AmeriHealth PPO

Individual Summary of Benefits
IHC $30/$50/90%

AmeriHealth NEW JERSEY

Benefit	Network	Non network[1]
Individual deductible	$2,500	$5,000
Family deductible (must be satisfied by at least two separate covered persons)	$5,000	$10,000
After deductible plan pays	90%	70%
Out-of-pocket maximum Individual/Family	$5,000/$10,000[2]	$10,000/$20,000[3]
Lifetime maximum	Unlimited	Unlimited
Physician visit	$30 copay	70%, subject to deductible
Specialist visit	$50 copay	70%, subject to deductible
Preventive Care: (exam, related tests and x-rays, immunizations, pap smears, mammography and screening tests)	Covered 100% to maximum benefit of $750 per covered person per calendar-year from birth until 1st birthday. $500 calendar-year maximum for all others.[4]	Covered 100% to maximum benefit of $750 per covered person per calendar-year from birth until 1st birthday. $500 calendar-year maximum for all others.[4]
Outpatient Diagnostic/Routine radiology	90%, subject to deductible	70%, subject to deductible
MRI/MRA, CT, PET scans	90%, subject to deductible	70%, subject to deductible
Laboratory	100%, no deductible (when provided by a network lab)	70%, subject to deductible
Maternity	$30 copay for first OB visit, covered 100% after	70%, subject to deductible
Maternity - hospital	90%, subject to deductible	70%, subject to deductible
Hospital inpatient	90%, subject to deductible	70%, subject to deductible
Emergency room (copay waived if admitted)	$100 copay	$100 copay
Outpatient surgery	90%, subject to deductible	70%, subject to deductible
Spinal manipulation 30 visits per calendar year[4]	$50 copay	70%, subject to deductible

1 Non network providers may bill you for differences between the plan allowance, which is the amount paid by AmeriHealth, and the provider's actual charge. This amount may be significant. It is important to note that all percentages for non network services are a percentage of the plan allowance, not the provider's actual charge.

2 Network out-of-pocket maximum includes deductible, coinsurance, and copayments, when applicable.

3 Non network out-of-pocket maximum includes deductible, coinsurance and copayments.

4 Combined network/non network

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.

AmeriHealth NEW JERSEY
AmeriHealth Insurance Company of New Jersey
www.amerihealth.com

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Benefit	Network	Non network[1]
Physical occupational, speech, and cognitive therapy 30 visits per therapy, per calendar year[4]	$50 copay	70%, subject to deductible
Inpatient extended care or rehab center[5] Combined 120 days per calendar year[4]	90%, subject to deductible	70%, subject to deductible
Home health care[5]	90%, subject to deductible	70%, subject to deductible
Hospice care[5]	90%, subject to deductible	70%, subject to deductible
Non-biologically based mental illness and drug abuse services		
Inpatient Combined 30 days per calendar year[4]	90%, subject to deductible	70%, subject to deductible
Outpatient Combined 20 visits per calendar year[4]	$50 copay	70%, subject to deductible
Alcohol abuse[5]		
Inpatient	90%, subject to deductible	70%, subject to deductible
Outpatient	$50 copay	70%, subject to deductible
Biologically based mental illness		
Inpatient	90%, subject to deductible	70%, subject to deductible
Outpatient	$50 copay	70%, subject to deductible
Durable medical equipment[5]	90%, subject to deductible	70%, subject to deductible
Blood	90%, subject to deductible	70%, subject to deductible
Ambulance	100%, no deductible	70%, subject to deductible
Prescription drugs	50%, no deductible	50%, no deductible

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4 Combined network/non network

5 Subject to preapproval

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.

Services and benefits not covered
AmeriHealth IHC PPO

AmeriHealth NEW JERSEY

As with all health insurance plans, AmeriHealth coverage excludes certain services. Those not covered by AmeriHealth include, but are not limited to, the following:

- services or supplies furnished in connection with any procedures to enhance fertility;
- completion of claim forms;
- cosmetic surgery, except as stated in this policy; complications of cosmetic surgery; drugs prescribed for cosmetic purposes;
- services related to custodial care or domiciliary care;
- dental care or treatment, including appliances and dental implants, except otherwise stated in the policy;
- dose-intensive chemotherapy, except as otherwise stated in this policy;
- experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this policy;
- extraction of teeth, except for bony impacted teeth;
- services and supplies, unless stated in this policy for exams to determine the need or change of eyeglasses, eyeglass lenses of any type, except initial replacements for the loss of a lens; or eye surgery for lasik surgery, myopia, hyperopia, or astigmatism;
- services or supplies related to hearing aids and hearing exams to determine the need for the hearing aids or the need to adjust them, except as stated in the newborn hearing screening provision;
- marriage, career or financial counseling, sex therapy or family therapy, except as otherwise stated in the policy;
- private-duty nursing, except as provided for under home health care;
- self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training;
- sterilization reversal;
- surgery, sex hormones, and related medical, psychological and psychiatric services to change your sex; services and supplies arising from complications of sex transformation;
- transplants, unless otherwise listed in this policy;
- services or supplies which are not medically necessary and appropriate except as otherwise stated in this policy.

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