AmeriHealth PPO

PPO 15 Summary of Benefits

AmeriHealth PPO, our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You maximize your coverage by obtaining care provided by the area's hospitals and thousands of doctors, and specialists who participate in the AmeriHealth PPO network. Of course, with AmeriHealth PPO, you have the freedom to select providers who do not participate in the AmeriHealth PPO network. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

With AmeriHealth PPO...

- You do not need to enroll with a primary care physician
- You never need a referral

Benefit	In-network	Out-of-network[1]
BENEFIT PERIOD	Calendar Year+	Calendar Year+
DEDUCTIBLE*		
Individual	$0	$250
Family	$0	$500
AFTER DEDUCTIBLE, PLAN PAYS	100%	80%
OUT-OF-POCKET MAXIMUM (includes coinsurance only)		
Individual	None	$1,000
Family	None	$2,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	$15 copayment	80%, after deductible
Specialist services	$15 copayment	80%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	80%, NO deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	80%, NO deductible

1 Non-Preferred Providers may bill you for differences between the Plan allowance, which is the amount paid by AmeriHealth (AH), and the actual charge of the provider. This amount may be significant. Claims payments for Non-Preferred Professional Providers (physicians) are based on the lesser of the Medicare Professional Allowable Payment or the actual charge of the provider. For covered services that are not recognized or reimbursed by Medicare, the payment is based on the lesser of the AmeriHealth (AH) applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or AH's fee schedule, payment is based on 50% of the actual charge of the provider. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

* **To find an AmeriHealth PPO network doctor or specialist, call the Health Resource Center at 1-800-275-2583,** or visit the AmeriHealth website at www.amerihealth.com

\+ A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount start at $0 at the beginning of each calendar year on January 1.

The benefits may be changed by Amerihealth to comply with applicable federal/state laws and regulations.

AmeriHealth
QCC Insurance Company d/b/a AmeriHealth Insurance Company
www.amerihealth.com

08/11 - DE - 51+ PPO 15 In-Area
85779

Benefit	In-network	Out-of-network[1]
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age[2]	100%	80%, NO deductible
MAMMOGRAM	100%	80%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per year[2]	100%	80%, after deductible
MATERNITY		
First OB Visit	$15 copayment	80%, after deductible
Hospital	100%	80%, after deductible[3]
INPATIENT HOSPITAL SERVICES	100%	80%, after deductible[3]
INPATIENT HOSPITAL DAYS	Unlimited	70[3]
OUTPATIENT SURGERY	100%	80%, after deductible
EMERGENCY ROOM	$25 copayment (waived if admitted)	$25 copayment (waived if admitted) no deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	80%, after deductible
OUTPATIENT X-RAY/RADIOLOGY	100%	80%, after deductible
THERAPY SERVICES		
Physical and occupational 30 total visits per year for PT/OT combined[2]	$15 copayment	80%, after deductible
Cardiac rehabilitation 36 visits per year[2]	$15 copayment	80%, after deductible
Pulmonary rehabilitation 12 visits per year[2]	$15 copayment	80%, after deductible
Speech 20 visits per year[2]	$15 copayment	80%, after deductible
Respiratory therapy	$15 copayment	80%, after deductible
SPINAL MANIPULATIONS 20 visits per year[2]	$15 copayment	80%, after deductible
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	100%	80%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE Orthoptic/Pleoptic Therapy limited to 8 sessions lifetime maximum[2]	$15 copayment	80%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	80%, after deductible
SKILLED NURSING FACILITY	100%	80%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	80%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%	80%, after deductible

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2 Combined in/out-of-network

3 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness, substance abuse and substance dependency services.

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Benefit	In-network	Out-of-network[1]
OUTPATIENT DIABETIC EDUCATION	100%	Not Covered
MENTAL HEALTH CARE		
Outpatient	$15 copayment	80%, after deductible
Inpatient	100%	80%, after deductible[3]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$15 copayment	80%, after deductible
Inpatient	100%	80%, after deductible[3]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits	$15 copayment	80%, after deductible
Rehabilitation	100%	80%, after deductible[3]
Detoxification	100%	80%, after deductible[3]
SUBSTANCE DEPENDENCY		
Outpatient	$15 copayment	80%, after deductible
Rehabilitation	100%	80%, after deductible[3]
Detoxification	100%	80%, after deductible[3]

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What is not covered?

- services not medically necessary
- services not billed and performed by a provider properly licensed and qualified to render the medically appropriate and/or necessary treatment, service, or supply
- cosmetic services/supplies
- routine foot care
- supportive devices for the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- vision care (except as specified in a group contract)
- dental care, including dental implants
- military or occupational injuries or illness
- benefits payable by the government, Medicare or through motor vehicle insurance
- charges in excess of benefit maximums or allowable charges as set forth in the group contract
- services or supplies that are experimental or investigative except routine costs associated with clinical trials
- inpatient private duty nursing
- alternative therapies/complementary medicine
- immunizations required for employment or travel
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices; except hearing aids for dependents under age 24 are covered
- maintenance of chronic conditions
- cranial prosthesis, including wigs intended to replace hair, except for scalp hair prostheses as a result of alopecia areata
- assisted fertilization techniques such as but not limited to, in-vitro fertilization, artificial insemination, GIFT, ZIFT
- self-injectable drugs

This summary represents only a partial listing of the benefits and exclusions of the PPO program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your benefit booklet carefully to determine which health care services are covered. If you need more information please call 1-800-877-9829.

For Care Provided Out-of-Network

Services that require precertification

- All Non-Emergency Inpatient Admissions
  (Except maternity admissions)
- Hyperbaric Oxygen
- Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)
- Surgical Procedures

  Bunionectomy

  Cataract surgery

  Cochlear implant surgery

  Laparoscopic cholecystectomy

  Hemorrhoidectomy

  Hernia repair

  Arthroscopic knee surgery/diagnostic arthroscopy

  Obesity surgery

  Prostate surgery

  Spinal/vertebral surgery

  Submucous resection (nasal surgery)

  Tonsillectomy and/or adenoidectomy
- RECONSTUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES (for a complete list of these procedures, please see Benefits that Require preauthorization available on ibx.com)
- Surgery for varicose veins, including perforators and sclerotherapy
- Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies
- Transplants
- Operative and Diagnostic Endoscopies
- MRI/MRA
- CT/CTA Scan
- PET Scan
- Nuclear Cardiac Studies
- Outpatient therapies:
  Speech
- Outpatient Private Duty Nursing
- Other facility services:
  Skilled Nursing, Inpatient Hospice, Home Health, Birth Center
- Inpatient Mental Health, Substance Abuse/Dependency, and Serious Mental Illness Treatment
- Day Rehabilitation Programs
- Partial Hospitalization Programs/Intensive Outpatient Programs, Mental Health and Serious Mental Illness Treatment
- Dental Services as a Result of Accidental Injury
- Non-Emergency Ambulance
- Prosthetics and Orthotics
  Purchase items (including repairs and replacements) over $500 (excluding ostomy supplies)
- Durable Medical Equipment
  Purchase items (including repairs and replacements) over $500, and ALL rentals (except oxygen, diabetic supplies, and unit dose medication for nebulizer)
- Infusion Therapy in a Home Setting
- Infusion Therapy Drugs
  Administered in an outpatient facility or in a professional provider's office (see list included in your open enrollment packet)

AmeriHealth PPO network providers will obtain precertification for you, if it is required for the service provided. You are not required to obtain precertification when you are treated in an AmeriHealth PPO network hospital or facility or by an AmeriHealth PPO network doctor. Members are not responsible for financial penalties because an AmeriHealth PPO network provider does not obtain prior approval.

When an AmeriHealth PPO member receives services outside of the network, the obligation to obtain precertification is with the member. If the out-of-network provider recommends one of the services listed above, you must obtain precertification by calling the precertification telephone number listed on the back of your ID card.

If services are received outside of the AmeriHealth PPO network without precertification, benefits will be reduced by $1,000 for inpatient services or treatment and 20% for outpatient services or treatment.

Precertification is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the precertification is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions and other specific terms of the health benefits plan that apply to the coverage request. If you need more information please call 1-800-877-9829.