

Preventive Care and Screening Services for Adults

The following evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”). This listing may change from time to time. For an up-to-date list of preventive services by date of release of the current USPSTF “A” or “B” recommendations go to: <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;
2. Alcohol Misuse screening and counseling;
3. Aspirin use to prevent cardiovascular disease for adults of certain ages;
4. Blood Pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at an increased risk for coronary heart disease;
6. Colorectal Cancer screening for adults over 50;
7. Depression screening for adults;
8. Diabetes screening for type 2 diabetes for adults with sustained high blood pressure;
9. Falls prevention screening for exercise or physical therapy or vitamin D supplementation in adults age 65 and older who are at increased risk for falls;
10. Healthy diet counseling for adults at higher risk factors for cardiovascular and diet-related chronic disease;
11. Hepatitis B screening for adults at high risk for infection;
12. Hepatitis C virus infection screening for adults of certain ages;
13. HIV screening for all adults at higher risk;
14. Lung cancer screening for adults of certain ages who have a history of smoking and currently smoke or quit within the past 15 years;
15. Obesity screening and counseling for all adults;
16. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
17. Skin cancer behavioral counseling in young adults to 24 years of age who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
18. Syphilis screening for all adults at higher risk;
19. Tobacco Use screening for all adults and cessation interventions for tobacco users.
20. Immunization vaccines for adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (“ACIP”) of the Centers for Disease Control and Prevention, including: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, and Varicella. The ACIP recommendations include the ages when the vaccine should be given, the number of doses needed, the amount of time between doses, and precautions and contradictions. For an up-to-date listing of the ACIP immunization vaccines’ recommendations go to: <http://www.cdc.gov/vaccines/acip/recs/>.

I) Preventive Care and Screening Services For Women, Including Pregnant Women

In addition to the USPSTF “A” or “B” rating preventive services for adults described above, the following is a listing of the USPSTF recommendations with respect to women:

1. Anemia screening for iron deficiency anemia on a routine basis for pregnant women;
2. Bacteriuria screening with urine culture in pregnant women at 12 to 16 weeks’ gestation or at the first prenatal visit, if later;
3. BRCA risk assessment and generic counseling/testing for women who have family members with breast, ovarian, tubal or peritoneal cancer;
4. Breast Cancer preventive medications counseling for women at increased risk for breast cancer;
5. Breast cancer screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older;
6. Breastfeeding counseling during pregnancy and after birth to promote and support breastfeeding;
7. Cervical Cancer screening for sexually active women, in women ages 21 to 65 years with cytology (pap smear) every 3 years, or for women ages 30-65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years;
8. Chlamydia Infection screening for pregnant and non-pregnant women age 24 years and younger and for older women at increased risk;
9. Folic Acid supplements for women planning or capable of pregnancy;
10. Gestational Diabetes mellitus screening for pregnant women 24 to 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes;
11. Gonorrhea screening for all women at increased risk for infection, including those who are pregnant;
12. Hepatitis B screening for pregnant women at their first prenatal visit;
13. Human Immunodeficiency Virus (HIV) screening and counseling for all adults, including pregnant women who present in labor who are untested and whose HIV status is unknown;
14. Intimate partner violence, such as domestic violence, screening for women of childbearing age who do not have signs or symptoms of abuse;
15. Osteoporosis screening for women age 65 and older and in younger women whose fracture risk is equal to or greater than that of a 65-year old white women who has no additional risk factors;
16. Rh incompatibility screening for Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care; and for all unsensitized Rh (D)-negative women at 24-28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative;
17. Sexually Transmitted Infections (STI) counseling for women at increased risk for STIs;
18. Syphilis screening for all pregnant women;
19. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users;

II) With respect to women, such additional preventive care and screenings not addressed above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration including:

1. One well-woman preventive care visit per Policy Year for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate, including preconception. More than one visit may be needed to obtain all the recommended preventive screening services, depending on a woman's health status, health needs and other risk factors. Additional well-woman visits will be covered if the Physician determines they are necessary to help establish what preventive screening services are appropriate and to set up a plan to help the woman get the care she will need to be healthy. If covered preventive screening services are received during an office visit, and the primary purpose of the office visit is other than the delivery of preventive care services, only the portion of the billed services pertaining to the preventive screening services will be reimbursed by SSL under the Excess Loss coverage.
2. High-risk human papillomavirus DNA testing in women with normal cytology results. One screening is covered for females 30 years of age and over and will be covered no more frequently than once every 3 years.
3. One counseling session per Policy Year for counseling on sexually transmitted infections for all sexually active women.
4. One counseling session and screening per Policy Year for human immune-deficiency virus infection for all sexually active women.
5. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include coverage for abortifacient drugs.
6. One screening and counseling for interpersonal and domestic violence per Policy Year.
7. Breastfeeding support, supplies and counseling in conjunction with each birth: Comprehensive lactation support and counseling by a trained Provider during Pregnancy and/or in the postpartum period. Coverage includes the costs for renting or purchase of one breast pump per Pregnancy for the duration of the breast feeding.
8. Routine prenatal obstetrical office visits, up to one visit per month for women at 4-24 weeks' gestation, 2 visits per month for 28-36 weeks' gestation, one visit per week at 36 weeks' gestation to birth, and one postpartum office visit after birth. This also covers lab services explicitly identified in the health reform Affordable Care Act, tobacco cessation counseling specific to pregnant women and immunizations recommended by the Advisory Committee on Immunizations Practices. This does not cover radiology (i.e., obstetrical ultrasounds) delivery and high-risk pre-natal services (i.e., chorionic villus sampling and amniocentesis and other genetic testing).

Preventive Care and Screening Services For Children

With respect to infants, children and adolescents, evidence based items or services that have in effect a USPSTF “A” or “B” rating, and evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; For an up-to-date listing of the preventive services for children, including the recommended ages and schedules, and immunization vaccines, go to: <http://www.hhs.gov/healthcare/prevention/children>.

1. Alcohol and drug use assessments for adolescents;
2. Autism screening for children at 18 and 24 months;
3. Behavioral assessments for children of all ages (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
4. Blood Pressure screening for children (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
5. Cervical Dysplasia screening for sexually active females;
6. Congenital Hypothyroidism screening for newborns;
7. Depression screening for adolescents;
8. Developmental screening for children under age 3, and surveillance throughout childhood;
9. Dyslipidemia screening for children at higher risk of lipid disorders (1-4 years; 5-10 years; 11-14 years; 15-17 years)
10. Fluoride Chemoprevention supplements starting at age 6 months for children without fluoride in their water source; and the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption;
11. Gonorrhea preventive medication for the eyes of all newborns;
12. Hearing screening for all newborns;
13. Height, Weight, and Body Mass Index measurements for children (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
14. Hematocrit or Hemoglobin screening for children;
15. Hemoglobinopathies or sickle cell screening for newborns;
16. Hepatitis B screening for adolescents at high risk for infection;
17. HIV screening for adolescents at higher risk;
18. Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis; Haemophilus influenzae type b; Hepatitis A; Hepatitis B; Human Papillomavirus; Inactivated Poliovirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Rotavirus; Varicella;
19. Iron supplements for children ages 6 to 12 months who are at increased risk for anemia;
20. Lead screening for children at risk of exposure;
21. Medical history for all children throughout development (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
22. Obesity screening and counseling;
23. Oral Health risk assessment for young children (ages 0-11 months; 1-4 years; 5-10 years);
24. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
25. Sexually Transmitted Infection (STI) prevention counseling and Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
26. Tuberculin testing for children at higher risk of tuberculosis disorders (ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years);
27. Vision screening for all children.



IMPORTANT QUESTIONS	ANSWERS	WHY IS THIS IMPORTANT?
What is the overall deductible?	For participating providers \$2,000 person/\$4,000 family. Deductible may not apply to all services. See your cost information starting on page 2 for specific details.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$6,350 person/\$12,700 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, out-of-network balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-certification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.amerhealthnj.com/provider_finder or call 1-888-968-7241 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	Yes. Electronic referral required.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan does not cover?	Yes	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about excluded services .



SILVER PLAN

Summary of Benefits & Coverage—What this plan covers & what it costs

- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS & EXCEPTIONS
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$50 copay	Not Covered	None
If you visit a health care provider's office or clinic	Specialist visit	\$75 copay	Not Covered	Referral Required
If you visit a health care provider's office or clinic	Other practitioner office visit	\$75 copay	Not Covered	Therapeutic Manipulations: 30 visits per calendar year; PCP referral is required
If you visit a health care provider's office or clinic	Preventive care / screening / Immunization	No Charge, no deductible	Not Covered	Routine Gynecological exam limited to 1 per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	\$50 copay (X-Ray) / No Charge, no deductible (Blood Work)	Not Covered	There is no cost for diagnostic services received in the Emergency Room or during a doctor's office visit.
If you have a test	Imaging (CT/PET scans, MRIs)	\$100 copay	Not Covered	Pre-certification required; There is no cost for diagnostic services received in the Emergency Room or during a doctor's office visit.



SILVER PLAN

Summary of Benefits & Coverage—What this plan covers & what it costs

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS & EXCEPTIONS
If you need drugs to treat your illness or condition	Generic drugs	50% Coinsurance, up to \$125 max	Not Covered	Generic Preventive covered at no charge; Subject to \$125 maximum out of pocket per prescription fill for a 1-30 day supply; \$250 maximum out of pocket per prescription fill for a 31-90 day supply. Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
If you need drugs to treat your illness or condition	Preferred brand drugs	50% Coinsurance, up to \$125 max	Not Covered	Subject to \$125 maximum out of pocket per prescription fill for a 1-30 day supply; \$250 maximum out of pocket per prescription fill for a 31-90 day supply. Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
If you need drugs to treat your illness or condition	Non-preferred brand drugs	50% Coinsurance, up to \$125 max	Not Covered	Subject to \$125 maximum out of pocket per prescription fill for a 1-30 day supply; \$250 maximum out of pocket per prescription fill for a 31-90 day supply. Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
If you need drugs to treat your illness or condition	Specialty drugs	50% Coinsurance, up to \$125 max	Not Covered	Subject to \$125 maximum out of pocket per prescription fill for a 1-30 day supply; \$250 maximum out of pocket per prescription fill for a 31-90 day supply. Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.



SILVER PLAN

Summary of Benefits & Coverage—What this plan covers & what it costs

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS & EXCEPTIONS
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50%, after deductible	Not Covered	Some outpatient surgeries require pre-certification. A complete list of surgeries requiring pre-certification is available at www.amerihealthnj.com/precert
If you have outpatient surgery	Physician/surgeon fees	50%, after deductible	Not Covered	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.amerihealthnj.com/precert
If you need immediate medical attention	Emergency room services	\$100 copay, after deductible	\$100 copay, after in-network deductible	Your costs for Emergency Room services are waived if you are admitted to the hospital.
If you need immediate medical attention	Emergency medical transportation	50%, after deductible	50%, after in-network deductible	None
If you need immediate medical attention	Urgent care	\$85 copay	Not Covered	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.



SILVER PLAN

Summary of Benefits & Coverage—What this plan covers & what it costs

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS & EXCEPTIONS
If you have a hospital stay	Facility fee (e.g., hospital room)	50%, after deductible	Not Covered	If your plan includes a copay for these services, your copay will be waived if you are readmitted to the hospital within 90 days of discharge. However, if your plan covers these services with coinsurance, your costs will not be waived if you are readmitted. Pre-certification is required.
If you have a hospital stay	Physician/surgeon fee	50%, after deductible	Not Covered	Pre-certification required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$75 copay	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	50%, after deductible	Not Covered	Pre-certification required.
If you have mental health, behavioral health, or substance abuse needs	Substance abuse disorder outpatient services	\$75 copay	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Substance abuse disorder inpatient services	50%, after deductible	Not Covered	Pre-certification required.



SILVER PLAN

Summary of Benefits & Coverage—What this plan covers & what it costs

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS & EXCEPTIONS
If you are pregnant	Prenatal and postnatal care	No Charge no deductible	Not Covered	None
If you are pregnant	Delivery and all inpatient services	50%, after deductible	Not Covered	Pre-notification requested
If you need help recovering or have other special health needs	Home health care	50%, after deductible	Not Covered	Pre-certification is required 60 visits per calendar year
If you need help recovering or have other special health needs	Rehabilitation services	\$75 copay	Not Covered	Physical Therapy/Occupational Therapy: 30 visits per calendar year (combined); Speech Therapy/Cognitive Therapy: 30 visits per calendar year (combined). PCP Referral is Required.
If you need help recovering or have other special health needs	Habilitation services	\$75 copay	Not Covered	Physical Therapy/Occupational Therapy: 30 visits per calendar year (combined); Speech Therapy/Cognitive Therapy: 30 visits per calendar year (combined). PCP Referral is Required.
If you need help recovering or have other special health needs	Skilled nursing care, durable medical equipment, hospice service	50%, after deductible	Not Covered	Pre-certification is required
If your child needs dental or eye care	Eye exam, glasses	No Charge, no deductible	Not Covered	Pediatric vision; once every calendar year.
If your child needs dental or eye care	Dental check-up	Not Covered	Not Covered	None



Services Your Plan Does NOT Cover:

Acupuncture, Long-term care, Routine foot care, Cosmetic surgery, Non-emergency care when traveling outside the U.S., Weight loss programs, Dental care (Adult), Routine eye care (Adult) — (This isn't a complete list. Check your policy or plan document for other excluded services.)

Other Covered Services:

Bariatric surgery, Infertility treatment, Chiropractic care, Private-duty nursing, Hearing Aids (see benefit booklet / member handbook for limitations) — (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-968-7241. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements or if you are dissatisfied with a denial of coverage for claims under your plan, you may contact AmeriHealth NJ at 1-877-585-5731, prompt 2. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. As an alternative, the New Jersey Department of Banking and Insurance can also provide assistance. Please contact them via the Internet: <http://www.state.nj.us/dobi/consumer.htm>, by email: ombudsman@dobi.state.nj.us, or by telephone: 1-888-393-1062.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.