AmeriHealth New Jersey POS

POS $30/$50 $400/Day - OOPM 2015

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	None	$2,500
Family	None	$5,000
COINSURANCE	None	60%
OUT-OF-POCKET LIMIT *(includes copayments, coinsurance and deductible where applicable)*		
Individual	$4,000	$12,000
Family	$8,000	$24,000
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 FOR ADULTS AND CHILDREN	100%	60%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%	60%, NO deductible
ROUTINE EYE EXAM	$50 Copayment/visit; one exam every two years	Not Covered

* 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 NEW JERSEY

AmeriHealth Insurance Company of New Jersey

amerihealthnj.com

Benefit	Network	Non-Network*
ROUTINE GYNECOLOGICAL EXAM/PAP	100%	60%, NO deductible
MAMMOGRAM	100%	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		
Facility	$400 Copayment/day; maximum of 5 days ($2,000)***	60%, after deductible
Physician/Surgeon	100%	60%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited
OUTPATIENT SURGERY		
Facility	$200 Copayment	60%, after deductible
Physician/Surgeon	100%	60%, after deductible
EMERGENCY ROOM	$100 Copayment Copayment not waived if admitted	$100 Copayment Copayment not waived if admitted
URGENT CARE CENTER	$75 Copayment	60%, after deductible
AMBULANCE		
Emergency	100%	60%, after deductible
Non-emergency	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 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

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*** Copayment waived if readmitted within 10 days of discharge.

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Benefit	Network	Non-Network*
SPINAL MANIPULATIONS *20 visits per calendar year*	$50 Copayment/visit	60%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per calendar year (combined)*	80%	60%, after deductible
INFUSION/CHEMOTHERAPY/RADIATION	100%	60%, after deductible
DIALYSIS	100%	60%, after deductible
SKILLED NURSING FACILITY *maximum of 120 days/calendar year*	$200 Copayment/day	60%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	60%, after deductible
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible
PROSTHETICS	50%	50%, after deductible
MENTAL ILLNESS CARE		
Outpatient	$50 Copayment/visit	60%, after deductible
Inpatient	$400 Copayment/day; maximum of 5 days ($2,000)***	60%, after deductible
TREATMENT FOR SUBSTANCE ABUSE		
Outpatient	$50 Copayment/day	60%, after deductible
Inpatient	$400 Copayment/day; maximum of 5 days ($2,000)***	60%, 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, 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 Commit2Wellness℠ 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
- 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 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 1-888-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.amerihealthnj.com/precert** or call the phone number that is listed on the back of your identification card.