AmeriHealth HMO

HMO $20/$40 $0/Day SEH Summary of Benefits

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 benefit description material 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	100%
Inpatient Hospital Services	100%
Inpatient Hospital Days	Unlimited
Outpatient Surgery	100%
Emergency Room	$100 Copayment (not waived if admitted)

* Office visits subject to copayment.

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Benefit	Coverage
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 (combined)	$40 Copayment
Cardiac Rehabilitation 36 visits per calendar year	$40 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	$40 Copayment
Speech and Cognitive 30 visits per calendar year (combined)	$40 Copayment
Orthoptic/Pleoptic 8 session lifetime maximum	$40 Copayment
Therapeutic Manipulations **20 visits per calendar year**	$40 Copayment
Infusion Therapy / Chemotherapy / Radiation Therapy	100%
Dialysis	100%
Extended Care Center **120 days per calendar year**	100%
Hospice and Home Health Care	100%
Durable Medical Equipment and Prosthetics	50%
Non-Biologically Based Mental Illness & Substance Abuse	
Outpatient 20 visits per calendar year	$40 Copayment
Inpatient 30 days per calendar year 90 days per lifetime (substance abuse only)	100%
Biologically-Based Mental Illness & Alcohol Abuse	
Outpatient	$40 Copayment
Inpatient	100%

What Is Not Covered?

- Any charge identified as a Non-Covered Charge, specifically limited or which are not Medically Necessary and Appropriate
- Services or supplies related to hearing aids, including cochlear electromagnetic hearing devices and hearing exams, except as stated in the Newborn Hearing Screening provision
- Care or treatment by means of acupuncture except when used as a substitute for other forms of anesthesia
- Maintenance of chronic conditions
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention or as a result of complications associated with diabetes
- Benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law
- Extraction of teeth, except for bony impacted teeth
- Services or supplies which are not billed by a participating Provider
- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices
- Services or supplies rendered for reversal of sterilization
- Dental care or treatment, including but not limited to appliances and dental implants
- Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products
- Services or supplies related to routine, palliative or cosmetic foot care
- Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness or intended to replace hair
- Immunizations for employment or travel
- Services,supplies or operations related to Cosmetic Surgery including complications of Cosmetic Surgery and drugs prescribed for cosmetic purposes
- Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm

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/benefit description material 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
- Extended Care Center
- 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 Cardiac Studies
- 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

BIOLOGICALLY-BASED MENTAL ILLNESS/NON-BIOLOGICALLY BASED MENTAL ILLNESS/SUBSTANCE ABUSE/ALCOHOL ABUSE

- Network Outpatient Non-Biologically based Mental Illness Treatement/Substance Abuse Treatment (NOT Alcohol Abuse)
- Inpatient Non-Biologically based Mental Illness Treatment/ Inpatient Substance Abuse Treatment
- Inpatient Biologically-based Mental Illness Treatment/Inpatient Alcohol Abuse Treatment

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 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
- 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.

Select Drug Program®

SEH $7/$35/$50 with Oral Contraceptives

AmeriHealth NEW JERSEY

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.

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05/05 - NJ - SEH HMO/POS Select RX $7/$35/$50 with Oral Contraceptives
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