AmeriHealth PPO

PPO HDHP $2,000/90% Summary of Benefits

AmeriHealth PPO, our popular Preferred Provider Organization, gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing care through AmeriHealth PPO's expansive network of hospitals, doctors and specialists. Of course, with AmeriHealth PPO, you have the freedom to select providers who do not participate in the AmeriHealth PPO network. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

With AmeriHealth PPO...

- You do not need to enroll with a primary care physician
- You never need a referral

Benefit	In-Network	Out-of-Network[1]
BENEFIT PERIOD[+]	Calendar Year[+]	Calendar Year[+]
DEDUCTIBLE		
Single	$2,000	$5,000
Family	$4,000	$10,000
AFTER DEDUCTIBLE, PLAN PAYS	90%	60%
OUT-OF-POCKET MAXIMUM[2]		
Single	$5,000	$10,000
Family	$10,000	$20,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	90%, after deductible	60%, after deductible
Specialist Services	90%, after deductible	60%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, NO deductible	60%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%, NO deductible	60%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age[4]	100%, NO deductible	60%, NO deductible
MAMMOGRAM	100%, NO deductible	60%, NO deductible

1 Out-of-network providers may bill you for differences between the Plan allowance, which is the amount paid by AmeriHealth, and the provider's actual charge. This amount may be significant. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

2 Includes deductible, coinsurance and copayments, when applicable.

4 Combined in/out-of-network

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

AmeriHealth®

AmeriHealth Insurance Company of New Jersey

www.amerihealth.com

04/11 - NJ - 51+ NJ PPO 51+ HDHP w/o integ Rx $2,000/90% In Area
10916

Benefit	In-Network	Out-of-Network[1]
OUTPATIENT LABORATORY/PATHOLOGY	90%, after deductible	60%, after deductible
MATERNITY		
First OB visit	90%, after deductible	60%, after deductible
Hospital	90%, after deductible	60%, after deductible
INPATIENT HOSPITAL SERVICES	90%, after deductible	60%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70
OUTPATIENT SURGERY	90%, after deductible	60%, after deductible
EMERGENCY ROOM	90%, after deductible	Covered at in-network level
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	90%, after deductible	60%, after deductible
MRI/MRA/CT/PET Scans	90%, after deductible	60%, after deductible
THERAPY SERVICES		
Physical and Occupational 30 visits per calendar year[4]	90%, after deductible	60%, after deductible
Cardiac Rehabilitation 36 visits per calendar year[4]	90%, after deductible	60%, after deductible
Pulmonary Rehabilitation 36 visits per calendar year[4]	90%, after deductible	60%, after deductible
Speech 20 visits per calendar year[4]	90%, after deductible	60%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum[4]	90%, after deductible	60%, after deductible
SPINAL MANIPULATIONS 20 visits per calendar year[4]	90%, after deductible	60%, after deductible
CHEMO/RADIATION/DIALYSIS THERAPY	90%, after deductible	60%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per calendar year[4]	90%, after deductible	60%, after deductible
SKILLED NURSING FACILITY 120 days per calendar year[4]	90%, after deductible	60%, after deductible
HOSPICE AND HOME HEALTH CARE	90%, after deductible	60%, after deductible
DURABLE MEDICAL EQUIPMENT	90%, after deductible	60%, after deductible
PROSTHETICS	90%, after deductible	60%, after deductible

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4 Combined in/out-of-network

Benefit	In-Network	Out-of-Network[1]
MENTAL ILLNESS CARE (OTHER THAN FOR SERIOUS MENTAL ILLNESS)		
Outpatient	90%, after deductible	60%, after deductible
Inpatient	90%, after deductible	60%, after deductible (up to 20 days per calendar year)
OUTPATIENT PSYCHIATRIC 20 visits per calendar year[4]	90%, after deductible	60%, after deductible
SERIOUS MENTAL ILLNESS CARE/TREATMENT FOR ALCOHOL ABUSE TREATMENT		
Outpatient	90%, after deductible	60%, after deductible
Inpatient	90%, after deductible	60%, after deductible
TREATMENT FOR DRUG ABUSE AND DEPENDENCY		
Outpatient	90%, after deductible	60%, after deductible
Inpatient	90%, after deductible	60%, after deductible

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4 Combined in/out-of-network

What Is Not Covered?

- Services not medically necessary
- Services or supplies which are experimental or investigative except routine costs associated with clinical trials
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Alternative Therapies/complementary medicine
- Dental care, including dental implants or dentures, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy and hippotherapy
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Service or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Vision care

This summary represents only a partial listing of the benefits and exclusions of the AmeriHealth PPO 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. As a result, this managed care plan may not cover all of your health care expenses. Read your benefit booklet carefully for a complete listing of the terms, limitations and exclusions of the program. If you need more information, please call 1-800-422-2457.

Services That Require Precertification

INPATIENT SERVICES

- Surgical and non-surgical inpatient admissions
- Acute Rehabilitation
- Skilled Nursing Facility
- Inpatient Hospice
- Maternity Admission (for notification only)

OUTPATIENT FACILITY/OFFICE SERVICES
(other than inpatient)

- CT Scan, PET Scan 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 administered 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 - Purchase items (including repairs and replacements) over $500 (excluding ostomy supplies)

DURABLE MEDICAL EQUIPMENT - Purchase items (including repairs and replacements) over $500, 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 ILLNESS/SERIOUS MENTAL ILLNESS/ALCOHOL AND DRUG ABUSE

- Mental Illness/Serious Mental Illness/Alcohol and Drug Abuse (Inpatient) Mental Illness and Drug Abuse (Outpatient/Partial hospitalization)-In-Network Only

AmeriHealth PPO network providers will obtain precertification for you if it is required. You are not required to obtain precertification when treated in an AmeriHealth PPO network hospital or facility or by an AmeriHealth PPO network physician. Members are not responsible for financial penalties because an AmeriHealth PPO network provider does not obtain precertification.

If the provider is an out-of-network provider, you must obtain precertification if required. You may be subject to a 20% reduction in benefits if precertification is not obtained.

In addition to the precertification requirements listed above, you should contact AmeriHealth and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. This applies to network providers and members who elect to receive treatment provided by out-of-network providers. The categories of treatment (in any setting) include:

- Any surgical procedure that may be considered potentially cosmetic; and
- Any procedure, treatment, drug or device that represents new or emerging technology; and
- Services that might be considered experimental/investigative.

Precertification 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 precertification 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.