AmeriHealth Direct POS

C1-F1-01 Summary of Benefits

AmeriHealth

AmeriHealth Direct POS lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. Under this plan, you must select a Primary Care Physician, but can access most care in-network or out-of-network without a referral. Referrals are required for routine radiology/diagnostic, podiatry, spinal manipulation and physical/occupational therapy. You maximize your benefits when you access care from a AmeriHealth participating provider. If you access care from a provider who does not participate in our network higher out-of-pocket costs apply.

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.

Benefit	In-Network	Out-of-Network*
DEDUCTIBLE		
Individual	$0	$500
Family	$0	$1,500
COINSURANCE LIMIT		
Individual	None	$3,000
Family	None	$9,000
LIFETIME MAXIMUM	Unlimited	$1 Million
ANNUAL COPAYMENT MAXIMUM		
Individual	$1,000	Not Applicable
Family	$2,000	Not Applicable
DOCTOR'S OFFICE VISITS		
Primary Care Services	$10 Copayment[1]	70%, after deductible
Specialist Services	$20 Copayment	70%, after deductible
To receive the highest level of benefits, you must receive the following services from your Primary Care Physician's designated sites. You can view your Primary Care Physician's designated sites at www.amerihealth.com.		
OUTPATIENT X-RAY/RADIOLOGY* **		
Routine Radiology/Diagnostic	$20 Copayment[2]	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$40 Copayment	70%, after deductible

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge.

1 Must go to the Primary Care Physician chosen by the member.

2 Referral required from Primary Care Physician.

*** Copayment not applicable when service performed in Emergency Room or office setting.

To receive maximum benefits, services must be provided by a AmeriHealth participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

AmeriHealth

In-network benefits are underwritten or administered by AmeriHealth HMO, Inc.
Out-of-network benefits underwritten or administered by QCC Insurance Company d/b/a AmeriHealth Insurance Company
www.amerihealth.com

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Benefit	In-Network	Out-of-Network*
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible
PHYSICAL AND OCCUPATIONAL THERAPIES 30 visits per calendar year	$20 Copayment[2]	70%, after deductible
PODIATRY	$20 Copayment[2]	70%, after deductible
To receive the highest level of benefits, you can see any AmeriHealth participating provider for the following services.		
SPINAL MANIPULATIONS 20 visits per calendar year	$20 Copayment[2]	70%, after deductible
THERAPY SERVICES		
Cardiac Rehabilitation 36 visits per calendar year	$20 Copayment	70%, after deductible
Pulmonary Rehabilitation 36 visits per calendar year	$20 Copayment	70%, after deductible
Speech 20 visits per calendar year	$20 Copayment	70%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	$20 Copayment	70%, after deductible
INPATIENT HOSPITAL SERVICES	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70
OUTPATIENT SURGERY	100%	70%, after deductible
EMERGENCY ROOM	$100 Copayment (not waived if admitted)	$100 Copayment (not waived if admitted)
AMBULANCE	100%	70%, after deductible
MATERNITY		
First OB Visit	$10 Copayment	70%, after deductible
Hospital	100%	70%, after deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age	$10 Copayment	70%, NO deductible
MAMMOGRAM	100%	70%, NO deductible
NUTRITIONAL COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year	100%	70%, after deductible
PEDIATRIC IMMUNIZATIONS	100%**	70%, NO deductible
ROUTINE EYE EXAM	$20 Copayment (once every two calendar years)	Not Covered
INJECTABLE MEDICATIONS		
Standard Injectables	100%**	70%, after deductible
Biotech/Specialty Injectables	$50 Copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per calendar year	90%	70%, after deductible
SKILLED NURSING FACILITY	100% 120 days per calendar year	70%, after deductible; 60 days per calendar year
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT	70%	50%, after deductible $2,500 benefit maximum per calendar year

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge.

** Office visits subject to copayment.

2 Referral required from Primary Care Physician.

To receive maximum benefits, services must be provided by a AmeriHealth participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

Benefit	In-Network	Out-of-Network*
PROSTHETICS	70%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$20 Copayment per visit; 20 visits per calendar year	50%, after deductible; 20 visits per calendar year
Inpatient	100%; 30 days per calendar year	70%, after deductible; 20 days per calendar year
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$20 Copayment per visit; 60 visits per calendar year	50%, after deductible; 60 visits per calendar year
Inpatient	100%; 30 days per calendar year	70%, after deductible; 30 days per calendar year
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits 120 visit lifetime maximum	$20 Copayment per visit; 60 visits per calendar year	70%, after deductible; 60 visits per calendar year
Inpatient Rehabilitation 90 day lifetime maximum	100%; 30 days per calendar year	70%, after deductible; 30 visits per calendar year
Detoxification 4 admissions per lifetime	100%; 7 days per admission	70%, after deductible; 7 days per admission

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge.

To receive maximum benefits, services must be provided by a AmeriHealth participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

What Is Not Covered?

- Services not medically necessary
- Services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials and when approved by AmeriHealth.
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques, such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Acupuncture
- Dental care, including dental implants and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy, and hippotherapy
- Treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses, including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Contraceptives, except by additional rider
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Alternative therapies/complementary medicine

This summary represents only a partial listing of benefits and exclusions of the AmeriHealth Direct POS 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 HMO group contract/member handbook and Out-of-Network group health benefits booklet/certificate carefully to determine which health care services are covered. If you need more information, please call 1-866-681-7372

Services That Require Preapproval/Precertification

INPATIENT SERVICES

- Surgical and Nonsurgical Inpatient Admissions
- Acute Rehabilitation
- Skilled Nursing Facility
- Inpatient Hospice
- Maternity Admission (FOR NOTIFICATION ONLY)

OUTPATIENT FACILITY/OFFICE SERVICES
(other than inpatient)

- MRI/MRA
- CT/CTA Scan
- PET Scan
- 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
- Day Rehabilitation Programs
- Dental Services as a result of Accidental Injury
- Uvulopalatopharyngoplasty
  (including laser-assisted)

ALL HOME CARE SERVICES
(including infusion therapy in the home)

INFUSION THEARAPY DRUGS
Administered 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

PROSTHETICS AND ORTHOTICS
Purchase items over $500, including repairs and replacements (except ostomy supplies)

DURABLE MEDICAL EQUIPMENT
Purchase items $500, inluding repairs and replacements, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES AND 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/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

- Mental Health and Serious Mental Illness Treatment
  (Inpatient/Partial Hospitalization Programs/Intensive Outpatient Programs)
- Substance Abuse Treatment
  (Inpatient/Outpatient/Partial Hospitalization)

BIOTECHNOLOGY/SPECIALTY INJECTABLE DRUGS (see list included in your open enrollment packet)

SERVICES BY A NON-PARTICIPATING PHYSICIAN/PROVIDER FOR NON-EMERGENCY SERVICES (IN-NETWORK CARE)

Preapproval/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 preapproval/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. Preapproval/precertification list subject to change annually.

In addition to the preapproval/precertification requirements listed above, you should contact AmeriHealth and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. This applies to network providers and members who elect to recieve treatment provided by out-of-network providers (for members using Out-of-Network care). The categories of treatment (in any setting) include:

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

Your provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories. You are encouraged to have your provider place the call for you.

PENALTIES:

POS In-Network Care: It is the network provider's responsibility to obtain preapproval for services listed. Members are held harmless from financial penalties if the network provider does not obtain preapproval.

POS Out-of-Network Care: It is the member's responsibility to initiate precertification for the services listed. The member will be subject to a 20% reduction in benefits if precertification is not obtained for the inpatient/outpatient treatment services listed above.