# AmeriHealth POS

*POS SEH Coinsurance Option 3 Summary of Benefits*

AmeriHealth Point-of-Service lets you maintain Freedom of Choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your Primary Care Physician. Of course, with AmeriHealth Point-of-Service, you have the freedom to self-refer your care to an AmeriHealth participating specialist or to specialists who do not participate in our network, however higher out-of-pocket costs apply.

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 benefit description material 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 | Network | Non-Network* |
|---|---|---|
| **BENEFIT PERIOD+** | Calendar Year | Calendar Year |
| **DEDUCTIBLE** | | |
| Individual | $1,000 | $2,000 |
| Family | $2,000 | $4,000 |
| **COINSURANCE** | 80% | 60% |
| **OUT OF POCKET LIMIT** (includes deductible, coinsurance and copayments when applicable) | | |
| Individual | $2,000 | $6,000 |
| Family | $4,000 | $12,000 |
| **LIFETIME MAXIMUM** | Unlimited | Unlimited |
| **DOCTOR'S OFFICE VISITS** | | |
| Primary Care Services | $30 Copayment/visit | 60%, after deductible |
| Specialist Services | $50 Copayment/visit | 60%, after deductible |
| **PREVENTIVE CARE SERVICES FOR ADULT AND CHILDREN** | 100%, NO deductible | 60%, NO deductible, Up to $750 per dependent child from birth to end of calendar year of age one. $500 per year for all other members. |

* Non-network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the providers actual charge.

\+ 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 Insurance Company of New Jersey

**www.amerihealth.com**

| Benefit | Network | Non-Network* |
| --- | --- | --- |
| **PEDIATRIC IMMUNIZATIONS** | 100%, NO deductible | 60%, NO deductible |
| **ROUTINE EYE EXAM** | $50 Copayment/visit; one exam every two years | Not Covered |
| **ROUTINE GYNECOLOGICAL EXAM/PAP** | 100%, NO deductible | 60%, NO deductible |
| **MAMMOGRAM** | 100%, NO deductible | 60%, NO deductible |
| **OUTPATIENT LABORATORY/PATHOLOGY** | 100% | 60%, after deductible |
| **MATERNITY** | | |
| First OB visit | $30 Copayment/visit, then 100% | 60%, after deductible |
| Hospital | 80%, after deductible | 60%, after deductible |
| **INPATIENT HOSPITAL SERVICES**[1] | 80%, after deductible | 60%, after deductible |
| **INPATIENT HOSPITAL DAYS** | Unlimited | Unlimited |
| **OUTPATIENT SURGERY**[1] | 80%, after deductible (facility) | 60%, after deductible |
| **EMERGENCY ROOM**<br>Copayment not waived if admitted | $100 Copayment | $100 Copayment |
| **AMBULANCE** | 80%, after deductible | 60%, after deductible |
| **OUTPATIENT X-RAY/RADIOLOGY** | | |
| Routine Radiology/Diagnostic | $50 Copayment/visit | 60%, after deductible |
| MRI/MRA, CT, PET Scans[1] | $100 Copayment/visit | 60%, after deductible |
| **THERAPY SERVICES** | | |
| Physical and Occupational Therapy<br>30 visits per calendar year (combined) | $50 Copayment/visit | 60%, after deductible |
| Cardiac Rehabilitation<br>36 sessions per calendar year | 80%, after deductible | 60%, after deductible |
| Pulmonary Rehabilitation<br>36 sessions per calendar year | 80%, after deductible | 60%, after deductible |
| Speech and Cognitive Therapy<br>30 visits per calendar year (combined) | $50 Copayment/visit | 60%, after deductible |
| Orthoptic/Pleoptic Therapy<br>8 session lifetime maximum | $50 Copayment/visit | 60%, after deductible |
| **THERAPEUTIC MANIPULATIONS**<br>30 visits per calendar year | $50 Copayment/visit | 60%, after deductible |

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1 Pre-authorization required

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| Benefit | Network | Non-Network* |
|---|---|---|
| **INFUSION THERAPY/CHEMOTHERAPY/RADIATION THERAPY** | 80%, after deductible | 60%, after deductible |
| **DIALYSIS** | 80%, after deductible | 60%, after deductible |
| **EXTENDED CARE CENTER**[1] maximum of 120 days/calendar year | 80%, after deductible | 60%, after deductible |
| **HOSPICE AND HOME HEALTH CARE**[1] | 80% | 60%, after deductible |
| **DURABLE MEDICAL EQUIPMENT**[1] | 50%, after deductible | 50%, after deductible |
| **PROSTHETICS**[1] | 50%, after deductible | 50%, after deductible |
| **SUBSTANCE ABUSE** | | |
| Outpatient | $50 Copayment/visit | 50%, after deductible |
| Inpatient[1] | 80%, after deductible | 60%, after deductible |
| **MENTAL HEALTH** | | |
| Outpatient | $50 Copayment/visit | 60%, after deductible |
| Inpatient[1] | 80%, after deductible | 60%, after deductible |

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## What Is Not Covered?

- Any charge identified as a Non-Covered Charge, specifically limited or which are not Medically Necessary and Appropriate
- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices
- Services or supplies related to hearing aids, including cochlear electromagnetic hearing devices and hearing exams, except as stated in the Newborn Hearing Screening and Hearing aids (Grace's Law) Provisions
- Services or supplies rendered for reversal of sterilization
- Care or treatment by means of acupuncture except when used as a substitute for other forms of anesthesia
- Dental care or treatment, including appliances and dental implants
- Maintenance of chronic conditions
- Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Routine foot care, except as otherwise stated in the group contract/booklet-certificate
- Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness
- Immunizations for employment or travel
- Benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law
- Services or supplies related to Cosmetic Surgery including complications of Cosmetic Surgery and drugs prescribed for cosmetic purposes
- Extraction of teeth, except for bony impacted teeth
- Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm
- Services or supplies that are not furnished by an eligible Provider

This summary represents only a partial listing of benefits and exclusions of the AmeriHealth POS program described in this summary. If your employer purchases another program, the benefits 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 group contract/benefit description material carefully to determine which health care services are covered. If you need more information, please call 1-800-877-9829.

## Services That Require Preapproval/Precertification

**INPATIENT SERVICES**

- Surgical and non-surgical inpatient admissions
- Acute Rehabilitation
- Extended Care Center
- Inpatient Hospice
- Maternity Admission (for notification only)

**OUTPATIENT FACILITY/OFFICE SERVICES**
(other than inpatient)

- Infusion Therapy except Cancer Chemotherapy, Whole Blood, Blood Plasma (outpatient facility and office)
- PET Scans, MRI, MRA, CT and Nuclear Cardiology
- 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)

**BIRTHING CENTER (for notification only)**

**ELECTIVE (non-emergency) AMBULANCE TRANSPORT**

**OUTPATIENT PRIVATE DUTY NURSING**

**PROSTHETICS AND ORTHOTICS - PURCHASE ITEMS OVER $100, INCLUDING REPAIRS AND REPLACEMENTS (Except Mandated Appliances)**

**DURABLE MEDICAL EQUIPMENT - PURCHASE ITEMS OVER $100, INCLUDING REPAIRS AND REPLACEMENTS, 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 HEALTH/SUBSTANCE ABUSE**

- Network Outpatient Mental Health Treatment/Substance Abuse Treatment
- Inpatient Mental Health Treatment/Inpatient Substance Abuse Treatment

**Your provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories. You are encouraged to have your provider place the call for you.**

**PENALTIES:**

**POS Network: It is the network provider's responsibility to obtain preapproval for services listed. Members are held harmless from financial penalties if the network provider does not obtain preapproval.**

**POS Non-Network: It is the member's responsibility to initiate precertification for the services listed. The member will be subject to a 50% reduction in benefits if precertification is not obtained for the inpatient/outpatient treatment services listed above.**