dosing and length of therapy; and use of other drug therapies, if necessary.

The prior authorization process may take up to two business days once FutureScripts receives complete information from the prescribing doctor. Incomplete information will delay a decision.

Prior authorization approvals are limited, in most cases, approvals are valid for up to 2 years.

In these cases, the approval notice will state an expiration date. If the doctor wants you to continue the drug therapy after that expiration date, they must request a new prior authorization for approval to continue coverage for the drug.



Age limits

The FDA has established specific procedures that govern prescribing practices. These rules are designed to prevent potential harm to patients and to confirm that the medication is prescribed according to FDA guidelines. For example, the FDA may approve a particular drug only for individuals age five and older. If your prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained.

In addition, an age limit may apply when certain drugs are more likely to be used in certain age groups. For example, drugs to treat Alzheimer's may require prior authorization for use in young adults. The prescribing doctor may request prior authorization for restricted medications when they are medically necessary.

To confirm if a covered drug prescribed for you has an age limit, call the pharmacy benefits phone number on 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, or length of therapy. These limits are intended to ensure safe and appropriate use. If you require more than the limit, your doctor must request prior authorization. If an approved formulary exception allows for coverage of a non-formulary drug, quantity limits will apply.

- **Quantity over time.** Quantity limit is based on dosing guidelines over a rolling time period. For example, if a drug has a quantity limit over a 30-day time period and you went to the pharmacy on January 1, for one of these medications, the plan would have looked back 30 days to December 2, to see how much medication was dispensed. The purpose of these limits is to prevent the dispensing of excessive quantities. Examples of quantity limits over time are: "9 tablets of 50 mg each per 30 days" or "18 tablets of 50mg each per 30 days."
- **Maximum daily dose.** This limits the number of units of the drug 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. An example of a maximum daily dose quantity limit is "2 tablets per day."

Refill too soon

This limit is in place to encourage appropriate use and avoid stockpiling of prescription drugs. You can refill a prescription after you would have used 75 percent of your last fill. However, if the same prescription is refilled every month at the 75 percent point, an excess supply will accumulate. The plan will look back over the past 180 days to calculate how many days' supply was dispensed.



Day supply limit

This limit is based on the number of days for which you can get doses, not the quantity. Quantity limits may also apply to the same drug. Day supply limits apply to some classes of drugs, such as narcotics. If a quantity limit also applies, you will be limited to the maximum daily dose for that drug. The following is an example of a drug with a day supply limit and a quantity limit:

- Headache medications such as butalbital or narcotics such as oxycodone tablets
 - day supply limit = You can get a 5-day supply in a 30-day period
 - quantity limit = You can get 6 doses for 1 day
 - maximum quantity allowed in a 30-day period without prior authorization = 30
(6 per day x 5 days)

If your doctor wants to prescribe a medication therapy that exceeds any of these utilization limits, they must request a quantity limit override. You must contact your prescribing doctor to initiate the request.

If your doctor gets approval for a larger quantity of a drug, the approval may be limited to a certain period. If it is, the approval notice will state the date the exception runs out. If your doctor wants you to continue the drug therapy longer, they must submit a new request for approval to continue coverage for the drug.

To determine if a covered drug prescribed for you has a quantity limit or requires prior authorization, call the pharmacy benefits phone number on your ID card.



How to request prior authorization*

1. Your doctor must complete a prior authorization form or write a letter of medical necessity and fax it to the PBM at 1-888-671-5285.
2. The PBM reviews the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director reviews the document.
3. The PBM makes a decision regarding the request.
4. If it is approved:
 - a. The PBM notifies the prescribing doctor by fax or telephone and enters the approval into the prescription claims system.
 - b. You may call the pharmacy benefits phone number on your ID card to find out if the prior authorization is approved.
5. If it is denied:
 - a. The PBM will notify the prescribing doctor by letter, fax, or telephone.
 - b. They will notify you by letter.
 - c. The letter to you and your doctor explains the process if you want to appeal the denial.

Appealing a decision

If a request for prior authorization or an 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 help in the appeals process, we suggest you keep your doctor involved to provide any additional information based on the appeal.



Most prescription plans include the prior authorization program. These sections marked with an asterisk () apply to you if your plan includes prior authorization. If you're not sure if prior authorization applies to you, please call the pharmacy benefits phone number on your ID card or check with your employer or plan sponsor.

An independent pharmacy benefits management (PBM) company administers prescription drug benefits for certain plans. It is responsible for providing a network of participating pharmacies and for processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. The health plan's claims administrator may incorporate certain savings resulting from rebates into reductions in the overall cost of pharmacy benefits. Most plans include a copayment (or other cost sharing) for prescription drugs.