AmeriHealth POS Plus

POS Plus $20/$40 $300/Day SEH Summary of Benefits

AmeriHealth NEW JERSEY

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 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	$1,500
Family	Not Applicable	$3,000
Coinsurance	Not Applicable	70%
Out of Pocket Limit		
Individual	$5,000	$15,000
Family	$10,000	$30,000
LIFETIME MAXIMUM	Unlimited	$5 Million
DOCTOR'S OFFICE VISITS		
Primary Care Services	$20 Copayment/visit	70%, after deductible; Preventive Care: Up to $750 per dependent child from birth to end of calendar year of age one. $500 per year for all other members. (Not subject to deductible)
Specialist Services	$40 Copayment/visit	70%, after deductible
PEDIATRIC IMMUNIZATIONS	100%**	70%, NO deductible
ROUTINE EYE EXAM	$30 Copayment/visit; one exam every two years	Not Covered
ROUTINE GYNECOLOGICAL EXAM/PAP	$20 Copayment/visit	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.**

AmeriHealth NEW JERSEY

AmeriHealth Insurance Company of New Jersey

www.amerihealth.com

Benefit	Network	Non-Network*
MAMMOGRAM	100%	70%, NO deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible
MATERNITY		
First OB visit	$20 Copayment/visit	70%, after deductible
Hospital	$300 Copayment /day; maximum of 5 days ($1,500)***	70%, after deductible
INPATIENT HOSPITAL SERVICES	$300 Copayment /day; maximum of 5 days ($1,500)***	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited
OUTPATIENT SURGERY	$150 Copayment (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 and Cognitive Therapy 30 visits per calendar year (combined)	$40 Copayment/visit	70%, after deductible
Orthoptic/Pleoptic Therapy 8 session lifetime maximum	$40 Copayment/visit	70%, after deductible
THERAPEUTIC 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
EXTENDED CARE FACILITY maximum of 120 days/calendar year	$150 Copayment/day; maximum of 5 days ($750)***	70%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	70%, 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.**

*** **Copayment waived if readmitted within 90 days of discharge.**

Benefit	Network	Non-Network*
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible: $2,500 benefit maximum per calendar year
PROSTHETICS	50%	50%, after deductible
NON-BIOLOGICALLY BASED MENTAL ILLNESS AND SUBSTANCE ABUSE		
Outpatient maximum of 20 visits/calendar year	$40 Copayment/visit	50%, after deductible
Inpatient maximum of 30 days/calendar year; maximum of 90 days/lifetime (Substance Abuse only)	$300 Copayment /day; maximum of 5 days ($1,500)***	70%, after deductible
BIOLOGICALLY-BASED MENTAL ILLNESS AND ALCOHOL ABUSE		
Outpatient	$40 Copayment/visit	70%, after deductible
Inpatient	$300 Copayment /day; maximum of 5 days ($1,500)***	70%, 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.**

*** **Copayment waived if readmitted within 90 days of discharge.**

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 provision
- 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
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention or treatment of complications associated with diabetes
- 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

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

BIOLOGICALLY-BASED MENTAL ILLNESS/NON-BIOLOGICALLY BASED MENTAL ILLNESS / SUBSTANCE ABUSE / ALCOHOL ABUSE

- Network outpatient Non-Biologically based Mental Illness Treatment / Substance Abuse Treatment (NOT Alcohol Abuse)
- Inpatient Non-Biologically based Mental Health Treatment / Inpatient Substance Abuse Treatment
- Inpatient Biologically-based Mental Illness Treatment / Inpatient Alcohol 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 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.

Select Drug Program

SEH $10/$40/$60

AmeriHealth NEW JERSEY

Here's how the program works!

When you purchase covered prescription drugs at a participating pharmacy, you pay...

GENERIC FORMULARY	$10 Copayment
BRAND FORMULARY	$40 Copayment
NON-FORMULARY BRAND	$60 Copayment

You receive coverage for medically appropriate prescription drugs*, including oral contraceptives, under this additional benefit when the drugs are prescribed by a licensed, practicing physician.

Your Select Drug Program® uses a formulary, which includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results and value.

You may receive up to a 90-day supply** of covered medication at a retail pharmacy as follows:

- At participating retail pharmacies, you will pay the following applicable generic formulary, brand formulary, or non-formulary copayments:
  - 1-30 day supply for one copayment
  - 31-60 day supply for two copayments
  - 61-90 day supply for three copayments

Non-participating retail pharmacy purchases will be reimbursed at 50% of the drug's retail cost for the total amount dispensed. For emergency claims, you will be responsible for the applicable copayment indicated above.

In addition, covered medications for chronic conditions (such as blood pressure medications) may be provided through our convenient mail order service allowing you to order up to a 90-day supply. You will pay two times the generic or brand copayment for a formulary drug or two times the non-formulary brand copayment for covered non-formulary drugs. This benefit can save you time and money.

To qualify as a covered benefit and ensure that the drug prescribed is medically appropriate, certain drugs require prior authorization. As a member, your physician can initiate prior authorization for these medications if they are medically appropriate.

As a member, you may visit any participating pharmacy to fill your prescription needs. The Select Drug Program gives you access to more than 56,000 retail pharmacies nationwide through the FutureScripts™ network.

* **This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations and exclusions, refer to your benefit booklet or group contract. Examples of some items not covered include: All injectable medications (except those listed on the formulary); weight control drugs; experimental drugs; drugs and supplies that can be purchased over the counter; drugs used for cosmetic purposes (e.g. anabolic steroids and minoxidil lotion, Retin-A for aging skin); and nicotine gum or patches for smoking cessation.**

** **Certain Prescription Drugs may be subject to quantity level limits.**

AmeriHealth NEW JERSEY

AmeriHealth HMO, Inc.

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