AmeriHealth POS

POS $20/$40 $0/Day 51+ Summary of Benefits

AmeriHealth NEW JERSEY

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*
DEDUCTIBLE		
Individual	Not Applicable	$1,000
Family	Not Applicable	$2,000
Coinsurance	Not Applicable	70%
Out-of-Pocket Limit		
Individual	$2,000	$6,000
Family	$4,000	$12,000
LIFETIME MAXIMUM	Unlimited	$5 Million
DOCTOR'S OFFICE VISITS		
Primary Care Services	$20 Copayment/visit	70%, after deductible
Specialist Services	$40 Copayment/visit	70%, after deductible
PEDIATRIC IMMUNIZATIONS	100%**	70%, NO deductible
ROUTINE EYE EXAM	$40 Copayment/visit; one exam every two years	Not Covered
ROUTINE GYNECOLOGICAL EXAM/PAP	$20 Copayment/visit	70%, NO deductible
MAMMOGRAM	100%	70%, 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.

** Office visits subject to copayment.

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www.amerihealth.com

Benefit	Network	Non-Network*
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible
MATERNITY		
First OB visit	$20 Copayment/visit	70%, after deductible
Hospital	100%	70%, after deductible
INPATIENT HOSPITAL SERVICES	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited
OUTPATIENT SURGERY	100% (facility)	70%, after deductible
EMERGENCY ROOM Copayment not waived if admitted	$100 Copayment	$100 Copayment
AMBULANCE	100%	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	$40 Copayment/visit	70%, after deductible
MRI/MRA, CT, PET Scans	$80 Copayment/visit	70%, after deductible
THERAPY SERVICES		
Physical and Occupational Therapy 30 visits per calendar year (combined)	$40 Copayment/visit	70%, after deductible
Cardiac Rehabilitation 36 sessions per calendar year	$40 Copayment/visit	70%, after deductible
Pulmonary Rehabilitation 36 sessions per calendar year	$40 Copayment/visit	70%, after deductible
Speech Therapy 20 visits per calendar year	$40 Copayment/visit	70%, after deductible
Orthoptic/Pleoptic Therapy 8 session lifetime maximum	$40 Copayment/visit	70%, after deductible
SPINAL MANIPULATIONS 20 visits per calendar year	$40 Copayment/visit	70%, after deductible
INFUSION THERAPY/CHEMOTHERAPY/RADIATION THERAPY	100%	70%, after deductible
DIALYSIS	100%	70%, after deductible
SKILLED NURSING FACILITY maximum of 120 days/calendar year	100%	70%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible; $2,500 benefit maximum per calendar year

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Benefit	Network	Non-Network*
PROSTHETICS	50%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient maximum of 20 visits/calendar year	$40 Copayment/visit	50%, after deductible
Inpatient maximum of 30 days/calendar year	100%	70%, after deductible
SERIOUS MENTAL ILLNESS AND ALCOHOL ABUSE		
Outpatient	$40 Copayment/visit	70%, after deductible
Inpatient	100%	70%, after deductible
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits 30 visits per calendar year, 120 visit lifetime maximum	$40 Copayment/visit	70%, after deductible
Rehabilitation 30 days per calendar year	100%	70%, after deductible
Detoxification 7 days per admission	100%	70%, after deductible

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What Is Not Covered?

- Services not medically necessary
- Services or supplies which are experimental or investigative, except routine costs associated with clinical trials
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic 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
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses, including wigs intended to replace hair
- 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 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
- 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)

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 HEALTH / SERIOUS MENTAL ILLNESS / SUBSTANCE ABUSE / ALCOHOL ABUSE

- Network Outpatient Mental Health Treatment / Substance Abuse Treatment (Not Alcohol Abuse)
- Inpatient Serious Mental Illness Treatment / Inpatient Alcohol Abuse Treatment
- Inpatient Mental Health Treatment / Inpatient Substance Abuse Treatment

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 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 non-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 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 20% reduction in benefits if precertification is not obtained for the inpatient/outpatient treatment services listed above.