

AmeriHealth HMO PLUS

HMO Plus \$20/\$40 \$300/Day Summary of Benefits



AmeriHealth HMO Plus lets you maintain Freedom of Choice by allowing you to select your own doctors and hospitals within the AmeriHealth Network. Under this plan, you must select a Primary Care Physician, but can access care within the AmeriHealth Network without a referral.

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	Coverage
Doctor's Office Visits	
Primary Care Services	\$20 Copayment
Specialist Services	\$40 Copayment
Pediatric Immunizations	100%*
Routine Eye Exam	\$40 Copayment (once every two years)
Routine Gynecological Exam/PAP (No referral required)	\$20 Copayment
Mammogram (No referral required)	100%
Outpatient Laboratory/Pathology	100%
Maternity	
First OB Visit	\$20 Copayment
Hospital	\$300/day up to 5 days**
Inpatient Hospital Services	\$300/day up to 5 days**
Inpatient Hospital Days	Unlimited
Outpatient Surgery	\$150 Copayment

* Office visits subject to copayment.

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



Benefit	Coverage
Emergency Room	\$100 Copayment (not waived if admitted)
Ambulance	100%
Outpatient X-Ray/Radiology	
Routine Radiology/Diagnostic	\$40 Copayment
MRI/MRA, CT, PET Scans	\$80 Copayment
Therapy Services	
Physical and Occupational 30 visits per calendar year	\$40 Copayment
Cardiac Rehabilitation 36 visits per calendar year	\$40 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	\$40 Copayment
Speech 20 visits per calendar year	\$40 Copayment
Orthoptic/Pleoptic 8 session lifetime maximum	\$40 Copayment
Spinal Manipulations 20 visits per calendar year	\$40 Copayment
Infusion / Chemotherapy / Radiation	100%
Dialysis	100%
Outpatient Private Duty Nursing 360 hours per calendar year	85%
Skilled Nursing Facility 120 days per calendar year	\$150/day up to 5 days**
Hospice and Home Health Care	100%
Durable Medical Equipment and Prosthetics	50%
Mental Health Care	
Outpatient 20 visits per calendar year	\$40 Copayment
Inpatient 30 days per calendar year	\$300/day up to 5 days**
Serious Mental Illness Care and Alcohol Abuse	
Outpatient	\$40 Copayment
Inpatient	\$300/day up to 5 days**

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

Benefit	Coverage
Substance Abuse Treatment	
Outpatient/Partial Facility Visits 30 visits per calendar year, 120 visit lifetime maximum	\$40 Copayment
Rehabilitation 30 days per calendar year	\$300/day up to 5 days**
Detoxification 7 days per admission	\$300/day up to 5 days**
Annual Out-of-Pocket Maximum***	
Individual	\$5,000
Family	\$10,000

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

*** Annual out-of-pocket (OOP) maximum per person/per family; copayments and coinsurance apply to OOP maximum.

What Is Not Covered?

- Services not medically necessary
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Expenses related to organ donation for non-member recipients
- Dental care, including dental implants or dentures, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Treatment of obesity, except for surgical treatment of morbid obesity and weight loss programs provided through AmeriHealth Healthy LifestylesSM programs
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Cranial prostheses including wigs intended to replace hair
- Services or supplies which are experimental or investigative except routine costs associated with clinical trials
- Reversal of voluntary sterilization
- Acupuncture
- Music therapy, equestrian therapy and hippotherapy
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Immunizations for travel or employment
- Cosmetic services/supplies
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose

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 1-800-877-9829.

Services That Require Preapproval

INPATIENT SERVICES

Surgical and non-surgical inpatient admissions
Acute Rehabilitation
Skilled Nursing Facility
Inpatient Hospice
Maternity Admission (for notification only)

OUTPATIENT FACILITY/OFFICE SERVICES

(other than inpatient)

Infusion Therapy (except Cancer Chemotherapy, Whole Blood, Blood Plasma) in outpatient facility and office
PET Scans, MRI, MRA, CT and Nuclear Cardiology
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
Uvulopalatopharyngoplasty (including laser-assisted)

ALL HOME CARE SERVICES

(including Infusion Therapy in the home)

BIRTHING CENTER (for notification only)

ELECTIVE (non-emergency) AMBULANCE TRANSPORT

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS - PURCHASE ITEMS OVER \$100, INCLUDING REPAIRS AND REPLACEMENTS

DURABLE MEDICAL EQUIPMENT - PURCHASE ITEMS OVER \$100, 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
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/ALCOHOL ABUSE

Outpatient Mental Health/ Substance Abuse Treatment (Not Alcohol Abuse)
Inpatient Mental Health/ Inpatient Substance Abuse Treatment
Inpatient Serious Mental Illness/ Inpatient Alcohol Abuse

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.

Here's how the program works!

When you purchase covered prescription drugs at a participating pharmacy, you pay...

Listed on the Select Drug Program Formulary

Not Listed on the Select Drug Program Formulary

GENERIC

\$7 Copayment

\$50 Non-Formulary Copayment

BRAND NAME

\$35 Copayment

\$50 Non-Formulary Copayment

You receive coverage for medically appropriate prescription drugs*, including oral contraceptives, under this additional benefit when the drugs are prescribed by a licensed, practicing physician.

Your Select Drug Program uses a formulary, which is a defined list of selected drugs that have been evaluated for their medical effectiveness, positive results and value.

You may receive up to a 90-day supply** of covered medication at a retail pharmacy as follows:

- At participating retail pharmacies, you will pay the following applicable generic formulary, brand name formulary, or non-formulary copayments:
 - 1-30 day supply for one copayment
 - 31-60 day supply for two copayments
 - 61-90 day supply for three copayments
- Non-participating retail pharmacy purchases will be reimbursed at 50% of the drug's retail cost for the total amount dispensed. For emergency claims, you will be responsible for the applicable copayment indicated above.

In addition, covered medications for chronic conditions (such as blood pressure medications) may be provided through our convenient mail order service allowing you to order up to a 90-day supply. You will pay two times the generic or brand name copayment for a formulary drug or two times the non-formulary copayment for covered non-formulary drugs. This benefit can save you time and money.

To qualify as a covered benefit and ensure that the drug prescribed is medically appropriate, certain drugs require prior authorization. As a member, your physician can initiate prior authorization for these medications if they are medically appropriate.

As a member, you may visit any participating pharmacy to fill your prescription needs. The Select Drug Program gives you access to the Caremark network which currently includes approximately 98% of retail pharmacies locally and 95% of retail pharmacies nationwide.

* This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations and exclusions, refer to your benefit booklet or group contract. Examples of some items not covered include: All injectable medications (except those listed on the formulary); weight control drugs; experimental drugs; drugs and supplies that can be purchased over the counter; drugs used for cosmetic purposes (e.g. anabolic steroids and minoxidil lotion, Retin-A for aging skin); and nicotine gum or patches for smoking cessation.

** Certain Prescription Drugs may be subject to quantity level limits.