AmeriHealth HMO

D4-N2 Summary of Benefits

AmeriHealth

AmeriHealth is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided by an 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 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	Coverage
DEDUCTIBLE	
Individual	$3,000
Family	$9,000
AFTER DEDUCTIBLE, PLAN PAYS	70%
COINSURANCE LIMIT	
Individual	$5,000
Family	$15,000
LIFETIME MAXIMUM	Unlimited
DOCTOR'S OFFICE VISITS	
Primary Care Services	$20 Copayment, No deductible
Specialist Services	$40 Copayment, No deductible
PEDIATRIC IMMUNIZATIONS	100%, No deductible*
ROUTINE EYE CARE	$40 Copayment, No deductible (once every two years)
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age	$20 Copayment, No deductible
MAMMOGRAM (no referral required)	100%, No deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year	100%, No deductible

*** Office visit subject to copayment**

AmeriHealth

AmeriHealth HMO, Inc.
AmeriHealth HMO benefits are underwritten or administered by AmeriHealth HMO, Inc.
www.amerihealth.com

06/08 - PA - HMO D4-N2
9671

Benefit	Coverage
OUTPATIENT LABORATORY/PATHOLOGY	100%, No deductible
MATERNITY	
First OB Visit	$20 Copayment, No deductible
Hospital	70%, after deductible
INPATIENT HOSPITAL SERVICES	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited
OUTPATIENT SURGERY	70%, after deductible
EMERGENCY ROOM	70%, after deductible (not waived if admitted)
AMBULANCE	70%, after deductible
OUTPATIENT X-RAY / RADIOLOGY+	
Routine Radiology/Diagnostic	$40 Copayment, No deductible
MRI/MRA, CT/CTA Scan, PET Scan	$80 Copayment, No deductible
THERAPY SERVICES	
Physical and Occupational 30 visits per calendar year	$40 Copayment, No deductible
Cardiac Rehabilitation 36 visits per calendar year	$40 Copayment, No deductible
Pulmonary Rehabilitation 36 visits per calendar year	$40 Copayment, No deductible
Speech 20 visits per calendar year	$40 Copayment, No deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum	$40 Copayment, No deductible
SPINAL MANIPULATIONS 20 visits per calendar year	$40 Copayment, No deductible
INJECTABLE MEDICATIONS	
Standard Injectables	100%, No deductible*
Biotech/Specialty Injectables	$100 Copayment, No deductible
CHEMO/RADIATION/DIALYSIS	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per calendar year	70%, after deductible
SKILLED NURSING FACILITY 120 days per calendar year	70%, after deductible
HOSPICE AND HOME HEALTH CARE	70%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	50%, after deductible

*** Office visit subject to copayment**

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

Benefit	Coverage
MENTAL HEALTH CARE	
Outpatient 20 visits per calendar year	$40 Copayment, No deductible
Inpatient 30 days per calendar year	70%, after deductible
SERIOUS MENTAL ILLNESS	
Outpatient 60 visits per calendar year	$40 Copayment, No deductible
Inpatient 30 days per calendar year	70%, after deductible
SUBSTANCE ABUSE TREATMENT	
Outpatient/Partial Facility Visits 60 visits per calendar year; 120 visits per lifetime	$40 Copayment, No deductible
Rehabilitation 30 days per calendar year; 90 days lifetime maximum	70%, after deductible
Detoxification 7 days per admission; 4 admissions per lifetime	70%, after deductible

What Is Not Covered?

- Services not medically necessary
- Routine foot care, unless medically necessary or associated with the treatment of diabetes.
- Services or supplies that are experimental or investigative except routine costs associated with qualifying clinical trials and when approved by AmeriHealth
- Foot orthotics, except for orthotics and podiatric apliances required for the prevention of complications associated with diabetes
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Cranial prostheses including wigs intended to replace hair
- Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- Routine physical exams for non preventive purposes such as insurance or employment applications, college or premarital examinations
- Non-medical, rehabilitative services for the treatment of substance abuse in an acute care hospital
- Reversal of voluntary sterilization
- Contraceptives, except by additional rider
- Expenses related to organ donation for non member recipients
- Immunization for travel or employment
- Alternative therapies/complementary medicine
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance or other legislation of similar purpose
- Dental care including dental implants and nonsurgical treatment of tempomandibular joint syndrome (TMJ)
- Cosmetic services/supplies
- Music therapy, equestrian therapy and hippotherapy
- Outpatient services that are not performed by your Primary Care Physician's Designated Provider
- Cosmetic surgery except for those services which occurred while a member of AmeriHealth and are performed to restore bodily function or correct deformity resulting from disease, recent trauma or previous therapeutic process
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury

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/member handbook carefully to determine which health care services are covered. If you need more information, please call 866-681-7372.

Services That Require Preauthorization

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 OUTPATIENT)

- MRI/MRA
- CT/CTA Scan
- PET Scan
- Nuclear Cardiac Studies
- Hysterectomy
- Cataract Surgery
- Nasal Surgery for Sub-mucus Resection and Septoplasy
- Transplants (except Cornea)
- Comprehensive Outpatient Pain Management Programs
- 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 THERAPY DRUGS in an OUTPATIENT FACILITY or in a PROFESSIONAL PROFESSIONAL PROVIDER'S OFFICE
(See list included in your Open Enrollment packet)

BIRTHING CENTERS (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 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
- Mastropexy
- Otoplasty
- Panniculectomy
- Reduction Mammmoplasty
- 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 & Illness Treatment
  (Inpatient/Outpatient/Partial Hospitalization)
- 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

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

Your PCP or other network provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories and should generally provide this prenotification for you.

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.