# AmeriHealth HMO

## AmeriHealth Coinsurance Option 3 Summary of Benefits

AmeriHealth NEW JERSEY

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 Evidence of Coverage 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 | Benefits and Services | Coverage |
|---|---|---|
| **Deductible** | Individual | $1,500 |
| | Family | $3,000 |
| **Out of Pocket Limit** | Individual | $3,000 |
| | Family | $6,000 |
| **Doctor Visits** | Office visits to your primary care physician | $30 Copayment |
| | Home visits by your primary care physician | $50 Copayment |
| | Non-routine after-hours visits to your primary care physician | $50 Copayment |
| | Office visits to referred specialists | $50 Copayment |
| **Preventive Health Services** | Periodic health assessment | $30 Copayment |
| | Immunizations (except for travel or employment) | Covered 100%** |
| | Routine gynecological care (no referral required) | $30 Copayment |
| | Mammography (no referral required) | Covered 100%, NO Deductible |
| | Well-baby/Well-child care | $30 Copayment |

** Office visits subject to copay

AmeriHealth NEW JERSEY

AmeriHealth HMO, Inc.

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

**www.amerihealth.com**

| Benefit | Benefits and Services | Coverage |
|---|---|---|
| **Maternity** | Obstetrical care (including pre- and postnatal care) | Covered with a $30 copayment for first visit. Subsequent visits to your OB/GYN covered 70%. |
| | Newborn care (both doctor and hospital) | Covered 70% |
| **Hospital Services*** | Unlimited inpatient stay | Covered 70% |
| | Surgery | Covered 70% |
| | Anesthesia | Covered 70% |
| | Drugs and medication | Covered 70% |
| | Inpatient doctor care | Covered 70% |
| | General nursing care | Covered 70% |
| | Administration of blood | Covered 70% |
| | Organ transplantation, non-experimental | Covered 70% |
| **Emergency Care** | Treatment in hospital emergency room | Covered with a $100 copayment, which is waived if you are admitted to the hospital |
| **Specialized Services** | Diagnostic and Laboratory | Covered 70% |
| | Routine Radiology/Diagnostic Services | $50 Copayment |
| | MRI/MRA, CT, PET Scan*** | $100 Copayment |
| | Physical and Occupational Therapies | $50 Copayment. Up to 30 visits per calendar year combined |
| | Speech Therapy | $50 Copayment up to 20 visits per calendar year |
| | Spinal Manipulation | $50 Copayment. Up to 20 visits per calendar year |
| | Cardiac Rehabilitation Therapy | $50 Copayment up to 36 sessions per calendar year |
| | Pulmonary Rehabilitation Therapy | $50 Copayment up to 36 sessions per calendar year |
| | Orthoptic/Pleoptic Therapy (8 sessions/lifetime combined) | $50 Copayment |
| | Chemotherapy | Covered 70% |
| | Radiation Therapy | Covered 70% |
| | Vision Care, including screening, eye exams and refractions | $50 copayment; once every two calendar years |
| | Hearing Screening | Covered 70%** |

* Pre-authorization required. Pre-authorization 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 pre-authorization 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.

** Office visits subject to copay

*** MRI, MRA, PET, CT and Nuclear Cardiology require pre-authorization

| Benefit | Benefits and Services | Coverage |
|---|---|---|
| **Specialized Services (Continued)** | Skilled nursing facility services* | Covered 70% (up to 120 days per calendar year) |
| | Outpatient Surgery* | Covered 70% |
| | Durable Medical Equipment* | All purchases and rentals (including repairs and replacements) are covered 70% when authorized by your Primary Care Physician[1] |
| | Prosthetics* | All purchases (including repairs and replacements) are covered 70% when authorized by your Primary Care Physician[1] |
| | Home Health Care* | Covered 70% |
| | Hospice* | Covered 70% |
| | Dialysis* | Covered 70% |
| | Non-Biologically Based Mental Illness | $50 copayment per outpatient visit, up to 20 outpatient visits per calendar year. 35 inpatient days per calendar year covered 70%* |
| | Biologically Based Mental Illness/ Alcohol Abuse | Outpatient visits covered with a $50 copayment per visit. Inpatient days covered 70%* |
| | Drug Abuse/ Dependency Treatment | $50 copayment per outpatient visit, up to 60 outpatient visits per calendar year. 30 inpatient days per calendar year covered 70%* (lifetime limit of 120 outpatient visits) |
| | Detoxification | $50 copayment per outpatient visit/session. Inpatient covered 70%*. Outpatient Detox and inpatient treatment limited to seven (7) days/visits/sessions per episode. |
| | Ambulance | Covered 70% |
| | Lifetime Maximum | Unlimited |

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1 Purchases over $500 and all rentals require pre-authorization.

## Services and Benefits Not Covered

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

- Services not medically necessary
- Services not provided or referred by your primary care physician, except in emergencies
- Experimental and investigational services or items
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- The cost of services for which another party has primary responsibility
- Long-term rehabilitative therapy (e.g. maintenance of chronic conditions)
- Non-medical, rehabilitative services for the treatment of substance abuse in an acute care hospital
- Hearing aids
- Radial keratotomy
- Custodial or domiciliary care
- Weight loss programs, except when provided through AmeriHealth Healthy Lifestyles[SM] programs
- Personal or comfort items not medically necessary, such as air conditioners, humidifiers, telephones or similar items
- Reversal of voluntary sterilization
- Transsexual surgery
- Cosmetic surgery, except for those services which are performed to restore bodily function or correct deformity resulting from disease, recent trauma or previous therapeutic process
- Immunization for travel or employment
- Prescription drugs and medications, except as required by law or by additional rider
- Treatment for temporomandibular joint syndrome (TMJ)
- Care of the feet, unless medically necessary
- Services required by a member who is an organ donor
- Dental care including, but not limited to, orthognathic surgery, unless as a result of an accident

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