AmeriHealth POS Plus

POS Plus Coinsurance $30/$50 80% 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, you must select a Primary Care Physician, but can access care in-network or out-of-network without a referral. You maximize your benefits when you access care from an AmeriHealth participating provider.

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 Booklet/Certificate 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	In-Network	Out-of-Network*
BENEFIT PERIOD+	Calendar Year	Calendar Year
DEDUCTIBLE		
Individual	$1,500	$3,000
Family	$3,000	$6,000
COINSURANCE	80%	60%
OUT OF POCKET LIMIT (includes deductible, coinsurance and copayments when applicable)		
Individual	$2,500	$6,000
Family	$5,000	$12,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$30 Copayment/visit	60%, after deductible
Preventive Care Services for Adults and Children	100% NO deductible	60%, NO deductible
Specialist Services	$50 Copayment/visit	60%, after deductible
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

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

To receive maximum benefits, services must be provided by an AmeriHealth participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network care are not the same. All benefits are provided in accordance with the group 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
NEW JERSEY
AmeriHealth Insurance Company of New Jersey
www.amerihealth.com

Benefit	In-Network	Out-of-Network*
MAMMOGRAM	100%, NO deductible	60%, NO deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, NO deductible	60%, after deductible
MATERNITY		
First OB visit	$50 Copayment/visit	60%, after deductible
Hospital	80%, after deductible	60%, after deductible
INPATIENT HOSPITAL SERVICES	80%, after deductible	60%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70 days
OUTPATIENT SURGERY	80%, after deductible (facility)	60%, after deductible
EMERGENCY ROOM	$100 Copayment Copayment not waived if admitted	$100 Copayment Copayment not waived if admitted
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	$100 Copayment/visit	60%, after deductible
THERAPY SERVICES		
Physical and Occupational Therapy 30 visits per calendar year (combined)	$50 Copayment/visit	60%, after deductible
Cardiac Rehabilitation 36 sessions per calendar year	$50 Copayment/visit	60%, after deductible
Pulmonary Rehabilitation 36 sessions per calendar year	$50 Copayment/visit	60%, after deductible
Speech Therapy 20 visits per calendar year	$50 Copayment/visit	60%, after deductible
Orthoptic/Pleoptic Therapy 8 session lifetime maximum	$50 Copayment/visit	60%, after deductible
SPINAL MANIPULATIONS 20 visits per calendar year	$50 Copayment/visit	60%, after deductible
INFUSION THERAPY/CHEMOTHERAPY/RADIATION THERAPY	80%, after deductible	60%, after deductible
DIALYSIS	80%, after deductible	60%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours / calendar year	80%, after deductible	60%, after deductible
SKILLED NURSING FACILITY maximum of 120 days/calendar year	80%, after deductible	60%, after deductible
HOSPICE AND HOME HEALTH CARE	80%, after deductible	60%, after deductible
DURABLE MEDICAL EQUIPMENT	50%, after deductible	50%, after deductible
PROSTHETICS	50%, after deductible	50%, after deductible

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

To receive maximum benefits, services must be provided by an AmeriHealth participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network care are not the same. All benefits are provided in accordance with the group 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.

Benefit	In-Network	Out-of-Network*
MENTAL ILLNESS CARE (OTHER THAN SERIOUS MENTAL ILLNESS)		
Outpatient	$50 Copayment/visit	60%, after deductible
Inpatient	80%, after deductible	60%, after deductible
SERIOUS MENTAL ILLNESS CARE/ TREATMENT FOR ALCOHOL ABUSE		
Outpatient	$50 Copayment/visit	60%, after deductible
Inpatient	80%, after deductible	60%, after deductible
TREATMENT OF DRUG ABUSE AND DEPENDENCY		
Outpatient	$50 Copayment / visit	60%, after deductible
Inpatient	$400 Copayment/day; maximum of 5 days ($2,000)***	60%, after deductible

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

To receive maximum benefits, services must be provided by an AmeriHealth participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network care are not the same. All benefits are provided in accordance with the group 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.

What Is Not Covered?

- Services not medically necessary
- Experimental/investigational services, except when approved by AmeriHealth, routine costs associated with a qualifying clinical trial
- Hearing aids, except as stated for dependent children, hearing examinations/ tests for the prescription/ fitting of hearing aids, and cochlear electromagnetc hearing devices
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Acupuncture
- Dental care, including dental implants or dentures, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy and hippotherapy
- Treatment of obesity, except for surgical treatment of morbid obesity, and weight loss programs provided through AmeriHealth Healthy Lifestyles programs
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of 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
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies

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 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 group contract/booklet-certificate 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
- Skilled Nursing Facility
- Inpatient Hospice
- Maternity Admission (for notification only)

OUTPATIENT FACILITY/OFFICE SERVICES
(other than inpatient)

- 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)

INFUSION THERAPY DRUGS administered in an Outpatient Facility or in a Professional Provider's Office (see list included in your open enrollment packet)

BIRTHING CENTER (for notification only)

ELECTIVE (non-emergency) AMBULANCE TRANSPORT

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS - PURCHASE ITEMS OVER $500, INCLUDING REPAIRS AND REPLACEMENTS
(Except Ostomy Supplies and Mandated Prosthetic and Orthotic appliances)

DURABLE MEDICAL EQUIPMENT - PURCHASE ITEMS OVER $500 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 ILLNESS CARE (OTHER THAN FOR SERIOUS MENTAL ILLNESS)/ SERIOUS MENTAL ILLNESS CARE/ TREATMENT FOR ALCOHOL ABUSE TREATMENT/ TREATMENT FOR DRUG ABUSE AND DEPENDENCY

- Mental Health and Serious Mental Illness Treatment (Inpatient)
- Mental Health (outpatient)

TREATMENT FOR DRUG ABUSE AND DEPENDENCY (inpatient/outpatient) - excluding Alcohol Abuse (precertification required for inpatient treatment only)

Preapproval/precertification is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the preapproval/precertification is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request. Preapproval/precertification list subject to change annually.

In addition to the preapproval/precertification requirements listed above, you should contact AmeriHealth and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. This applies to network providers and members who elect to receive treatment provided by out-of-network providers. The categories of treatment (in any setting) include:

- **Any surgical procedure that may be considered potentially cosmetic; and**
- **Any procedure, treatment, drug or device that represents 'new or emerging technology;' and**
- **Services that might be considered experimental/investigative.**

PENALTIES:

POS Plus In-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 Out-of-Network: It is the member's responsibility to initiate precertification for the services listed. The member will be subject to a 20% reduction in benefits if precertification is not obtained for the inpatient/outpatient treatment services listed above.