AmeriHealth HMO

Individual Health Summary of Benefits - IHC Basic

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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 Member Handbook 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.

BENEFITS AND SERVICES*	Coverage
Benefit Period+	Calendar year
Primary Care Physician Office Visits	$30 copay per visit
Preventive Care for Adults and Children: (exam, related test and xrays, immunizations, pap smears, mammography, and screening tests)	100%
Specialist Office Visits	$30 copay per visit
Outpatient X-Ray and Laboratory Services	100%
Well-Child Care including immunizations	100%
Prenatal Care/Maternity - delivery & newborn care covered; prenatal (with exception of 1st three visits) & post natal care not covered	See hospital services inpatient 1st three prenatal visits covered as specialist office visits
Outpatient Surgery & Ambulatory Surgery	
Facility	$250 copay per surgery then 100%
Hospital Services Inpatient	$500 copay per confinement then covered at 100%; maximum 90 days per calendar year
Emergency Room	$100 copay per visit
Non Biologically -Based Mental Illness:	Not Covered
Alcohol and Substance Abuse	
Outpatient	Plan pays 70%; 30 visits per calendar year
Inpatient	70%; 30 days maximum per calendar year
Biologically Based Mental Illness:	
Outpatient	$50 copay per visit
Inpatient	$500 copay per confinement then covered at 100%; maximum 90 days per calendar year
Pre-admission Testing	100%
Rehabilitation Centers	Not Covered
Therapy Services Outpatient Physical Therapy	$20 copay per visit; 30 visits per calendar year
Outpatient Prescription Drug	Not Covered

*** 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.**

+ 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.

AmeriHealth NEW JERSEY

AmeriHealth HMO, Inc.

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

www.amerihealth.com

BENEFITS AND SERVICES*	Coverage
Lifetime Maximum	Unlimited

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

Services and Benefits Not Covered

- Ambulance
- Any service provided without prior written Referral by the Members Primary Care Physician except in case of emergency.
- Any service or supply not specifically included in the Covered Services and Supplies section of the contract.
- Chemotherapy
- Cosmetic Surgery, except as stated in the Contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes
- Conditions related to behavior problems or learning disabilities
- Dental care or treatment, including appliances and dental implants
- Drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood
- Durable Medical Equipment
- Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract
- Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Contract; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy or lasik surgery
- Food and food products
- Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them
- Home health care
- Hospice care
- Infusion therapy
- Marriage, career or financial counseling, sex therapy or family therapy
- Nutritional counseling and related services
- Pregnancy charges for pre- and post-natal care with the exception of the first three pre-natal visits
- Prescription Drugs obtained while not confined in a Hospital
- Private Duty Nursing
- Routine Foot Care
- Services not Medically Necessary and Appropriate, except as otherwise stated in the Contract
- Skilled Nursing Facility charges
- Skilled nursing care charges
- Sterilization reversal
- Surgery, sex hormones, and related medical and psychiatric services to change your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders
- Temporomandibular Joint Disorder (TMJ) Treatment
- Therapeutic Manipulation, except that Inpatient hydrotherapy, as defined under Therapeutic Manipulation, is covered under Therapy Services
- Therapy services, except as specifically covered under the Contract
- Transplants, except to the extent a service or supply associated with a transplant is specifically covered under the Contract
- Treatment of a Non-Biologically-Based Mental Illness
- Vision therapy, vision or acuity training, orthoptics and pleoptics
- Vitamins and dietary supplements
- Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products
- Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness

This summary represents only a partial listing of the benefits and exclusions of the HMO 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 contract carefully to determine which health care services are covered. If you need more information please call 1-800-877-9829.

AmeriHealth
NEW JERSEY

PRE-EXISTING CONDITION LIMITATION

This limitation may apply to your policy if you are not transferring from another health insurance plan with a gap of less than 31 days between plans.

Should this limitation be applied, for the first 12 months following the effective date of coverage, we will not pay for:

- conditions for which medical advice, diagnosis, care or treatment was recommended or received during the six months before enrollment;
- conditions for which during the last six months there were symptoms that would cause a prudent person to seek medical advice, care, or treatment;
- pregnancy existing on the effective date of your policy.

For further information, please contact Customer Service at 1-800-275-2583.