AmeriHealth New Jersey POS Plus

POS Plus Option 8 - OOPM 2015

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*
BENEFIT PERIOD+	Calendar Year	Calendar Year
DEDUCTIBLE		
Individual	None	$2,000
Family	None	$6,000
COINSURANCE	100%, except where otherwise noted	60%, except where otherwise noted
OUT OF POCKET LIMIT1		
Individual	$3,000	$9,000
Family	$6,000	$18,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$30 Copayment/visit	60%, after deductible
Preventive Care Services for Adults and Children	100%, NO deductible	60%, NO deductible
Specialist Services	$40 Copayment/visit	60%, after deductible
PEDIATRIC IMMUNIZATIONS	100%	60%, NO deductible
ROUTINE EYE EXAM	$40 Copayment/visit; one exam every two years	Not Covered
ROUTINE GYNECOLOGICAL EXAM/PAP	100%	60%, 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.**

+ A calendar year benefit period begins on January 1 and ends on December 31.

1 Includes deductible, coinsurance and copayments, when applicable.

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.

AmeriHealth NEW JERSEY

AmeriHealth Insurance Company of New Jersey

amerihealthnj.com

Benefit	In-Network	Out-of-Network*
MAMMOGRAM	100%	60%, NO deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	60%, after deductible
MATERNITY		
First OB visit	$30 Copayment/visit	60%, after deductible
Hospital	$300 Copayment/day; maximum of 5 days ($1,500)***	60%, after deductible
INPATIENT HOSPITAL SERVICES		
Facility	$300 Copayment/day; maximum of 5 days ($1,500)***	60%, after deductible
Physician/Surgeon	100%	60%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70 days
OUTPATIENT SURGERY		
Facility	$150 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
AMBULANCE		
Emergency	100%	60%, after deductible
Non-Emergency	100%	60%, after deductible
URGENT CARE CENTER	$75 Copayment	60%, after deductible
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	$40 Copayment/visit	60%, after deductible
MRI/MRA, CT, PET Scans	$80 Copayment/visit	60%, after deductible
THERAPY SERVICES		
Physical and Occupational Therapy 30 visits per calendar year (combined)[2]	$40 Copayment/visit	60%, after deductible
Cardiac Rehabilitation 36 sessions per calendar year[2]	$40 Copayment/visit	60%, after deductible
Pulmonary Rehabilitation 36 sessions per calendar year[2]	$40 Copayment/visit	60%, after deductible
Speech Therapy 20 visits per calendar year[2]	$40 Copayment/visit	60%, after deductible
Orthoptic/Pleoptic Therapy 8 session lifetime maximum[2]	$40 Copayment/visit	60%, after deductible
SPINAL MANIPULATIONS *20 visits per calendar year*[2]	$40 Copayment/visit	60%, after 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.**

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

2 Combined in/out-of-network.

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.

Benefit	In-Network	Out-of-Network*
INFUSION THERAPY/CHEMOTHERAPY/RADIATION THERAPY	100%	60%, after deductible
DIALYSIS	100%	60%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours/calendar year*[2]	80%	60%, after deductible
SKILLED NURSING FACILITY *maximum of 120 days/calendar year*[2]	$150 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	$40 Copayment/visit	60%, after deductible
Inpatient	$300 Copayment/day; maximum of 5 days ($1,500)***	60%, after deductible
TREATMENT FOR SUBSTANCE ABUSE		
Outpatient	$40 Copayment/visit	60%, after deductible
Inpatient	$300 Copayment/day; maximum of 5 days ($1,500)***	60%, after 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.**

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

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

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.

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 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 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
- 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.amerihealthnj.com/precert** or call the phone number that is listed on the back of your identification card.