Medical Benefit Highlights

Drexel University PHO AH-PA Point-of-Service

Covered Services	Your Costs (You pay)		
Benefits per Calendar Year	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Deductible (Embedded)[1] Individual/Family	$0/$0		$500/$1,500
Out-of-Pocket Maximum (Embedded)[2] Individual/Family	$1,500/$3,000	$2,000/$4,000	$3,000/$9,000
Coinsurance	0%	0%	30%
Total Maximum Out-of-Pocket (Embedded)[2] Individual/Family	$2,000/$4,000	$2,000/$4,000	$3,000/$9,000

Preventive Services	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Preventive Care	No charge	No charge	30% no deductible
Preventive Colonoscopy			
Preventive Plus Providers	No charge	No charge	Not covered
Hospital Based	No charge	No charge	30% no deductible

Physician Services	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Primary Care Physician (PCP)			
Office Visit	No charge	$20	30% after deductible
Telemedicine Visit	No charge	$20	30% after deductible
Specialist			
Office Visit	$10	$40	30% after deductible
Telemedicine Visit	$10	$40	30% after deductible
Retail Health Clinic Visit	No charge	$20	30% after deductible
Urgent Care Visit	No charge	$35	30% after deductible

Virtual Care[3]	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Telemedicine	No charge	No charge	Not covered
Teledermatology	No charge	No charge	Not covered
Telebehavioral Health	No charge	No charge	Not covered

Therapy Services	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Physical Therapy (Referred: 30 visits/year; Self-Referred: 30 visits/year)[4]			
Freestanding	No charge	$20	30% after deductible
Hospital Based	No charge	$20	30% after deductible
Occupational Therapy (Referred: 30 visits/year; Self-Referred: 30 visits/year)[4]			
Freestanding	No charge	$20	30% after deductible
Hospital Based	No charge	$20	30% after deductible
Speech Therapy (Referred: 20 visits/year; Self-Referred: 20 visits/year)	No charge	$20	30% after deductible

Emergency Services	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Emergency Room (copay waived if admitted)	$100	$100	Covered at In-Network level
Emergency Ambulance	No charge	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	No charge	30% after deductible

AmeriHealth

Hospital Services	In-Network Tier 1	In-Network Tier 2	Self-Referred
Inpatient Hospital Services (Referred: 365 days/year; Self-Referred: 70 days/year)[5]	$240/Admission	$100/Day; max of 5 copays per admission	30% after deductible
Observation Services	$100	$100	30% after deductible
Maternity Hospital Services[5]	$240/Admission	$100/Day; max of 5 copays per admission	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	No charge	30% after deductible

Outpatient Surgery	In-Network Tier 1	In-Network Tier 2	Self-Referred
Freestanding	No charge	$50	30% after deductible
Hospital Based	No charge	$50	30% after deductible
Outpatient Professional Services	No charge	No charge	30% after deductible

Outpatient Diagnostics	In-Network Tier 1	In-Network Tier 2	Self-Referred
Diagnostic Medical (EKG)	No charge	$20	30% after deductible
Routine Radiology (X-Ray)			
Freestanding	No charge	$20	30% after deductible
Hospital Based	No charge	$20	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)			
Freestanding	No charge	$80	30% after deductible
Hospital Based	No charge	$80	30% after deductible

Outpatient Lab and Pathology	In-Network Tier 1	In-Network Tier 2	Self-Referred
Freestanding	No charge	No charge	30% after deductible
Hospital Based	No charge	No charge	30% after deductible

Other Medical Services	In-Network Tier 1	In-Network Tier 2	Self-Referred
Spinal Manipulations (Referred: 20 visits/year; Self-Referred: 20 visits/year)	Not covered	$20	30% after deductible
Acupuncture (Referred: 18 visits/year; Self-Referred: 18 visits/year)	$10	$40	30% after deductible
Standard Injectables	No charge	$20	30% after deductible
Allergy Injections	No charge	$20	30% after deductible
Biotech/Specialty Injectables			
Home/Office	$100	$100	30% after deductible
Outpatient	$100	$100	30% after deductible
Chemotherapy	No charge	No charge	30% after deductible
Dialysis	No charge	No charge	30% after deductible
Skilled Nursing Facility (Referred: 120 days/year; Self-Referred: 60 days/year)	Not covered	$50/Day; max of 5 copays per admission	30% after deductible
Home Health	No charge	No charge	30% after deductible
Hospice	No charge	No charge	30% after deductible
Durable Medical Equipment (DME)	Not covered	30%	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)			
Office Visit	Not covered	$20	30% after deductible
All Other Services	Not covered	$20	30% after deductible
Mental Health – Inpatient (includes serious	Not covered	$100/Day; max of 5	30% after deductible

mental illness and substance abuse)[5]		copays per admission	

1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

3 Telemedicine is provided by a designated telemedicine provider, please visit **www.amerihealth.com/findcarenow**.

4 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.

5 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

AmeriHealth Point-of-Service lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your primary care physician (PCP). You have the freedom to self-refer your care either to an AmeriHealth participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply. This program may not cover all your health care services.
Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their AmeriHealth members. You can view the sites selected by your PCP at **www.amerihealth.com**.

This summary represents only a partial listing of benefits and exclusions of the Medical 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. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.amerihealth.com/LGBooklet** or call **1-800-275-2583** (TTY: 711).

Benefits may be changed by AmeriHealth to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to **http://www.amerihealth.com/preapproval** or call the phone number that is listed on the back of your identification card.

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