AmeriHealth POS Plus

POS Plus SEH Coinsurance Option 2 with National Access Summary of Benefits

AmeriHealth POS Plus lets you maintain Freedom of Choice by allowing you to select your own doctors and hospitals. Under this plan, it is not required that you select a Primary Care Physician, although it is highly recommended, and you can access care in-network of out-of-network without a referral.

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	$2,000	$5,000
Family	$4,000	$10,000
COINSURANCE	70%	50%
OUT OF POCKET LIMIT (includes deductibles, coinsurance and copayments, when applicable)		
Individual	$5,000	$10,000
Family	$10,000	$20,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$30 Copayment/visit	50% after deductible*
Specialist Services	$50 Copayment/visit	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100% NO deductible	50%, 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.
PEDIATRIC IMMUNIZATIONS	100% NO deductible	50%, NO deductible
ROUTINE EYE EXAM	$50 Copayment/visit; one exam every two years	Not Covered
ROUTINE GYNECOLOGICAL EXAM/PAP	100% NO deductible	50%, NO deductible

* **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 January 1 and ends 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
www.amerihealth.com

Benefit	Network	Non-Network*
MAMMOGRAM	100% NO deductible	50%, NO deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	50%, after deductible
MATERNITY		
First OB visit	$30 Copayment/visit	50%, after deductible
Hospital	70%, after deductible	50%, after deductible
INPATIENT HOSPITAL SERVICES[1]	70%, after deductible	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited
OUTPATIENT SURGERY[1]	70%, after deductible (facility)	50%, after deductible
EMERGENCY ROOM Copayment not waived if admitted	$100 Copayment	$100 Copayment
AMBULANCE	70%, after deductible	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	$50 Copayment/visit	50%, after deductible
MRI/MRA, CT, PET Scans[1]	$100 Copayment/visit	50%, after deductible
THERAPY SERVICES		
Physical and Occupational Therapy 30 visits per calendar year (combined)	$50 Copayment/visit	50%, after deductible
Cardiac Rehabilitation 36 sessions per calendar year	70%, after deductible	50%, after deductible
Pulmonary Rehabilitation 36 sessions per calendar year	70%, after deductible	50%, after deductible
Speech and Cognitive Therapy 30 visits per calendar year (combined)	$50 Copayment/visit	50%, after deductible
Orthoptic/Pleoptic Therapy 8 session lifetime maximum	$50 Copayment/visit	50%, after deductible
THERAPEUTIC MANIPULATIONS 30 visits per calendar year	$50 Copayment/visit	50%, after deductible
INFUSION THERAPY/CHEMOTHERAPY/RADIATION THERAPY	70%, after deductible	50%, after deductible
DIALYSIS	70%, after deductible	50%, after deductible
EXTENDED CARE FACILITY[1] maximum of 120 days/calendar year	70%, after deductible	50%, after deductible
HOSPICE AND HOME HEALTH CARE[1]	70%	50%, after deductible
DURABLE MEDICAL EQUIPMENT[1]	50%	50%, after deductible
PROSTHETICS[1]	50%	50%, after deductible

*** 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.**

1 Pre-authorization required

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

Benefit	Network	Non-Network*
SUBSTANCE ABUSE		
Outpatient	$50 Copayment/visit	50%, after deductible
Inpatient[1]	70%, after deductible	50%, after deductible
MENTAL HEALTH		
Outpatient	$50 Copayment/visit	50%, after deductible
Inpatient[1]	70%, after deductible	50%, after deductible

*** 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.**

1 Pre-authorization required

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

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 Plus 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 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 Plus 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 Plus 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.