Medical Benefit Highlights

SEH Select Silver EPO AmeriHealth Advantage LV $30/$60

AmeriHealth Advantage is a two-tiered Exclusive Provider Organization (EPO) plan which provides members with two levels of cost sharing. With the first tier, members who receive services from AmeriHealth Advantage facilities and professional providers have the lowest out-of-pocket costs. Members can also use Value Network facilities and professional providers in the second tier and experience higher out-of-pocket costs. The AmeriHealth Advantage EPO allows members to choose their own doctors and hospitals from our participating provider network. Services are also received without referrals from a PCP. The AmeriHealth Advantage EPO does not have out-of-network benefits; therefore members must use network providers in order to access their benefits.

With AmeriHealth New Jersey EPO...

- You are required to select a primary care physician
- You never need a referral

Covered Services	Your Costs (You pay)		
Benefits per Calendar Year	**Tier 1**	**Tier 2**	**Out-of-Network**
Deductible[1] (Embedded)[2] Individual/Family	$2,500/$5,000		Not covered
Out-of-Pocket Maximum[3] (Embedded)[4] Individual/Family	$9,100/$18,200		Not covered
Coinsurance	20%	50%	Not covered
Preventive Services	**Tier 1**	**Tier 2**	**Out-of-Network**
Preventive Care	No charge no deductible	No charge no deductible	Not covered
Physician Services	**Tier 1**	**Tier 2**	**Out-of-Network**
Primary Care Physician (PCP)			
Office Visit	$30 no deductible	50% after deductible	Not covered
Telemedicine Visit	$30 no deductible	50% after deductible	Not covered
Specialist			
Office Visit	$60 no deductible	50% after deductible	Not covered
Telemedicine Visit	$60 no deductible	50% after deductible	Not covered
Retail Health Clinic Visit	$30 no deductible	50% after deductible	Not covered
Telemedicine (through MDLive®)[5]	No charge no deductible	No charge no deductible	Not covered
Urgent Care Visit	$75 after deductible	$75 after deductible	Covered at In-Network Tier 2 level
Therapy Services	**Tier 1**	**Tier 2**	**Out-of-Network**
Physical Therapy (30 visits/year)[6]	$60 no deductible	$60 no deductible	Not covered
Occupational Therapy (30 visits/year)[6]	$60 no deductible	$60 no deductible	Not covered
Speech Therapy (30 visits/year)[7]	$60 no deductible	$60 no deductible	Not covered
Cognitive Therapy (30 visits/year)[7]	$60 no deductible	$60 no deductible	Not covered

Emergency Services	Tier 1	Tier 2	Out-of-Network
Emergency Room	20% after deductible	50% after deductible	Covered at In-Network Tier 2 level
Emergency Ambulance	50% after deductible	50% after deductible	Covered at In-Network Tier 2 level
Non-Emergency Ambulance	50% after deductible	50% after deductible	Not covered

Hospital Services	Tier 1	Tier 2	Out-of-Network
Inpatient Hospital Services	20% after deductible	50% after deductible	Not covered
Maternity Hospital Services	20% after deductible	50% after deductible	Not covered
Inpatient Professional Services (includes Maternity)	20% after deductible	50% after deductible	Not covered

Outpatient Surgery	Tier 1	Tier 2	Out-of-Network
Freestanding	20% after deductible	50% after deductible	Not covered
Hospital Based	20% after deductible	50% after deductible	Not covered
Outpatient Professional Services	20% after deductible	50% after deductible	Not covered

Outpatient Diagnostics	Tier 1	Tier 2	Out-of-Network
Diagnostic Medical (EKG)	50% after deductible	50% after deductible	Not covered
Routine Radiology (X-Ray)			
Freestanding	50% after deductible	50% after deductible	Not covered
Hospital Based	50% after deductible	50% after deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)			
Freestanding	50% after deductible	50% after deductible	Not covered
Hospital Based	50% after deductible	50% after deductible	Not covered

Outpatient Lab and Pathology	Tier 1	Tier 2	Out-of-Network
Outpatient Lab and Pathology	No charge no deductible	No charge no deductible	Not covered

Other Medical Services	Tier 1	Tier 2	Out-of-Network
Spinal Manipulations (30 visits/year)	$40 no deductible	$40 no deductible	Not covered
Standard Injectables	$60 no deductible	50% after deductible	Not covered
Allergy Injections	$60 no deductible	50% after deductible	Not covered
Biotech/Specialty Injectables	$60 no deductible	50% after deductible	Not covered
Chemotherapy	50% after deductible	50% after deductible	Not covered
Dialysis	50% after deductible	50% after deductible	Not covered
Skilled Nursing Facility	20% after deductible	20% after deductible	Not covered
Home Health (60 visits/year)	50% after deductible	50% after deductible	Not covered
Hospice	50% after deductible	50% after deductible	Not covered
Private Duty Nursing	50% after deductible	50% after deductible	Not covered

Durable Medical Equipment (DME)	50% after deductible	50% after deductible	Not covered
Mental Health – Outpatient (includes substance abuse)			
Office Visit	$60 no deductible	$60 no deductible	Not covered
Telemedicine Visit	$60 no deductible	$60 no deductible	Not covered
Mental Health – Inpatient (includes substance abuse)	20% after deductible	20% after deductible	Not covered
Nutritional Counseling[8]	$60 no deductible	50% after deductible	Not covered

1 Deductible is combined for all tiers.

2 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

3 Out-of-pocket maximum is combined for all tiers.

4 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

5 Services include Teledermatology and Telebehavioral Health.

6 Physical Therapy and Occupational Therapy combined visit limit.

7 Speech Therapy and Cognitive Therapy combined visit limit.

8 Cost share may vary depending on place of service or network status of provider.

This summary represents only a partial listing of benefits and exclusions of the Medical 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 contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.amerihealthnj.com/SGBooklet** or call **1-888-YOUR-AH1** (TTY: 711).

Benefits may be changed by AmeriHealth New Jersey to comply with applicable federal/state laws and regulations.

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.

Drug Benefit Highlights

'SEH Select Silver EPO AmeriHealth Advantage LV $30/$60

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible Individual Only	$250	Not covered
Out-of-Pocket Maximum	Combined with Medical	Not covered
Formulary[1]	Value	
Retail Pharmacy	**In-Network**	**Out-of-Network[2]**
Tier 1 Generic Drugs	$20 no deductible	Not covered
Tier 2 Preferred Brand	50% up to $125 after deductible	Not covered
Dispensing Limits	30 day supply max	Not covered
Mail Order Pharmacy **Available for maintenance drugs**	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$40 no deductible	Not covered
Tier 2 Preferred Brand Drugs	50% up to $250 after deductible	Not covered
Dispensing Limits[3]	90 day supply max	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs	Covered	Not covered
Compound Medications	Covered	Not covered
Contraceptives	Covered	Not covered
Diabetic Supplies (i.e., test strips)	Covered	Not covered
Glucometers	Covered	Not covered
Injectable Fertility Drugs	Covered	Not covered
Insulin	Covered	Not covered
Insulin Needles and Syringes	Covered	Not covered
Lancets	Covered	Not covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Not covered
Allergy Serum	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Investigational/Experimental Drugs	Not covered	Not covered
Non-Federal Legend Drugs	Not covered	Not covered
Over-The-Counter Drugs (Non-Prescription)	Not covered	Not covered
Weight Control Drugs	Not covered	Not covered

1 Benefits will be provided for Covered Drugs and medicines appearing on the Drug Formulary. To check the formulary status of a drug or view a copy of the most recent formulary, log onto **www.amerihealthnj.com**.

2 Non-participating retail pharmacy purchases are not covered except in an emergency or urgent care situation.

3 Mail order cost-sharing for 1-30 day supplies is equal to the in-network retail cost-sharing.

This summary represents only a partial listing of benefits and exclusions of the Prescription Drug 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 pharmacy policy. As a result, this program may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.amerihealthnj.com/SGBooklet** or call **1-888-YOUR-AH1** (TTY: 711).

Benefits may be changed by AmeriHealth New Jersey to comply with applicable federal/state laws and regulations.

Certain designated preventative medications will not be subject to any cost-sharing or deductibles, but will be subject to the terms and conditions of your benefits contract. Refer to your summary of benefits, member handbook, and/or benefit booklet to determine if your plan includes 100 percent coverage for in-network preventive services.

Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order are not covered. Devices or supplies except those specifically listed under covered drugs are not covered.

Vision Benefit Highlights

SEH Pediatric Vision Care

PEDIATRIC BENEFITS

Covered Services (Calendar Year)	Your Costs (You pay)	
Exam	**In-Network**	**Out-of-Network**
Routine Eye Exam at Davis Participating Providers (1 exam/year)	No charge	Not covered
Retinal Imaging	$39	Not covered
Lenses (1 pair/year)	**In-Network**	**Out-of-Network**
Single Vision Lenses	No charge	Not covered
Bifocal Lenses	No charge	Not covered
Trifocal Lenses	No charge	Not covered
Lenticular Lenses	No charge	Not covered
Lens Options	**In-Network**	**Out-of-Network**
Progressive Lenses - Standard/Premium/Ultra/ Ultimate	$50/$90/$140/$175	Not covered
Polycarbonate Lenses - Single/Multifocal[1]	No charge	Not covered
Digital/Intermediate Lenses	$30	Not covered
Photochromic Lenses - Single/Multifocal	No charge	Not covered
Photosensitive Lenses - Single/Multifocal	$65	Not covered
High-Index 1.67 / High-Index 1.74 Lenses	$55/$120	Not covered
Blue Light Lenses	$15	Not covered
Polarized Lenses	$75	Not covered
Lens Coatings		
Tinted Plastic Lenses	No charge	Not covered
UV-Coated Lenses	No charge	Not covered
Scratch-Resistant Lenses - Single/Multifocal	No charge	Not covered
Scratch-Protection Plan - Single/Multifocal	$20/$40	Not covered
Anti-Reflective Coating - Standard/Premium/ Ultra/Ultimate	$35/$48/$60/$85	Not covered
Frames (1 pair/year)	**In-Network**	**Out-of-Network**
Collection Fashion Frames	No charge	Not covered
Collection Designer Frames	No charge	Not covered
Collection Premier Frames	No charge	Not covered
Non-Collection Frames	Up to $150 Allowance	Not covered
Additional Visionworks Frames Option	Up to $150 Discount (plus a 20% discount on overage)[2]	Not covered

Contact Lenses (in lieu of glasses) (1 pair/ year)	In-Network	Out-of-Network
Collection Contact Lenses Evaluation, Fitting & Follow-Up Care	No charge	Not covered
Collection Contact Lenses	Disposable Boxes/ Multipacks: 4 per year Planned Replacement Boxes/ Multipacks: 2 per year	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Non-Collection Contact Lenses	Up to $150 Allowance	Not covered
Medically-Necessary Contact Lenses[3]	No charge	Not covered

1 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

2 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

3 Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.amerihealthnj.com/SGBooklet** or call **1-888-YOUR-AH1** (TTY: 711).

Benefits may be changed by AmeriHealth New Jersey to comply with applicable federal/state laws and regulations.

Administered by Davis Vision.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.