AmeriHealth

Drexel University

Coverage Period: Beginning on or after 01/01/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: FAMILY | **PlanType:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.amerihealthpa.com or by calling 1-800-275-2583.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Tenet preferred providers $0. For participating $0. For non-participating providers $500 person / $1,500 family. Deductible may not apply to all services. See your cost information starting on page 2 for specific details.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For Tenet preferred providers $1,500 person / $3,000 family. For participating providers $2,000 person / $4,000 family. For non-participating providers $3,000 person / $9,000 family.	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, out-of-network balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.amerihealth.com/find_a_provider/index.html** or call **1-800-275-2583** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-800-275-2583 or visit us at www.amerihealthpa.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.amerihealthpa.com or call **1-800-275-2583** to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	Yes. Electronic referral required.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		A Tenet Preferred Provider	an AmeriHealth Referred Provider	a Self-Referred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copayment	$20 copayment	30%, after deductible	----------none----------
	Specialist visit	$10 copayment	$40 copayment	30%, after deductible	PCP referral required.
	Other practitioner office visit	Provider is only available in the AHPA network.	$20 copayment; 20 visits per calendar year	30%, after deductible; 20 visits per calendar year	Spinal Manipulations. PCP Referral required.
	Preventive care / screening / immunization	Covered at No Charge	Covered at No Charge	30%, no deductible	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	$20 copayment(X-Ray)/ No Charge(Blood Work)	30%, after deductible	PCP referral required for x-rays. Requisition form required for lab work.

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		A Tenet Preferred Provider	an AmeriHealth Referred Provider	a Self-Referred Provider	
	Imaging (CT/PET scans, MRIs)	No Charge	$80 copayment	30%, after deductible	Precertification required. Imaging copay not applicable if performed in ER or office setting.
If you need drugs to treat your illness or condition	Generic drugs	$5 copayment retail; $10 copayment mail	$5 copayment retail; $10 copayment mail	$5 copayment retail; $10 copayment mail; contact Express Scripts when using a nonparticipating pharmacy	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order)
	Preferred brand drugs	$15 copayment retail; $30 copayment mail	$15 copayment retail; $30 copayment mail	$15 copayment retail; $30 copayment mail; contact Express Scripts when using a nonparticipating pharmacy	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order)
	Non-preferred brand drugs	$30 copayment retail; $60 copayment mail	$30 copayment retail; $60 copayment mail	$30 copayment retail; $60 copayment mail; contact Express Scripts when using a nonparticipating pharmacy	Prior authorization may be required. Covers up to a 30 day supply (retail) and a 90 day supply (mail order)
	Specialty drugs	$100 copayment (Specialty Drugs covered under Medical Plan)	$100 copayment (Specialty Drugs covered under Medical Plan)	30%, after deductible (Specialty Drugs covered under Medical Plan)	Specialty Drugs covered under Medical Plan. Prior-authorization required. A complete list of drugs requiring prior-authorization is available at www.amerihealth.com/preapproval

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		A Tenet Preferred Provider	an AmeriHealth Referred Provider	a Self-Referred Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	$50 copayment	30%, after deductible	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.amerihealth.com/preapproval
	Physician/surgeon fees	No Charge	No Charge	30%, after deductible	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.amerihealth.com/preapproval
If you need immediate medical attention	Emergency room services	$75 copayment	$75 copayment	No Deductible, after $75 copayment	Your costs for Emergency Room services are waived if you are admitted to the hospital.
	Emergency medical transportation	No Charge	No Charge	No Charge no deductible	Prior Authorization is required for any Non- Emergency transportation.
	Urgent care	Covered No Charge at St. Chris Pediatric Urgent Care	$35 copayment	30%, after deductible	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$240 copayment per admission (reimbursable by Drexel HR with	$100/ day; maximum of 5 copayments/ admission	30%, after deductible	Precertification required.

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		A Tenet Preferred Provider	an AmeriHealth Referred Provider	a Self-Referred Provider	
		receipt)			
	Physician/surgeon fee	No Charge	No Charge	30%, after deductible	Precertification required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Provider is only available in the AHPA network.	$40 copayment	30%, after deductible	----------none----------
	Mental/Behavioral health inpatient services	Provider is only available in the AHPA network.	$100/ day; maximum of 5 copayments/ admission	30%, after deductible	Precertification required.
	Substance abuse disorder outpatient services	Provider is only available in the AHPA network.	$40 copayment	30%, after deductible	Precertification required.
	Substance abuse disorder inpatient services	Provider is only available in the AHPA network.	$100/ day; maximum of 5 copayments/ admission	30%, after deductible	Precertification required.
If you are pregnant	Prenatal and postnatal care	$10 copayment	$20 copayment	30%, after deductible	Your cost is for first OB visit only.
	Delivery and all inpatient services	$240 copayment per admission (reimbursable by Drexel HR with receipt)	$100/ day; maximum of 5 copayments/ admission	30%, after deductible	Pre-notification requested
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	30%, after deductible	Precertification required.
	Rehabilitation services	No charge for Speech Providers. Speech Therapy: Up to 60 consecutive days per condition covered, subject to significant improvement. Physical/ Occupational Therapy: Providers only available in the AHPA Network.	Speech Therapy: $20 copayment; 20 visits per calendar year. Physical and Occupational: $20 copayment; 30 visits per calendar year.	Speech Therapy: 30%, after deductible; 20 visits per calendar year. Physical & Occupational: 30%, after deductible; 30 visits per calendar year.	Speech/Physical/Occupational: Up to 60 consecutive days per condition covered, subject to significant improvement. PCP referral required for referred services.

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		A Tenet Preferred Provider	an AmeriHealth Referred Provider	a Self-Referred Provider	
	Habilitation services	No charge for Speech Providers. Speech Therapy: Up to 60 consecutive days per condition covered, subject to significant improvement. Physical/ Occupational Therapy: Providers only available in the AHPA Network.	Speech Therapy: $20 copayment; 20 visits per calendar year. Physical and Occupational: $20 copayment; 30 visits per calendar year.	Speech Therapy: 30%, after deductible; 20 visits per calendar year. Physical & Occupational: 30%, after deductible; 30 visits per calendar year.	PCP Referral required for referred services.
	Skilled nursing care	Provider is only available in the AHPA network.	$50/ day; maximum of 5 copayments/ admission 120 days per calendar year	30%, after deductible; 60 days per calendar year	Precertification required.
	Durable medical equipment	Provider is only available in the AHPA network.	Covered 30%	50%, after deductible	Precertification required for purchases (including repairs and replacements) over $500 and all rentals
	Hospice service	No Charge	No Charge	30%, after deductible	Precertification required.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	Please refer to the coverage available under the vision plan.
	Glasses	Not Covered	Not Covered	Not Covered	Please refer to the coverage available under the vision plan.
	Dental check-up	Not Covered	Not Covered	Not Covered	Please refer to the coverage available under the dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing aids
- Non-emergency care when traveling outside the U.S. (For details, see www.amerihealth.com)
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Long-term care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Routine eye care (Adult)
- Chiropractic care
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-492-2385.You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

Your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements. If you are dissatisfied with a denial of coverage for claims under your plan, you may contact AmeriHealth PA at 1-866-681-7373. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. As an alternative, the Pennsylvania Department of Insurance can also provide assistance. Please contact them at 1-877-881-6388.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays** $7,140
- **Patient Pays** $400

Sample Care Costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays

Deductibles	$0
Copays	$250
Coinsurance	$0
Limits or exclusions	$150
Total	**$400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays** $3,430
- **Patient Pays** $1,970

Sample Care Costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$1,950
Total	**$1,970**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles** and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts(HRAs) that help you pay out-of-pocket expenses.