Medical Benefit Highlights

Ventnor City BOE PPO 5

AmeriHealth New Jersey PPO, our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You maximize your coverage by having care provided by the area's hospitals and thousands of doctors and specialists who participate in the AmeriHealth New Jersey PPO network. Of course, with AmeriHealth New Jersey PPO, you have the freedom to select providers who do not participate in the AmeriHealth New Jersey PPO network. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.
With AmeriHealth New Jersey PPO...

- You do not need to enroll with a primary care physician
- You never need a referral

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$0/$0	$100/$250
Out-of-Pocket Maximum (Embedded)[2] Individual/Family	$400/$800	$2,000/$5,000
Coinsurance	0%	30%
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge	30% no deductible
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$5	30% after deductible
Telemedicine Visit	$5	Not covered
Specialist		
Office Visit	$5	30% after deductible
Telemedicine Visit	$5	Not covered
Retail Health Clinic Visit	$5	30% after deductible
Telemedicine (through MDLive®)[3]	No charge	Not covered
Urgent Care Visit	$5	30% after deductible
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy	$5	30% after deductible
Occupational Therapy	$5	30% after deductible
Speech Therapy	$5	30% after deductible
Cognitive Therapy	$5	30% after deductible
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$25	Covered at In-Network level

Emergency Ambulance	No charge	30% after deductible
Non-Emergency Ambulance	No charge	30% after deductible

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services	No charge	30% after deductible
Maternity Hospital Services	No charge	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	30% after deductible

Outpatient Surgery	In-Network	Out-of-Network
Facility	No charge	30% after deductible
Outpatient Professional Services	No charge	30% after deductible

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	No charge	30% after deductible
Routine Radiology (X-Ray)	No charge	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)	No charge	30% after deductible

Outpatient Lab and Pathology	In-Network	Out-of-Network
Outpatient Lab and Pathology	No charge	30% after deductible

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year)[4]	$5	30% after deductible
Acupuncture	No charge	30% after deductible
Standard Injectables	No charge	30% after deductible
Allergy Injections	No charge	30% after deductible
Biotech/Specialty Injectables	No charge	30% after deductible
Chemotherapy	No charge	30% after deductible
Dialysis	No charge	30% after deductible
Skilled Nursing Facility (120 days/year)[4]	No charge	30% after deductible
Home Health	No charge	30% after deductible
Hospice	No charge	30% after deductible
Private Duty Nursing	No charge	30% after deductible
Durable Medical Equipment (DME)	No charge	30% after deductible
Mental Health – Outpatient (includes substance abuse)		
Office Visit	No charge	30% after deductible
Telemedicine Visit	No charge	Not covered
Mental Health – Inpatient (includes substance abuse)	No charge	30% after deductible
Nutritional Counseling (6 visits/year)[5]	No charge	30% after deductible

1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

3 Services include Teledermatology and Telebehavioral Health.

4 Combined in and out-of-network.

5 Cost share may vary depending on place of service or network status of provider. Combined in and out-of-network.

This summary represents only a partial listing of benefits and exclusions of the Medical 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. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.amerihealthnj.com/LGBooklet** or call **1-888-YOUR-AH1** (TTY: 711).

Benefits may be changed by AmeriHealth New Jersey to comply with applicable federal/state laws and regulations.

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.

Vision Benefit Highlights

$5 Eye Exam Only - Fully Insured

Covered Services (Calendar Year)	Your Costs (You pay)	
Exam	**In-Network**	**Out-of-Network**
Routine Eye Exam at Davis Participating Providers (1 exam/year)	$5	Not covered
Retinal Imaging	Not covered	Not covered
Lenses	**In-Network**	**Out-of-Network[1]**
Single Vision Lenses	Not covered	Not covered
Bifocal Lenses	Not covered	Not covered
Trifocal Lenses	Not covered	Not covered
Lenticular Lenses	Not covered	Not covered
Lens Options	**In-Network**	**Out-of-Network**
Progressive Lenses - Standard/Premium/Ultra/ Ultimate	Not covered	Not covered
Polycarbonate Lenses - Single/Multifocal[2]	Not covered	Not covered
Digital/Intermediate Lenses	Not covered	Not covered
Photochromic Lenses - Single/Multifocal	Not covered	Not covered
Photosensitive Lenses - Single/Multifocal	Not covered	Not covered
High-Index 1.67 / High-Index 1.74 Lenses	Not covered	Not covered
Blue Light Lenses	Not covered	Not covered
Polarized Lenses	Not covered	Not covered
Lens Coatings		
Tinted Plastic Lenses	Not covered	Not covered
UV-Coated Lenses	Not covered	Not covered
Scratch-Resistant Coating - Single/Multifocal	Not covered	Not covered
Scratch-Protection Plan - Single/Multifocal	Not covered	Not covered
Anti-Reflective Coating - Standard/Premium/ Ultra/Ultimate	Not covered	Not covered
Frames	**In-Network**	**Out-of-Network**
Collection Fashion Frames	Not covered	Not covered
Collection Designer Frames	Not covered	Not covered
Collection Premier Frames	Not covered	Not covered
Non-Collection Frames	Not covered	Not covered
Visionworks Frames Option	Not covered	Not covered

Contact Lenses (in lieu of glasses)	In-Network	Out-of-Network
Collection Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Collection Contact Lenses	Not covered	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Non-Collection Contact Lenses	Not covered	Not covered
Medically-Necessary Contact Lenses[3]	Not covered	Not covered

1 Lens Options are subject to out-of-network base lens reimbursement. See your benefit booklet for reimbursement amounts.

2 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

3 Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.amerihealthnj.com/LGBooklet** or call **1-888-YOUR-AH1** (TTY: 711).

Benefits may be changed by AmeriHealth New Jersey to comply with applicable federal/state laws and regulations.

Administered by Davis Vision.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.