

Individual Health Coverage (IHC)

PPO monthly rates



Effective October 1, 2011, through September 30, 2012

Please note that rates for these plans are subject to change effective October 1, 2012, regardless of plan effective date. Your application is subject to verification, and you may be subject to an exclusion for preexisting conditions. Preexisting conditions exclusion may apply for 12 months if the state/federal guidelines for continuous prior coverage are not met.*

IHC \$25/\$50/70%

Age	Single	Parent & Child/Children	Couple (rate based on the age of the older adult)	Family (rate based on the age of the older adult)
0-24	\$293.29	\$747.82	\$586.58	\$1,041.11
25-29	\$331.45	\$785.97	\$662.90	\$1,117.42
30-34	\$396.11	\$850.63	\$792.22	\$1,246.74
35-39	\$429.05	\$883.58	\$858.10	\$1,312.63
40-44	\$445.14	\$899.67	\$890.28	\$1,344.81
45-49	\$466.94	\$921.46	\$933.88	\$1,388.40
50-54	\$533.42	\$987.95	\$1,066.84	\$1,521.37
55-59	\$616.05	\$1,070.57	\$1,232.10	\$1,686.62
60-64	\$736.38	\$1,190.90	\$1,472.76	\$1,927.28
65-69	\$736.38	\$1,190.90	\$1,472.76	\$1,927.28
70+	\$736.38	\$1,190.90	\$1,472.76	\$1,927.28

IHC \$30/\$50/90%

Age	Single	Parent & Child/Children	Couple (rate based on the age of the older adult)	Family (rate based on the age of the older adult)
0-24	\$358.02	\$912.46	\$716.04	\$1,270.48
25-29	\$404.58	\$959.03	\$809.16	\$1,363.61
30-34	\$483.50	\$1,037.94	\$967.00	\$1,521.44
35-39	\$523.74	\$1,078.19	\$1,047.48	\$1,601.93
40-44	\$543.47	\$1,097.81	\$1,086.74	\$1,641.18
45-49	\$569.97	\$1,124.42	\$1,139.94	\$1,694.39
50-54	\$651.12	\$1,205.57	\$1,302.24	\$1,856.69
55-59	\$751.96	\$1,306.41	\$1,503.92	\$2,058.37
60-64	\$898.86	\$1,453.31	\$1,797.72	\$2,352.17
65-69	\$898.86	\$1,453.31	\$1,797.72	\$2,352.17
70+	\$898.86	\$1,453.31	\$1,797.72	\$2,352.17

How to determine the age for IHC rates:

- For new policies, age is calculated based on the subscriber's age as of the last day of the month preceding the effective date of the policy.
- For the "Couple" and the "Family" tiers, the rate is based on the age of the older adult.
- Under most circumstances, changes from one age band to another for affected policyholders will take place on October 1 (or on October 15 for policies originally effective on the 15th of a month). In this case, the age is calculated based on the subscriber's age as of September 30.

*Under health care reform, children under 19 cannot be denied coverage because of a preexisting condition for policy years beginning on or after September 23, 2010.

Individual Health Coverage (IHC)

HMO monthly rates



Effective March 1, 2012, through February 28, 2013. Please note that rates for these plans are subject to change effective March 1, 2013, regardless of plan effective date. Your application is subject to verification, and you may be subject to an exclusion for preexisting conditions. Preexisting conditions exclusion may apply for 12 months if the state/federal guidelines for continuous prior coverage are not met.*

IHC basic plan rates

Age	Single		Parent and Child/ Children		Couple (rate based on the age of the older adult)			Family (rate based on the age of the older adult)		
	Male	Female	Male parent	Female parent	Male/ Female	Male/ Male	Female/ Female	Male/ Female	Male/ Male	Female/ Female
0-24	\$202	\$366	\$645	\$809	\$568	\$404	\$732	\$1,011	\$847	\$1,175
25-29	\$202	\$441	\$645	\$883	\$643	\$404	\$882	\$1,086	\$847	\$1,324
30-34	\$221	\$415	\$664	\$858	\$636	\$442	\$830	\$1,079	\$885	\$1,273
35-39	\$261	\$383	\$703	\$826	\$644	\$522	\$766	\$1,086	\$964	\$1,209
40-44	\$293	\$399	\$735	\$842	\$692	\$586	\$798	\$1,134	\$1,028	\$1,241
45-49	\$346	\$417	\$788	\$860	\$763	\$692	\$834	\$1,205	\$1,134	\$1,277
50-54	\$478	\$476	\$921	\$919	\$954	\$956	\$952	\$1,397	\$1,399	\$1,395
55-59	\$659	\$617	\$1,102	\$1,059	\$1,276	\$1,318	\$1,234	\$1,719	\$1,761	\$1,676
60-64	\$707	\$704	\$1,150	\$1,147	\$1,411	\$1,414	\$1,408	\$1,854	\$1,857	\$1,851
65-69	\$707	\$707	\$1,150	\$1,150	\$1,414	\$1,414	\$1,414	\$1,857	\$1,857	\$1,857
70+	\$707	\$707	\$1,150	\$1,150	\$1,414	\$1,414	\$1,414	\$1,857	\$1,857	\$1,857

IHC preferred plan rates

Age	Single		Parent and Child/ Children		Couple (rate based on the age of the older adult)			Family (rate based on the age of the older adult)		
	Male	Female	Male parent	Female parent	Male/ Female	Male/ Male	Female/ Female	Male/ Female	Male/ Male	Female/ Female
0-24	\$300	\$549	\$960	\$1,207	\$849	\$600	\$1,098	\$1,509	\$1,260	\$1,756
25-29	\$315	\$658	\$973	\$1,317	\$973	\$630	\$1,316	\$1,631	\$1,288	\$1,975
30-34	\$332	\$618	\$991	\$1,277	\$950	\$664	\$1,236	\$1,609	\$1,323	\$1,895
35-39	\$389	\$573	\$1,048	\$1,232	\$962	\$778	\$1,146	\$1,621	\$1,437	\$1,805
40-44	\$435	\$596	\$1,095	\$1,256	\$1,031	\$870	\$1,192	\$1,691	\$1,530	\$1,852
45-49	\$516	\$623	\$1,174	\$1,282	\$1,139	\$1,032	\$1,246	\$1,797	\$1,690	\$1,905
50-54	\$713	\$709	\$1,373	\$1,368	\$1,422	\$1,426	\$1,418	\$2,082	\$2,086	\$2,077
55-59	\$986	\$919	\$1,644	\$1,577	\$1,905	\$1,972	\$1,838	\$2,563	\$2,630	\$2,496
60-64	\$1,053	\$1,053	\$1,712	\$1,711	\$2,106	\$2,106	\$2,106	\$2,765	\$2,765	\$2,764
65-69	\$1,053	\$1,053	\$1,712	\$1,712	\$2,106	\$2,106	\$2,106	\$2,765	\$2,765	\$2,765
70+	\$1,053	\$1,053	\$1,712	\$1,712	\$2,106	\$2,106	\$2,106	\$2,765	\$2,765	\$2,765

IHC standard plan rates

Benefit Plan	Single	Parent and Child/ Children	Couple	Family
IHC 50	\$810	\$1,474	\$1,620	\$2,284
IHC 30/50	\$921	\$1,676	\$1,842	\$2,597
IHC 30	\$969	\$1,764	\$1,938	\$2,733
IHC 15	\$1,637	\$2,979	\$3,274	\$4,616

How to determine the age for IHC rates:

- For new policies, age is calculated based on the subscriber's age as of the last day of the month preceding the effective date of the policy.
- For the "Couple" and the "Family" tiers, the rate is based on the age of the older adult.
- Under most circumstances, changes from one age band to another for affected policyholders will take place on March 1 (or on March 15 for policies originally effective on the 15th of a month). In this case, the age is calculated based on the subscriber's age as of February 28.

*Under health care reform, children under 19 may not be denied coverage because of a preexisting condition for policy years beginning on or after September 23, 2010.

AmeriHealth PPO

Individual Summary of Benefits

IHC \$30/\$50/90%

Benefit	Network	Non network ¹
Benefit Period ⁺	Calendar year	Calendar year
Individual deductible (applies to single member policies only)	\$2,500	\$5,000
Family deductible (must be satisfied by at least two separate covered persons)	\$5,000	\$10,000
After deductible plan pays	90%	70%
Out-of-pocket maximum ²	\$5,000/\$10,000	\$10,000/\$20,000
Individual/Family		
Out-of-pocket maximum ²		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Lifetime maximum	Unlimited	Unlimited
Physician visit	\$30 copay	70%, subject to deductible
Specialist visit	\$50 copay	70%, subject to deductible
Preventive Care: (exam, related tests and x-rays, immunizations, pap smears, mammography and screening tests)	Covered 100% No deductible	Covered 100% to maximum benefit of \$500 per covered person per calendar year; \$750 for newborns until first birthday
Outpatient Diagnostic/Routine radiology	90%, subject to deductible	70%, subject to deductible
MRI/MRA, CT, PET scans	90%, subject to deductible	70%, subject to deductible
Laboratory	100%, no deductible (when provided by a network lab)	70%, subject to deductible
Maternity	\$30 copay for first OB visit, covered 100% after	70%, subject to deductible
Maternity - hospital	90%, subject to deductible	70%, subject to deductible
Hospital inpatient	90%, subject to deductible	70%, subject to deductible
Emergency room (copay waived if admitted)	\$100 copay	\$100 copay
Outpatient surgery	90%, subject to deductible	70%, subject to deductible
Spinal manipulation 30 visits per calendar year ³	\$50 copay	70%, subject to deductible
Physical occupational, speech, and cognitive therapy 30 visits per therapy, per calendar year ³	\$50 copay	70%, subject to deductible
Inpatient extended care or rehab center ⁴ Combined 120 days per calendar year ³	90%, subject to deductible	70%, subject to deductible

1 Non 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 non network services are a percentage of the plan allowance, not the provider's actual charge.

2 Out-of-pocket maximum includes deductible, coinsurance, and copayments, when applicable.

3 Combined network/non network

4 Subject to preapproval

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

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



AmeriHealth Insurance Company of New Jersey
www.amerihhealth.com

Benefit	Network	Non network¹
Home health care⁴	90%, subject to deductible	70%, subject to deductible
Hospice care⁴	90%, subject to deductible	70%, subject to deductible
Non-biologically based mental illness and drug abuse services		
Inpatient Combined 30 days per calendar year ³	90%, subject to deductible	70%, subject to deductible
Outpatient Combined 20 visits per calendar year ³	\$50 copay	70%, subject to deductible
Alcohol abuse⁴		
Inpatient	90%, subject to deductible	70%, subject to deductible
Outpatient	\$50 copay	70%, subject to deductible
Biologically based mental illness		
Inpatient	90%, subject to deductible	70%, subject to deductible
Outpatient	\$50 copay	70%, subject to deductible
Durable medical equipment⁴	90%, subject to deductible	70%, subject to deductible
Blood	90%, subject to deductible	70%, subject to deductible
Ambulance	100%, no deductible	70%, subject to deductible
Prescription drugs	50%, no deductible	50%, no deductible

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AmeriHealth PPO

Individual Summary of Benefits

IHC \$25/\$50/70%

Benefit	Network	Non network ¹
Benefit Period⁺	Calendar year	Calendar year
Individual deductible (applies to single member policies only)	\$2,500	\$7,500
Family deductible (must be satisfied by at least two separate covered persons)	\$5,000	\$15,000
After deductible plan pays	70%	50%
Out-of-pocket maximum²		
Individual	\$5,000	\$15,000
Family	\$10,000	\$30,000
Lifetime maximum	Unlimited	Unlimited
Physician visit	\$25 copay	50%, subject to deductible
Specialist visit	\$50 copay	50%, subject to deductible
Preventive Care: (exam, related tests and x-rays, immunizations, pap smears, mammography and screening tests)	Covered 100%, No deductible	Covered 100% to maximum benefit of \$500 per covered person per calendar year; \$750 for newborns until first birthday
Outpatient Diagnostic/Routine radiology	70%, subject to deductible	50%, subject to deductible
MRI/MRA, CT, PET scans	70%, subject to deductible	50%, subject to deductible
Laboratory	100%, no deductible (when provided by a network lab)	50%, subject to deductible
Maternity	\$25 copay first OB visit, Covered 100% after	50%, subject to deductible
Maternity - hospital	70%, subject to deductible	50%, subject to deductible
Hospital inpatient	70%, subject to deductible	50%, subject to deductible
Emergency room (copay waived if admitted)	\$100 copay	\$100 copay
Outpatient surgery	70%, subject to deductible	50%, subject to deductible
Spinal manipulation 30 visits per calendar year ³	\$50 copay	50%, subject to deductible
Physical occupational, speech, and cognitive therapy 30 visits per therapy, per calendar year ³	\$50 copay	50%, subject to deductible
Inpatient extended care or rehab center⁴ Combined 120 days per calendar year ³	70%, subject to deductible	50%, subject to deductible
Home health care⁴	70%, subject to deductible	50%, subject to deductible

1 Non 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 non network services are a percentage of the plan allowance, not the provider's actual charge.

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AmeriHealth Insurance Company of New Jersey
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Benefit	Network	Non network¹
Hospice care⁴	70%, subject to deductible	50%, subject to deductible
Non-biologically based mental illness and drug abuse services		
Inpatient Combined 30 days per calendar year ³	70%, subject to deductible	50%, subject to deductible
Outpatient Combined 20 visits per calendar year ³	\$50 copay	50%, subject to deductible
Alcohol abuse⁴		
Inpatient	70%, subject to deductible	50%, subject to deductible
Outpatient	\$50 copay	50%, subject to deductible
Biologically based mental illness		
Inpatient	70%, subject to deductible	50%, subject to deductible
Outpatient	\$50 copay	50%, subject to deductible
Durable medical equipment⁴	70%, subject to deductible	50%, subject to deductible
Blood	70%, subject to deductible	50%, subject to deductible
Ambulance	100%, no deductible	50%, subject to deductible
Prescription drug	50%, no deductible	50%, no deductible

1 Non 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 non network services are a percentage of the plan allowance, not the provider's actual charge.

3 Combined network/non network

4 Subject to preapproval

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

AmeriHealth HMO

Individual Health Summary of Benefits - IHC Basic

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, plan pays maximum of \$700 per calendar year
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 (not waived if admitted)
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	70%, 30 visits per calendar year
Inpatient	\$500 copay per confinement; maximum 90 days per calendar year
Pre-admission Testing	100%
Rehabilitation Centers	Not Covered
Therapy Services	\$20 copay per visit; 30 visits per calendar year
Outpatient Physical Therapy	

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

www.amerhealth.com

BENEFITS AND SERVICES*	Coverage
Outpatient Prescription Drug	Not Covered
Lifetime Maximum	Unlimited

* 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. 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
- Epidural injections
- 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
- Sleep Studies
- 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 HMO

Individual Health Summary of Benefits - IHC Preferred

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
Preventative 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	\$50 copay for the initial visit; subsequent visits covered in full
Outpatient Surgery and Ambulatory Surgery	
Facility	\$250 copay per surgery then 100%
Hospital Services Inpatient	\$500 copay per confinement then covered at 100%
Emergency Room	\$100 copay per visit (not waived if admitted)
Non Biologically -Based Mental Illness:	Not Covered
Alcohol and Substance Abuse	
Outpatient	70%; maximum of 30 visits per calendar year
Inpatient	70%; 30 days maximum per calendar year
Biologically Based Mental Illness:	
Outpatient	Plan pays 70%; 30 visits per calendar year
Inpatient	\$500 copay per confinement

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

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BENEFITS AND SERVICES*	Coverage
Pre-admission Testing	100%
Rehabilitation Centers	\$500 copay, covered under inpatient admission only
Therapy Services Outpatient Physical Therapy	\$20 copay per visit; 30 visits per calendar year
Outpatient Prescription Drug	Plan pays 50%
Lifetime Maximum	Unlimited

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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
- Conditions related to behavior problems or learning disabilities
- Cosmetic Surgery, except as stated in the Contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes
- 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
- 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
- Marriage, career or financial counseling, sex therapy or family therapy
- Nutritional counseling and related services
- Private Duty Nursing
- Routine Foot Care
- Services not Medically Necessary and Appropriate, except as otherwise stated in the Contract
- 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
- Self injectables regardless of their intended use
- 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

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AmeriHealth HMO

Individual Health Summary of Benefits - IHC 30

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.

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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	\$30 copay per visit
Well-Child Care including immunizations	100%
Prenatal Care	\$25 copay for the initial visit; subsequent visits covered in full
Outpatient Surgery	
Facility	\$30 copay per visit
Practitioner	\$30 copay per visit
Hospital Services Outpatient	\$30 copay per visit
Hospital Services Inpatient	\$300 copay per day for maximum of 5 days per admission; \$3,000 maximum copay per calendar year
Emergency Room	\$100 copay per visit (credited toward inpatient admission if admission occurs within 24 hours of the emergency)
Non-Biologically Based Mental Illness and Substance Abuse (Combined):	
Outpatient	\$30 copay per visit; maximum of 20 visits per calendar year
Inpatient	\$300 copay per day for maximum of 5 days per admission; \$3,000 maximum copay per calendar year; maximum of 30 inpatient days per calendar year

* 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.

** One inpatient day may be exchanged for two outpatient visits, or partial hospital days after outpatient visits have been exhausted.

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

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BENEFITS AND SERVICES*	Coverage
Biologically Based Mental Illness:	
Outpatient	\$30 copay per visit
Inpatient	\$300 copay per day for a maximum of 5 days per admission; \$3,000 maximum copay per calendar year
Pre-admission Testing	\$30 copay per visit
Rehabilitation Centers	Subject to the Hospital Services Inpatient copayment above. The copayment does not apply if the admission is preceded by a hospital inpatient stay.
Therapy Services Speech, physical, occupational and cognitive therapies~(30 visits per therapy per calendar year)	\$30 copay per visit
Prescription Drug	50% coinsurance
Lifetime Maximum	Unlimited

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

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:

- Any service provided without prior written Referral by the Member's Primary Care Physician, except in emergencies.
- Any therapy not included in Our definition of Therapy Services.
- Artificial drugs and surgical procedures designed to enhance fertility, including but not limited to, in-vitro fertilization, or gamete-intro-fallopian-transfer (GIFT), and surrogate motherhood.
- Completion of forms.
- Conditions related to behavior problems or learning disabilities except as otherwise stated in the contract.
- Cosmetic Surgery, except as stated in the Contract; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.
- Custodial Care or domiciliary care.
- Dental care or treatment, including appliances.
- Dose Intensive Chemotherapy, except as otherwise stated in the Contract.
- Experimental or Investigational treatments, procedures hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the Contract.
- Extraction of teeth, including bony impacted teeth.
- 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 the Contract; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.
- Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.
- Marriage, career or financial counseling, sex therapy or family therapy.
- Private-Duty Nursing, except as provided for under Home Health Care.
- Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.
- Special medical reports not directly related to treatment of the Member (e.g. employment physicals, reports prepared in connection with litigation).
- 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.
- Transplants, unless otherwise specifically covered, and non-human organ transplants.
- Services or supplies which are not medically necessary and appropriate except as otherwise stated in the contract.

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/member handbook carefully to determine which health care services are covered. If you need more information please call 1-800-877-9829.