

AmeriHealth HMO

HMO \$25/\$50 \$500/Day SEH Summary of Benefits

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 (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 (No referral required)	100%, NO Deductible
Mammogram (No referral required)	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 benefits are underwritten or administered by AmeriHealth HMO, Inc.

Benefit	Coverage
Maternity	
First OB Visit	\$25 Copayment
Hospital	\$500/day; maximum of 5 Copayments/admission**
Inpatient Hospital Services	
	\$500/day; maximum of 5 Copayments/admission**
Inpatient Hospital Days	
	Unlimited
Outpatient Surgery	
	\$250 Copayment
Emergency Room	
	\$100 Copayment (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 30 visits per calendar year (combined)	\$50 Copayment
Cardiac Rehabilitation 36 visits per calendar year	\$50 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	\$50 Copayment
Speech and Cognitive 30 visits per calendar year (combined)	\$50 Copayment
Orthoptic/Pleoptic 8 session lifetime maximum	\$50 Copayment
Therapeutic Manipulations	
20 visits per calendar year	\$50 Copayment
Infusion Therapy / Chemotherapy / Radiation Therapy	
	100%
Dialysis	
	100%
Extended Care Center	
120 days per calendar year	\$500/day; maximum of 5 Copayments/admission**
Hospice and Home Health Care	
	100%
Durable Medical Equipment	
	50%
Prosthetics and Orthotics	
	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
Mental Health	
Outpatient	\$50 Copayment
Inpatient	\$500/day; maximum of 5 Copayments/admission**
Substance Abuse	
Outpatient	\$50 Copayment
Inpatient	\$500/day; maximum of 5 Copayments/admission**

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

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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 Hearing Aids (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

<p>INPATIENT SERVICES</p> <p>Surgical and non-surgical inpatient admissions</p> <p>Acute Rehabilitation</p> <p>Extended Care Center</p> <p>Inpatient Hospice</p> <p>Maternity Admission (for notification only)</p> <p>OUTPATIENT FACILITY/OFFICE SERVICES (other than inpatient)</p> <p>PET Scans, MRI, MRA, CT and Nuclear Cardiac Studies</p> <p>Hysterectomy</p> <p>Cataract Surgery</p> <p>Nasal Surgery for Submucous Resection and Septoplasty</p> <p>Transplants (except cornea)</p> <p>Comprehensive Outpatient Pain Management Programs (including epidural injections)</p> <p>Obesity Surgery</p> <p>Sleep Studies</p> <p>Uvulopalatopharyngoplasty (including laser-assisted)</p> <p>ALL HOME CARE SERVICES (including Infusion Therapy in the home)</p> <p>INFUSION THERAPY DRUGS IN AN OUTPATIENT FACILITY OR IN A PROFESSIONAL PROVIDER'S OFFICE (See list included in your Open Enrollment packet)</p> <p>BIRTHING CENTER (for notification only)</p> <p>ELECTIVE (non-emergency) AMBULANCE TRANSPORT</p> <p>OUTPATIENT PRIVATE DUTY NURSING</p> <p>DURABLE MEDICAL EQUIPMENT - PURCHASE ITEMS OVER \$500 INCLUDING, REPAIRS AND REPLACEMENTS, AND ALL RENTALS (except oxygen, diabetic supplies and unit dose medication for nebulizer)</p>	<p>RECONSTRUCTIVE PROCEDURES & POTENTIALLY COSMETIC PROCEDURES</p> <p>Abdominoplasty</p> <p>Augmentation Mammoplasty</p> <p>Blepharoplasty</p> <p>Chemical Peels</p> <p>Dermabrasion</p> <p>Excision of Redundant Skin</p> <p>Keloid Removal</p> <p>Lipectomy/Liposuction</p> <p>Orthognathic Surgery Procedures</p> <p>Mastopexy</p> <p>Otoplasty</p> <p>Panniculectomy</p> <p>Reduction Mammoplasty</p> <p>Removal or Reinsertion of Breast Implants</p> <p>Rhinoplasty</p> <p>Surgery for Varicose Veins</p> <p>Scar Revision</p> <p>Subcutaneous Mastectomy for Gynecomastia</p> <p>MENTAL HEALTH/SUBSTANCE ABUSE</p> <p>Network Outpatient Mental Health Treatment/Substance Abuse Treatment</p> <p>Inpatient Mental Health Treatment/ Inpatient Substance Abuse Treatment</p> <p>SERVICES BY A NON-PARTICIPATING PHYSICIAN/PROVIDER FOR NON-EMERGENCY SERVICES</p>
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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.