# AmeriHealth HMO Plus

*HMO Plus $25/$50  $500/Day SEH Summary of Benefits*

AmeriHealth HMO Plus lets you maintain Freedom of Choice by allowing you to select your own doctors and hospitals within the AmeriHealth Network. Under this plan, you must select a Primary Care Physician, but can access care within the AmeriHealth Network without a referral.

This program may not cover all your health care services. Services may not be covered because they are:

- Not covered under your benefit contract
- Not medically necessary
- Limited by a benefit maximum (e.g. visit limit)

Your benefit description material identifies details about your benefit program. It also includes information about exclusions and benefit limitations. After reviewing this information, please contact our Member Service department if you have additional questions.

| Benefit | Coverage |
|---|---|
| **Benefit Period**[+] | Calendar year |
| **Doctor's Office Visits** | |
| Primary Care Services | $25 Copayment |
| Specialist Services | $50 Copayment |
| **Preventive Care for Adults and Children** | 100%, NO Deductible |
| **Out-of-Pocket Limit**[***] | |
| Individual | $5,000 |
| Family | $10,000 |
| **Pediatric Immunizations** | 100%, NO Deductible |
| **Routine Eye Exam** | $50 Copayment (once every two years) |
| **Routine Gynecological Exam/PAP** | 100%, NO Deductible |
| **Mammogram** | 100%, NO Deductible |
| **Outpatient Laboratory/Pathology** | 100% |

*****Out-of-Pocket maximum includes copayments, coinsurances and deductible where applicable.**

**+ A calendar year benefit period begins on January 1 and ends on December 31.**

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

AmeriHealth HMO, Inc.
www.amerihealth.com

| Benefit | Coverage |
| --- | --- |
| **Maternity** | |
| First OB Visit | $25 Copayment |
| Hospital | $500 Copayment/day; maximum of 5 days ($2,500)** |
| **Inpatient Hospital Services** | $500 Copayment/day; maximum of 5 days ($2,500)** |
| **Inpatient Hospital Days** | Unlimited |
| **Outpatient Surgery** | $250 Copayment (facility) |
| **Emergency Room** | $100 Copayment<br>(not waived if admitted) |
| **Ambulance** | 100% |
| **Outpatient X-Ray/Radiology** | |
| Routine Radiology/Diagnostic | $50 Copayment |
| MRI/MRA, CT, PET Scans | $100 Copayment |
| **Therapy Services** | |
| Physical and Occupational<br>30 visits per calendar year (combined) | $50 Copayment |
| Cardiac Rehabilitation<br>36 visits per calendar year | $50 Copayment |
| Pulmonary Rehabilitation<br>36 visits per calendar year | $50 Copayment |
| Speech and Cognitive<br>30 visits per calendar year (combined) | $50 Copayment |
| Orthoptic/Pleoptic<br>8 session lifetime maximum | $50 Copayment |
| **Therapeutic Manipulations**<br>20 visits per calendar year | $50 Copayment |
| **Infusion Therapy / Chemotherapy / Radiation Therapy** | 100% |
| **Dialysis** | 100% |
| **Extended Care Center**<br>120 days per calendar year | $500 Copayment/day; maximum of 5 days |
| **Hospice and Home Health Care** | 100% |

****Copayment waived if readmitted within 90 days of discharge.**

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

| Benefit | Coverage |
| --- | --- |
| **Durable Medical Equipment** | 50% |
| **Prosthetics and Orthotics** | 100% |
| **Mental Health** | |
| Outpatient | $50 Copayment |
| Inpatient | $500 Copayment/day; maximum of 5 days |
| **Substance Abuse** | |
| Outpatient | $50 Copayment |
| Inpatient | $500 Copayment/day; maximum of 5 days |

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

## What Is Not Covered?

- Any charge identified as a Non-Covered Charge, specifically limited or which are not Medically Necessary and Appropriate
- Services or supplies rendered for reversal of sterilization
- Services or supplies related to hearing aids, including cochlear electromagnetic hearing devices and hearing exams, except as stated in the Newborn Hearing Screening and Haering Aid (Grace's Law) provisions
- Dental care or treatment, including but not limited to appliances and dental implants
- Care or treatment by means of acupuncture except when used as a substitute for other forms of anesthesia
- Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products
- Services or supplies related to routine, palliative or cosmetic foot care
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention or as a result of complications associated with diabetes
- Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness or intended to replace hair
- Benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law
- Immunizations for employment or travel
- Extraction of teeth, except for bony impacted teeth
- Services,supplies or operations related to Cosmetic Surgery including complications of Cosmetic Surgery and drugs prescribed for cosmetic purposes
- Services or supplies which are not billed by a participating Provider
- Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm
- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices
- Hearing aids and hearing examinations except as stated for dependent children

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

## Services That Require Preapproval

**INPATIENT SERVICES**

- Surgical and non-surgical inpatient admissions
- Acute Rehabilitation
- Extended Care Center
- Inpatient Hospice
- Maternity Admission (for notification only)

**OUTPATIENT FACILITY/OFFICE SERVICES**
(other than inpatient)

- PET Scans, MRI, MRA, CT and Nuclear Cardiac Studies
- Hysterectomy
- Cataract Surgery
- Nasal Surgery for Submucous Resection and Septoplasty
- Transplants (except cornea)
- Comprehensive Outpatient Pain Management Programs (including epidural injections)
- Obesity Surgery
- Sleep Studies
- Uvulopalatopharyngoplasty (including laser-assisted)

**ALL HOME CARE SERVICES**
(including Infusion Therapy in the home)

**INFUSION THERAPY DRUGS IN AN OUTPATIENT FACILITY OR IN A PROFESSIONAL PROVIDER'S OFFICE - (See list included in your Open Enrollment packet)**

**BIRTHING CENTER (for notification only)**

**ELECTIVE (non-emergency) AMBULANCE TRANSPORT**

**OUTPATIENT PRIVATE DUTY NURSING**

**DURABLE MEDICAL EQUIPMENT - PURCHASE ITEMS OVER $500 INCLUDING, REPAIRS AND REPLACEMENTS, AND ALL RENTALS**
(except oxygen, diabetic supplies and unit dose medication for nebulizer)

**RECONSTRUCTIVE PROCEDURES & POTENTIALLY COSMETIC PROCEDURES**

- Abdominoplasty
- Augmentation Mammoplasty
- Blepharoplasty
- Chemical Peels
- Dermabrasion
- Excision of Redundant Skin
- Keloid Removal
- Lipectomy/Liposuction
- Orthognathic Surgery Procedures
- Mastopexy
- Otoplasty
- Panniculectomy
- Reduction Mammoplasty
- Removal or Reinsertion of Breast Implants
- Rhinoplasty
- Surgery for Varicose Veins
- Scar Revision
- Subcutaneous Mastectomy for Gynecomastia

**MENTAL HEALTH/SUBSTANCE ABUSE**

- Outpatient Mental Health/Substance Abuse Treatment
- Inpatient Mental Health/Inpatient Substance Abuse Treatment

**SERVICES BY A NON-PARTICIPATING PHYSICIAN/PROVIDER FOR NON-EMERGENCY SERVICES**

**Preapproval 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 preapproval 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. Preapproval list subject to change annually.**

**In addition to the preapproval requirements listed above, you should contact AmeriHealth for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. The categories of treatment (in any setting) include:**

- **Any surgical procedure that may be considered potentially cosmetic**
- **Any procedure, treatment, drug or device that represents 'new or emerging technology;' and**
- **Services that might be considered experimental/investigative.**

**PENALTIES:**

**It is the network provider's responsibility to obtain preapproval for the services listed. Members are held harmless from financial penalties if the network provider does not obtain preapproval.**