# AmeriHealth New Jersey EPO

## 51 + EPO $30/$50/$500

AmeriHealth EPO, our popular Exclusive Provider Organization, gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing care through AmeriHealth EPO's expansive network of hospitals, doctors and specialists.

With AmeriHealth EPO...

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

| Benefit | In-Network | Not Applicable |
|---|---|---|
| **BENEFIT PERIOD**[+] | Calendar Year | Calendar Year |
| **DEDUCTIBLE** | | |
| Single | $0 | Not Applicable |
| Family | $0 | Not Applicable |
| **AFTER DEDUCTIBLE, PLAN PAYS** | 100% | Not Applicable |
| **OUT-OF-POCKET MAXIMUM**[1] | | |
| Single | $3,000 | Not Applicable |
| Family | $6,000 | Not Applicable |
| **LIFETIME MAXIMUM** | Unlimited | Not Applicable |
| **DOCTOR'S OFFICE VISITS** | | |
| Primary Care Services | $30 Copay | Not Applicable |
| Specialist Services | $50 Copay | Not Applicable |
| **PREVENTIVE CARE FOR ADULTS AND CHILDREN** | 100%, NO deductible | Not Applicable |
| **PEDIATRIC IMMUNIZATIONS** | 100%, NO deductible | Not Applicable |
| **ROUTINE GYNECOLOGICAL EXAM/PAP** *1 per calendar year for women of any age* | 100%, NO deductible | Not Applicable |
| **MAMMOGRAM** | 100%, NO deductible | Not Applicable |
| **OUTPATIENT LABORATORY/PATHOLOGY** | 100%, NO deductible | Not Applicable |
| **MATERNITY** | | |
| First OB visit | $30 Copay | Not Applicable |
| Hospital | $500 Copay/per day; maximum of 5 days ($2,500)* | Not Applicable |

+ A calendar year benefit period begins on January 1 and ends on December 31.
1 Includes deductible, coinsurance, and copayments, when applicable.
* Copayment waived if readmitted within 10 days of discharge.

The benefits may be changed by AmeriHealth to comply with applicable federal/state laws and regulations.

AmeriHealth Insurance Company of New Jersey
**amerihealthnj.com**

10/18 - NJ - 51+ EPO $30/$50/$500/Day _$3,000/$6,000
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| Benefit | In-Network | Not Applicable |
|---|---|---|
| **INPATIENT HOSPITAL SERVICES** | | |
| Facility | $500 Copay/per day; maximum of 5 days ($2,500)* | Not Applicable |
| Physician/Surgeon | 100%, NO deductible | Not Applicable |
| **INPATIENT HOSPITAL DAYS** | Unlimited | Not Applicable |
| **OUTPATIENT SURGERY** | | |
| Facility | $300 Copay | Not Applicable |
| Physician/Surgeon | 100%, NO deductible | Not Applicable |
| **EMERGENCY ROOM** | $100 Copay (copay not waived if admitted) | Covered at in-network level |
| **URGENT CARE CENTER** | $75 Copay | Covered at in-network level |
| **AMBULANCE** | | |
| Emergency | 100% | Covered at In-network level |
| Non-emergency | 100% | Not Applicable |
| **OUTPATIENT X-RAY/RADIOLOGY** | | |
| Routine Radiology/Diagnostic | 100% | Not Applicable |
| MRI/MRA/CT/PET Scans | 100% | Not Applicable |
| **THERAPY SERVICES** | | |
| Physical, Occupational and Speech<br>60 visits per calendar year (combined) | $50 Copay | Not Applicable |
| Cardiac Rehabilitation<br>36 visits per calendar year | $50 Copay | Not Applicable |
| Pulmonary Rehabilitation<br>12 visits per calendar year | $50 Copay | Not Applicable |
| Orthoptic/Pleoptic<br>8 sessions lifetime maximum | $50 Copay | Not Applicable |
| **CHIROPRACTIC CARE**<br>*30 visits per calendar year* | $50 Copay | Not Applicable |
| **CHEMO/RADIATION/DIALYSIS THERAPY** | 100%, no deductible | Not Applicable |
| **OUTPATIENT PRIVATE DUTY NURSING**<br>*360 hours per calendar year* | 100%, no deductible | Not Applicable |
| **SKILLED NURSING FACILITY**<br>*120 days per calendar year* | 100%, no deductible | Not Applicable |
| **HOSPICE AND HOME HEALTH CARE** | 100%, no deductible | Not Applicable |
| **DURABLE MEDICAL EQUIPMENT** | 50%, no deductible | Not Applicable |
| **PROSTHETICS** | 50%, no deductible | Not Applicable |
| **OUTPATIENT DIABETIC EDUCATION** | 100%, no deductible | Not Applicable |

* Copayment waived if readmitted within 10 days of discharge.

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| Benefit | In-Network | Not Applicable |
|---|---|---|
| **MENTAL ILLNESS CARE** | | |
| Outpatient | $50 Copay | Not Applicable |
| Inpatient | $500 Copay/per day; maximum of 5 days ($2,500)* | Not Applicable |
| **TREATMENT FOR SUBSTANCE ABUSE** | | |
| Outpatient | $50 Copay | Not Applicable |
| Inpatient | $500 Copay/per day; maximum of 5 days ($2,500)* | Not Applicable |

* Copayment waived if readmitted within 10 days of discharge.

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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.