AmeriHealth New Jersey EPO

AmeriHealth Advantage $15/$25 $1,500 Ded

AmeriHealth Advantage is a two-tiered Exclusive Provider Organization (EPO) plan which provides members with two levels of cost sharing. With the first tier, members who receive services from AmeriHealth Advantage facilities and professional providers have the lowest out of pocket costs. Members can also use Value Network facilities and professional providers in the second tier and experience higher out of pocket costs. The AmeriHealth Advantage EPO allows members to choose their own doctors and hospitals from our participating provider network without selecting a Primary Care Physician (PCP) from either Tier 1 or Tier 2. Services are also received without referrals from a PCP. The AmeriHealth Advantage EPO does not have out of network benefits; therefore members must use network providers in order to access their benefits.

With AmeriHealth EPO...

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

Benefit	Tier 1*	Tier 2**
BENEFIT PERIOD+	Calendar Year	Calendar Year
DEDUCTIBLE[1]		
Single	$1,500	$1,500
Family	$3,000	$3,000
AFTER DEDUCTIBLE, PLAN PAYS	50%, except where otherwise noted	50%, except where otherwise noted
OUT-OF-POCKET MAXIMUM[1] Includes deductible, coinsurance and copayments when applicable.		
Single	$5,000	$5,000
Family	$10,000	$10,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$15 copay, NO deductible	$30 copay, NO deductible
Specialist Services	$25 copay, NO deductible	$50 copay, NO deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, NO deductible	100%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%, NO deductible	100%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per calendar year for women of any age*	100%, NO deductible	100%, NO deductible

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

1 Combined for Tier 1 and Tier 2

* Tier 1 Network consists of Advantage Network professional and facility providers

** Tier 2 Network consists of AmeriHealth New Jersey Value Network professional and facility providers

This summary is intended to highlight the benefits available to you. For your company plan description, including all benefits and exclusions and limitations, refer to your benefit booklet.

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

10/18 - NJ - 51+ AmeriHealth Advantage $15/$25 $1,500 Ded _$5,000/$10,000
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Benefit	Tier 1*	Tier 2**
MAMMOGRAM	100%, NO deductible	100%, NO deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, NO deductible	100%, NO deductible
MATERNITY		
First OB visit	$15 copay, NO deductible	$30 copay, after deductible
Hospital	$100 copay; per day maximum of 5 days ($500), NO deductible	$300 copay; per day maximum of 5 days ($1,500), after deductible
INPATIENT HOSPITAL SERVICES		
Facility	$100 copay; per day maximum of 5 days ($500), NO deductible	$300 copay; per day maximum of 5 days ($1,500), after deductible
Physician/Surgeon	100%, NO deductible	100%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited
OUTPATIENT SURGERY		
Facility	$50 copay, NO deductible	$100 copay, after deductible
Physician/Surgeon	100%, NO deductible	100%, after deductible
EMERGENCY ROOM *(Copay waived if admitted)*	$100 copay, NO deductible	$100 copay, after deductible
URGENT CARE CENTER	$75 copay, NO deductible	$75 copay, NO deductible
AMBULANCE		
Emergency	50%, after deductible	50%, after deductible
Non-emergency	50%, after deductible	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	$50 copay, NO deductible	$50 copay, NO deductible
MRI/MRA/CT/PET Scans***	$100 copay, NO deductible	$100 copay, NO deductible
THERAPY SERVICES		
Physical, Occupational and Speech[1] 60 visits per calendar year (combined)	$30 copay, NO deductible	$30 copay, NO deductible
Cardiac Rehabilitation[1] 36 visits per calendar year	$30 copay, NO deductible	$30 copay, NO deductible
Pulmonary Rehabilitation[1] 12 visits per calendar year	$30 copay, NO deductible	$30 copay, NO deductible
Orthoptic/Pleoptic[1] 8 sessions lifetime maximum	$30 copay, NO deductible	$30 copay, NO deductible

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Benefit	Tier 1*	Tier 2**
CHIROPRACTIC CARE[1] 30 visits per calendar year	$30 copay, NO deductible	$30 copay, NO deductible
CHEMO/RADIATION/DIALYSIS THERAPY	50%, after deductible	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING*** 360 hours per calendar year[1]	50%, after deductible	50%, after deductible
SKILLED NURSING FACILITY*** *120 days per calendar year*[1]	$100 copay; per day maximum of 5 days ($500), NO deductible	$100 copay; per day maximum of 5 days ($500), NO deductible
HOSPICE AND HOME HEALTH CARE***	50%, after deductible	50%, after deductible
DURABLE MEDICAL EQUIPMENT	50%, after deductible	50%, after deductible
PROSTHETIC/ORTHOTIC DEVICES	50%, after deductible	50%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%, NO deductible	100%, NO deductible
MENTAL ILLNESS CARE		
Outpatient	$25 copay, NO deductible	$25 copay, NO deductible
Inpatient	$100 copay; per day maximum of 5 days ($500), NO deductible	$100 copay; per day maximum of 5 days ($500), NO deductible
TREATMENT FOR SUBSTANCE ABUSE		
Outpatient	$25 copay, NO deductible	$25 copay, NO deductible
Inpatient	$100 copay; per day maximum of 5 days ($500), NO deductible	$100 copay; per day maximum of 5 days ($500), NO 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 electromagnetic hearing devices
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Alternative Therapies/complementary medicine
- Dental care, including dental implants or dentures, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy and hippotherapy
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotic appliances or as required for the prevention of complications associated with 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
- Service or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Vision care

This summary represents only a partial listing of the benefits and exclusions of the AmeriHealth EPO 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 benefit booklet carefully for a complete listing of the terms, limitations and exclusions of the program. 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.