AmeriHealth HMO

HMO $30/$50 $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 (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*
Out-of-Pocket Limit	
Individual	None
Family	None
Doctor's Office Visits	
Primary Care Services	$30 Copayment
Specialist Services	$50 Copayment
Preventive Care for Adults and Children	100%
Pediatric Immunizations	100%*
Routine Eye Exam	$50 Copayment (once every two years)
Routine Gynecological Exam/PAP (No referral required)	100%
Mammogram (No referral required)	100%
Outpatient Laboratory/Pathology	100%

* **Office visits subject to copayment.**

The benefits may be changed by Amerihealth to comply with applicable federal/state laws and regulations.

AmeriHealth NEW JERSEY

AmeriHealth HMO, Inc.

AmeriHealth HMO benefits are underwritten or administered by AmeriHealth HMO, Inc.

www.amerihealth.com

Benefit	*Coverage*
Maternity	
First OB Visit	$30 Copayment
Hospital	100%
Inpatient Hospital Services	100%
Inpatient Hospital Days	Unlimited
Outpatient Surgery	100%
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	100%
Hospice and Home Health Care	100%

The benefits may be changed by Amerihealth to comply with applicable federal/state laws and regulations.

Benefit	Coverage
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)	100%
Biologically-Based Mental Illness & Alcohol Abuse	
Outpatient	$50 Copayment
Inpatient	100%
Benefit Period[+]	Calendar Year

+ **A calendar year benefit period begins on January 1 and ends on December 31.**

The benefits may be changed by Amerihealth to comply with applicable federal/state laws and regulations.

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

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.**
- **Out of Pocket maximum includes payments, coinsurance and deductible where applicable.**

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.