

# AmeriHealth New Jersey POS Plus

POS Plus \$30/\$50 \$2,000 Ded 70% Coins

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*
<b>Benefit Period*</b>	Calendar Year	Calendar Year
<b>DEDUCTIBLE</b>		
Individual	\$2,000	\$3,000
Family	\$4,000	\$6,000
<b>COINSURANCE</b>	70%	50%
<b>OUT OF POCKET LIMIT</b>		
Individual	\$4,000	\$15,000
Family	\$8,000	\$30,000
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>DOCTOR'S OFFICE VISITS</b>		
Primary Care Services	\$30 Copayment/visit	50%, after deductible
Preventive Care Services for Adults and Children	100%, NO deductible	50%, NO deductible
Specialist Services	\$50 Copayment/visit	50%, after deductible
<b>PEDIATRIC IMMUNIZATIONS</b>	100%, NO deductible	50%, NO deductible
<b>ROUTINE EYE EXAM</b>	\$50 Copayment/visit; one exam every two years	Not Covered
<b>ROUTINE GYNECOLOGICAL EXAM/PAP</b>	100%, NO deductible	50%, NO deductible
<b>MAMMOGRAM</b>	100%, NO deductible	50%, 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.

+ Calendar year benefit period begins January 1 and ends December 31.

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.

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



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<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network*</b>
<b>OUTPATIENT LABORATORY/PATHOLOGY</b>	100%, NO deductible	50%, after deductible
<b>MATERNITY</b>		
First OB visit	\$30 Copayment/visit	50%, after deductible
Hospital	70%, after deductible	50%, after deductible
<b>INPATIENT HOSPITAL SERVICES</b>		
Facility	70%, after deductible	50%, after deductible
Physician/Surgeon	70%, after deductible	50%, after deductible
<b>INPATIENT HOSPITAL DAYS</b>	Unlimited	70 days
<b>OUTPATIENT SURGERY</b>		
Facility	70%, after deductible	50%, after deductible
Physician/Surgeon	70%, after deductible	50%, after deductible
<b>EMERGENCY ROOM</b>	\$100 Copayment Copayment not waived if admitted	\$100 Copayment Copayment not waived if admitted
<b>AMBULANCE</b>		
Emergency	70%, after deductible	Covered at in-network level
Non-Emergency	70%, after deductible	50%, after deductible
<b>URGENT CARE CENTER</b>	\$75 Copayment	50%, after deductible
<b>OUTPATIENT X-RAY/RADIOLOGY</b>		
Routine Radiology/Diagnostic	\$50 Copayment/visit	50%, after deductible
MRI/MRA, CT, PET Scans	\$100 Copayment/visit	50%, after deductible
<b>THERAPY SERVICES</b>		
Physical and Occupational Therapy 30 visits per calendar year (combined) <sup>1</sup>	\$50 Copayment/visit	50%, after deductible
Cardiac Rehabilitation 36 sessions per calendar year <sup>1</sup>	\$50 Copayment/visit	50%, after deductible
Pulmonary Rehabilitation 36 sessions per calendar year <sup>1</sup>	\$50 Copayment/visit	50%, after deductible
Speech Therapy 20 visits per calendar year <sup>1</sup>	\$50 Copayment/visit	50%, after deductible
Orthoptic/Pleoptic Therapy 8 session lifetime maximum <sup>1</sup>	\$50 Copayment/visit	50%, after deductible
<b>SPINAL MANIPULATIONS</b> <i>20 visits per calendar year<sup>1</sup></i>	\$50 Copayment/visit	50%, after deductible
<b>INFUSION THERAPY/CHEMOTHERAPY/RADIATION THERAPY</b>	70%, after deductible	50%, after deductible
<b>DIALYSIS</b>	70%, after deductible	50%, after deductible

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<sup>1</sup> Combined in/out-of-network.

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Benefit	In-Network	Out-of-Network*
<b>OUTPATIENT PRIVATE DUTY NURSING</b> <i>360 hours / calendar year<sup>1</sup></i>	70%, after deductible	50%, after deductible
<b>SKILLED NURSING FACILITY</b> <i>maximum of 120 days/calendar year<sup>1</sup></i>	70%, after deductible	50%, after deductible
<b>HOSPICE AND HOME HEALTH CARE</b>	70%, after deductible	50%, after deductible
<b>DURABLE MEDICAL EQUIPMENT</b>	50%, after deductible	50%, after deductible
<b>PROSTHETICS</b>	50%, after deductible	50%, after deductible
<b>MENTAL ILLNESS CARE</b>		
Outpatient	\$50 Copayment/visit	50%, after deductible
Inpatient	70%, after deductible	50%, after deductible
<b>TREATMENT FOR SUBSTANCE ABUSE</b>		
Outpatient	\$50 Copayment/visit	50%, after deductible
Inpatient	70%, after deductible	50%, after deductible

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**1 Combined in/out-of-network.**

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## 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 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 Commit2Wellness<sup>SM</sup> 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
- Foot orthotics, except for orthotic appliances or as required for the prevention of complications associated with diabetes

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 **1-888-YOUR-AH1(1-888-968-7241)**.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to <http://www.amerhealthnj.com/precert> or call the phone number that is listed on the back of your identification card.