

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 contract 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	\$30 copay per visit
Specialist Office Visits	\$30 copay per visit
Outpatient X-Ray and Laboratory Services	100%
Well Baby Care	\$30 copay per visit
Prenatal Care	\$50 copay for the initial visit; subsequent visits covered in full
Outpatient & Ambulatory Surgery	\$250 copay per surgery then 100%
Hospital Services Inpatient	\$500 copay per confinement then covered at 100%
Emergency Room	\$100 copay per visit (not waived if admitted)
Non Biologically-Based Mental Illness:	Not covered
Alcohol and Substance Abuse	
Outpatient	Plan pays 70%; maximum of 30 visits per calendar year
Inpatient	\$500 copay per confinement then plan pays 70%; 30 days maximum per calendar year
Biologically-Based Mental Illness:	
Outpatient	Plan pays 70%; 30 visits per calendar year
Inpatient	\$500 copay per confinement
Pre Admission Testing	100%
Rehabilitation Centers	Subject to the Hospital Inpatient copayment above. The copayment does not apply if the admit is preceded by a hospital visit.
Outpatient Physical Therapy	\$20 copay per visit; 30 visits per calendar year
Outpatient Prescription Drug	Plan pays 50% up to \$1,500 per person per calendar year.
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.

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

## Services and Benefits Not Covered

- ✓ Any service provided without prior written Referral by the Member's Primary Care Physician except in case of emergency.
- ✓ Ambulance
- ✓ Any service or supply not specifically included in the Covered Services and Supplies section of the Contract.
- ✓ 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
- ✓ Dental care or treatment, including appliances and dental implants
- ✓ Drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood
- ✓ Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract
- ✓ 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 this Contract; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy or lasik surgery
- ✓ Food and food products
- ✓ 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
- ✓ Nutritional counseling and related services
- ✓ Private Duty Nursing
- ✓ Routine Foot Care
- ✓ Services not Medically Necessary and Appropriate, except as otherwise stated in the Contract.
- ✓ 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
- ✓ Temporomandibular Joint Disorder (TMJ) Treatment
- ✓ Therapeutic Manipulation, except that Inpatient hydrotherapy, as defined under Therapeutic Manipulation, is covered under Therapy Services.
- ✓ Therapy services, except as specifically covered under the Contract
- ✓ Transplants, unless otherwise specifically covered, and non-human organ transplants
- ✓ Treatment of a Non-Biologically-Based Mental Illness
- ✓ Vision therapy, vision or acuity training, orthoptics and pleoptics
- ✓ Vitamins and dietary supplements
- ✓ Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products
- ✓ Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness

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