

AmeriHealth POS

POS \$30/\$50 \$400/Day SEH 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	Not Applicable	\$2,500
Family	Not Applicable	\$5,000
Coinsurance	Not Applicable	60%
Out of Pocket Limit (includes deductible, coinsurance and copayments when applicable)		
Individual	\$5,000	\$15,000
Family	\$10,000	\$30,000
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
PEDIATRIC IMMUNIZATIONS	100%, NO deductible	60%, 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 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.amerhealth.com

Benefit	Network	Non-Network [*]
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	60%, after deductible
Hospital	\$400 Copayment/day; maximum of 5 days (\$2,000) ^{***}	60%, after deductible
INPATIENT HOSPITAL SERVICES	\$400 Copayment/day; maximum of 5 days (\$2,000) ^{***}	60%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited
OUTPATIENT SURGERY	\$200 Copayment (facility)	60%, after deductible
EMERGENCY ROOM Copayment not waived if admitted	\$100 Copayment	\$100 Copayment
AMBULANCE	100%	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 and Cognitive Therapy 30 visits per calendar year (combined)	\$50 Copayment/visit	60%, after deductible
Orthoptic/Pleoptic Therapy 8 session lifetime maximum	\$50 Copayment/visit	60%, after deductible
THERAPEUTIC MANIPULATIONS 20 visits per calendar year	\$50 Copayment/visit	60%, after deductible
INFUSION THERAPY/CHEMOTHERAPY/RADIATION THERAPY	100%	60%, after deductible

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*** Copayment waived if readmitted within 90 days of discharge for any diagnosis.

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Benefit	Network	Non-Network [*]
DIALYSIS	100%	60%, after deductible
EXTENDED CARE CENTER maximum of 120 days/calendar year	\$200 Copayment/day; maximum of 5 days (\$1,000) ^{***}	60%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	60%, after deductible
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible
PROSTHETICS	50%	50%, after deductible
NON-BIOLOGICALLY BASED MENTAL ILLNESS AND SUBSTANCE ABUSE		
Outpatient maximum of 20 visits/calendar year	\$50 Copayment/visit	50%, after deductible
Inpatient maximum of 30 days/calendar year; maximum of 90 days/lifetime (Substance Abuse only)	\$400 Copayment/day; maximum of 5 days (\$2,000) ^{***}	60%, after deductible
BIOLOGICALLY-BASED MENTAL ILLNESS AND ALCOHOL ABUSE		
Outpatient	\$50 Copayment/visit	60%, after deductible
Inpatient	\$400 Copayment/day; maximum of 5 days (\$2,000) ^{***}	60%, after deductible

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*** Copayment waived if readmitted within 90 days of discharge for any diagnosis.

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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

<p>INPATIENT SERVICES</p> <p>Surgical and non-surgical inpatient admissions</p> <p>Acute Rehabilitation</p> <p>Extended Care Center</p> <p>Inpatient Hospice</p> <p>Maternity Admission (for notification only)</p> <p>OUTPATIENT FACILITY/OFFICE SERVICES (other than inpatient)</p> <p>Infusion Therapy except Cancer Chemotherapy, Whole Blood, Blood Plasma (outpatient facility and office)</p> <p>PET Scans, MRI, MRA, CT and Nuclear Cardiology</p> <p>Hysterectomy</p> <p>Cataract Surgery</p> <p>Nasal Surgery for Submucous Resection and Septoplasty</p> <p>Transplants (except cornea)</p> <p>Comprehensive Outpatient Pain Management Programs (including epidural injections)</p> <p>Obesity Surgery</p> <p>Sleep Studies</p> <p>Uvulopalatopharyngoplasty (including laser-assisted)</p> <p>ALL HOME CARE SERVICES (including infusion therapy in the home)</p> <p>BIRTHING CENTER (for notification only)</p> <p>ELECTIVE (non-emergency) AMBULANCE TRANSPORT</p> <p>OUTPATIENT PRIVATE DUTY NURSING</p> <p>PROSTHETICS AND ORTHOTICS - PURCHASE ITEMS OVER \$100, INCLUDING REPAIRS AND REPLACEMENTS except mandated appliances</p> <p>DURABLE MEDICAL EQUIPMENT - PURCHASE ITEMS OVER \$100, INCLUDING REPAIRS AND REPLACEMENTS, AND ALL RENTALS (except oxygen, diabetic supplies and unit dose medication for nebulizer)</p>	<p>RECONSTRUCTIVE PROCEDURES & POTENTIALLY COSMETIC PROCEDURES</p> <p>Abdominoplasty</p> <p>Augmentation Mammoplasty</p> <p>Blepharoplasty</p> <p>Chemical Peels</p> <p>Dermabrasion</p> <p>Excision of Redundant Skin</p> <p>Keloid Removal</p> <p>Lipectomy/Liposuction</p> <p>Orthognathic Surgery Procedures</p> <p>Mastopexy</p> <p>Otoplasty</p> <p>Panniculectomy</p> <p>Reduction Mammoplasty</p> <p>Removal or Reinsertion of Breast Implants</p> <p>Rhinoplasty</p> <p>Surgery for Varicose Veins</p> <p>Scar Revision</p> <p>Subcutaneous Mastectomy for Gynecomastia</p> <p>BIOLOGICALLY-BASED MENTAL ILLNESS / NON-BIOLOGICALLY BASED MENTAL ILLNESS / SUBSTANCE ABUSE / ALCOHOL ABUSE</p> <p>Network Outpatient Non-Biologically based Mental Health Treatment / Substance Abuse Treatment (Not Alcohol Abuse)</p> <p>Inpatient Non-Biologically based Mental Health Treatment / Inpatient Substance Abuse Treatment</p> <p>Inpatient Biologically-based Mental Illness Treatment / Inpatient Alcohol Abuse Treatment</p>
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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 50% reduction in benefits if precertification is not obtained for the inpatient/outpatient treatment services listed above.