

You have enrolled in a Health Maintenance Organization (HMO). This is a managed care program. Your coverage is available when your care is provided by your AmeriHealth Primary Care Physician. Your AmeriHealth Primary Care Physician may also refer you to other AmeriHealth providers for care, if needed.

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 (i.e. visit limit)

Your Member Handbook 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.

BENEFITS AND SERVICES*	Coverage
Primary Care Physician Office Visits	\$15 copay per visit
Specialist Office Visits	\$15 copay per visit
Outpatient X-Ray and Laboratory Services	\$15 copay per visit
Well-Child Care including immunizations	\$15 copay per visit
Prenatal Care	\$25 copay for the initial visit; subsequent visits covered in full
Outpatient Surgery	
Facility	\$15 copay per visit
Practitioner	\$15 copay per visit
Hospital Services Outpatient	\$15 copay per visit
Hospital Services Inpatient	\$150 copay per day for maximum of 5 days per admission; \$1,500 maximum copay per calendar year
Emergency Room	\$100 copay per visit (credited toward inpatient admission if admission occurs within 24 hours of the emergency)
Non-Biologically Based Mental Illness and Substance Abuse (Combined):	
Outpatient	\$15 copay per visit; maximum of 20 visits per calendar year
Inpatient	\$150 copay per day for maximum of 5 days per admission; \$1,500 maximum copay per year; maximum of 30 inpatient days per calendar year**
Biologically Based Mental Illness:	
Outpatient	\$15 copay per visit
Inpatient	\$150 copay per day for a maximum of 5 days per admission; \$1,500 maximum copay per calendar year
Pre-admission Testing	\$15 copay per visit
Rehabilitation Centers	Subject to the Hospital Services Inpatient copayment above. The copayment does not apply if the admission is preceded by a hospital inpatient stay.
Therapy Services	\$15 copay per visit
Speech, physical, occupational and cognitive therapies (30 visits per therapy per calendar year)	
Prescription Drug	50% coinsurance
Lifetime Maximum	Unlimited

*This listing of benefits and services is only a summary. For a more detailed description, of benefits, exclusions and limitations refer to the IHC Contract.

**One inpatient day may be exchanged for two outpatient visits, or partial hospital days after outpatient visits have been exhausted.

Services and Benefits Not Covered

As with all health insurance plans, AmeriHealth's coverage excludes certain services. Those not covered by AmeriHealth include, but are not limited to, the following:

- ✓ Any service provided without prior written Referral by the Member's Primary Care Physician, except in emergencies.
- ✓ Any therapy not included in Our definition of Therapy Services.
- ✓ Artificial drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, or gamete-intro-fallopian-transfer (GIFT), and surrogate motherhood.
- ✓ Completion of forms.
- ✓ Conditions related to behavior problems or learning disabilities.
- ✓ Cosmetic Surgery, except as stated in the Contract; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.
- ✓ Custodial Care or domiciliary care.
- ✓ Dental care or treatment, including appliances.
- ✓ Dose Intensive Chemotherapy, except as otherwise stated in the Contract.
- ✓ Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract.
- ✓ Extraction of teeth, including bony impacted teeth.
- ✓ Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in the Contract; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.
- ✓ Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.
- ✓ Marriage, career or financial counseling, sex therapy or family therapy.
- ✓ Private-Duty Nursing, except as provided for under Home Health Care.
- ✓ Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.
- ✓ Special medical reports not directly related to treatment of the Member (e.g. employment physicals, reports prepared in connection with litigation).
- ✓ Sterilization reversal.
- ✓ Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.
- ✓ Transplants, unless otherwise specifically covered, and non-human organ transplants.
- ✓ Services or supplies which are not medically necessary and appropriate except as otherwise stated in the contract.

This summary represents only a partial listing of the benefits and exclusions of the HMO program described in this summary. If you purchase 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/member handbook carefully to determine which health care services are covered. If you need more information please call 1-800-877-9829.