AmeriHealth HMO Plus

HMO Plus $30/$50 $400/Day SEH Summary of Benefits

AmeriHealth NEW JERSEY

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 (e.g. 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	$30 Copayment
Specialist Services	$50 Copayment
Pediatric Immunizations	100%*
Routine Eye Exam	$50 Copayment (once every two years)
Routine Gynecological Exam/PAP	$30 Copayment
Mammogram	100%
Outpatient Laboratory/Pathology	100%
Maternity	
First OB Visit	$30 Copayment
Hospital	$400 Copayment/day; maximum of 5 days ($2,000)**
Inpatient Hospital Services	$400 Copayment/day; maximum of 5 days ($2,000)**

* **Office visits subject to copayment.**

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

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Benefit	Coverage
Inpatient Hospital Days	Unlimited
Outpatient Surgery	$200 Copayment (facility)
Emergency Room	$100 Copayment (not waived if admitted)
Ambulance	100%
Outpatient X-Ray/Radiology	
Routine Radiology/Diagnostic	$50 Copayment
MRI/MRA, CT, PET Scans	$100 Copayment
Therapy Services	
Physical and Occupational 30 visits per calendar year (combined)	$50 Copayment
Cardiac Rehabilitation 36 visits per calendar year	$50 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	$50 Copayment
Speech and Cognitive 30 visits per calendar year (combined)	$50 Copayment
Orthoptic/Pleoptic 8 session lifetime maximum	$50 Copayment
Therapeutic Manipulations 20 visits per calendar year	$50 Copayment
Infusion Therapy / Chemotherapy / Radiation Therapy	100%
Dialysis	100%
Extended Care Center 120 days per calendar year	$200 Copayment/day; maximum of 5 days ($1,000)**
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	$50 Copayment
Inpatient 30 days per calendar year; 90 days per lifetime (Substance Abuse only)	$400 Copayment/day; maximum of 5 days ($2,000)**

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

Benefit	Coverage
Biologically-Based Mental Illness & Alcohol Abuse	
Outpatient	$50 Copayment
Inpatient	$400 Copayment/day; maximum of 5 days ($2,000)**

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

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

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)

- 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)

Infusion Therapy Drugs in an Outpatient Facility or in a Professional Provider's Office-(See list included in your Open Enrollment packet)

BIRTHING CENTER (for notification only)

ELECTIVE (non-emergency) AMBULANCE TRANSPORT

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS - PURCHASE ITEMS OVER $500, INCLUDING REPAIRS AND REPLACEMENTS
(Except Ostomy Supplies)

DURABLE MEDICAL EQUIPMENT - PURCHASE ITEMS OVER $500 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 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.**

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.

Standard Prescription Drug Program

SEH $7/50%

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Here's how the program works!

When you purchase covered prescription drugs, you pay...

At A Participating Pharmacy (for a 30 day supply)	
GENERIC	$7 copayment
BRAND	50% coinsurance, up to $125 per fill*

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.

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 copayments:
  - 1-30 day supply for: Generic - $7; Brand - 50% coinsurance*
  - 31-60 day supply for Generic: $14; Brand - 50% coinsurance*
  - 61-90 day supply for Generic: $21; Brand - 50% coinsurance*

Nonparticipating retail pharmacy purchases will be reimbursed at 75% of the drug's retail cost for the total amount dispensed.

In addition, a mailorder service is available allowing you to order up to a 90-day supply of covered maintenance medications for only two generic copayments or 50% brand coinsurance*. Maintenance medications are prescribed for long-term treatment of a chronic health condition, i.e. arthritis, diabetes, heart disorders, high blood pressure, etc. 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 Standard Drug Program gives you access to more than 60,000 retail pharmacies nationwide through the FutureScripts® network.

* **Subject to $125 maximum out-of-pocket per prescription fill for a 1-30 day supply; $250 maximum out-of-pocket per prescription fill for a 31-90 day supply.**

** **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's booklet or group contract. Examples of some items not covered are: 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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02/09 - NJ - HMO-POS Standard SEH Rx $7/50%
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