AmeriHealth New Jersey PPO

PPO HDHP $1,350/100%

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	$1,350	$3,000
Family	$2,700	$6,000
AFTER DEDUCTIBLE, PLAN PAYS	100%	60%
OUT-OF-POCKET MAXIMUM *(includes deductible, coinsurance and copayments, when applicable)*		
Single	$1,500	$15,000
Family	$3,000	$30,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	100%, after deductible	60%, after deductible
Specialist Services	100%, 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*[2]	100%, NO deductible	60%, NO deductible
MAMMOGRAM	100%, NO deductible	60%, NO deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, after deductible	60%, after deductible
MATERNITY		
First OB visit	100%, NO deductible	60%, after deductible
Hospital	100%, after deductible	60%, after 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 Combined in/out-of-network

\+ 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 Insurance Company of New Jersey

amerihealthnj.com

Benefit	In-Network	Out-of-Network[1]
INPATIENT HOSPITAL SERVICES		
Facility	100%, after deductible	60%, after deductible
Physician/Surgeon	100%, after deductible	60%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70
OUTPATIENT SURGERY		
Facility	100%, after deductible	60%, after deductible
Physician/Surgeon	100%, after deductible	60%, after deductible
EMERGENCY ROOM SERVICES	100%, after deductible	Covered at in-network level
URGENT CARE	100%, after deductible	60%, after deductible
AMBULANCE		
Emergency	100%, after deductible	60%, after deductible
Non-emergency	100%, after deductible	60%, after deductible
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	100%, after deductible	60%, after deductible
MRI/MRA/CT/PET Scans	100%, after deductible	60%, after deductible
THERAPY SERVICES		
Physical and Occupational 30 visits per calendar year[2]	100%, after deductible	60%, after deductible
Cardiac Rehabilitation 36 visits per calendar year[2]	100%, after deductible	60%, after deductible
Pulmonary Rehabilitation 36 visits per calendar year[2]	100%, after deductible	60%, after deductible
Speech 20 visits per calendar year[2]	100%, after deductible	60%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum[2]	100%, after deductible	60%, after deductible
SPINAL MANIPULATIONS *20 visits per calendar year*[2]	100%, after deductible	60%, after deductible
CHEMO/RADIATION/DIALYSIS THERAPY	100%, after deductible	60%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per calendar year*[2]	100%, after deductible	60%, after deductible
SKILLED NURSING FACILITY *120 days per calendar year*[2]	100%, after deductible	60%, after deductible
HOSPICE AND HOME HEALTH CARE	100%, after deductible	60%, after deductible
DURABLE MEDICAL EQUIPMENT	100%, after deductible	60%, after deductible
PROSTHETICS	100%, after deductible	60%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%, after deductible	60%, after deductible
MENTAL ILLNESS CARE		
Outpatient	100%, after deductible	60%, after deductible
Inpatient	100%, after deductible	60%, after deductible

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2 Combined in/out-of-network

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

Benefit	In-Network	Out-of-Network[1]
TREATMENT FOR SUBSTANCE ABUSE		
Outpatient	100%, after deductible	60%, after deductible
Inpatient	100%, after deductible	60%, after deductible
PRESCRIPTION DRUG[3]	$10 generic formulary copayment/$40 brand formulary copayment/$60 non-formulary copayment, after deductible.	60%, after deductible

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3 In addition, covered medications for chronic conditions (such as blood pressure medications) may be provided through our convenient mail order service allowing you to order up to a 90-day supply. You will pay two times the generic or brand copayment for a formulary drug or two times the non-formulary brand copayment for covered non-formulary drugs. This benefit can save you time and money. (Excludes Out-of-Network Mail Orders).

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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 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
- Foot orthotics, except for orthotic appliances or as 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
- Treatment of obesity, except for surgical treatment of morbid obesity and weight loss programs provided through AmeriHealth Commit2Wellness℠ programs

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 **1-888-YOUR-AH1(1-888-968-7241)**.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to **http://www.amerihealthnj.com/precert** or call the phone number that is listed on the back of your identification card.