

# AmeriHealth New Jersey EPO

51 + EPO \$1,500/70% with HSA

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
<b>BENEFIT PERIOD<sup>+</sup></b>	Calendar Year	Calendar Year
<b>DEDUCTIBLE</b>		
Single	\$1,500	Not Applicable
Family	\$3,000	Not Applicable
<b>AFTER DEDUCTIBLE, PLAN PAYS</b>	70%	Not Applicable
<b>OUT-OF-POCKET MAXIMUM<sup>1</sup></b>		
Single	\$3,000	Not Applicable
Family	\$6,000	Not Applicable
<b>LIFETIME MAXIMUM</b>	Unlimited	Not Applicable
<b>DOCTOR'S OFFICE VISITS</b>		
Primary Care Services	70%, after deductible	Not Applicable
Specialist Services	70%, after deductible	Not Applicable
<b>PREVENTIVE CARE FOR ADULTS AND CHILDREN</b>	100%, NO deductible	Not Applicable
<b>PEDIATRIC IMMUNIZATIONS</b>	100%, NO deductible	Not Applicable
<b>ROUTINE GYNECOLOGICAL EXAM/PAP</b> <i>1 per calendar year for women of any age</i>	100%, NO deductible	Not Applicable
<b>MAMMOGRAM</b>	100%, NO deductible	Not Applicable
<b>OUTPATIENT LABORATORY/PATHOLOGY</b>	100%, after deductible	Not Applicable
<b>MATERNITY</b>		
First OB visit	100%, NO deductible	Not Applicable
Hospital	70%, after deductible	Not Applicable

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

1 Includes deductible, coinsurance and copayments, when applicable.

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	Not Applicable
<b>INPATIENT HOSPITAL SERVICES</b>		
Facility	70%, after deductible	Not Applicable
Physician/Surgeon	70%, after deductible	Not Applicable
<b>INPATIENT HOSPITAL DAYS</b>	Unlimited	Not Applicable
<b>OUTPATIENT SURGERY</b>		
Facility	70%, after deductible	Not Applicable
Physician/Surgeon	70%, after deductible	Not Applicable
<b>EMERGENCY ROOM</b>	70%, after deductible	Covered at In-network level
<b>URGENT CARE CENTER</b>	70%, after deductible	Covered at In-network level
<b>AMBULANCE</b>		
Emergency	70%, after deductible	Covered at In-network level
Non-emergency	70%, after deductible	Not Applicable
<b>OUTPATIENT X-RAY/RADIOLOGY</b>		
Routine Radiology/Diagnostic	70%, after deductible	Not Applicable
MRI/MRA/CT/PET Scans	70%, after deductible	Not Applicable
<b>THERAPY SERVICES</b>		
Physical, Occupational and Speech 60 visits per calendar year (combined)	70%, after deductible	Not Applicable
Cardiac Rehabilitation 36 visits per calendar year	70%, after deductible	Not Applicable
Pulmonary Rehabilitation 12 visits per calendar year	70%, after deductible	Not Applicable
Orthoptic/Pleoptic 8 sessions lifetime maximum	70%, after deductible	Not Applicable
<b>CHIROPRACTIC CARE</b> <i>30 visits per calendar year</i>	70%, after deductible	Not Applicable
<b>CHEMO/RADIATION/DIALYSIS THERAPY</b>	70%, after deductible	Not Applicable
<b>OUTPATIENT PRIVATE DUTY NURSING</b> <i>360 hours per calendar year</i>	70%, after deductible	Not Applicable
<b>SKILLED NURSING FACILITY</b> <i>120 days per calendar year</i>	70%, after deductible	Not Applicable
<b>HOSPICE AND HOME HEALTH CARE</b>	70%, after deductible	Not Applicable
<b>DURABLE MEDICAL EQUIPMENT</b>	70%, after deductible	Not Applicable
<b>PROSTHETICS</b>	70%, after deductible	Not Applicable

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Benefit	In-Network	Not Applicable
<b>MENTAL ILLNESS CARE</b>		
Outpatient	70%, after deductible	Not Applicable
Inpatient	70%, after deductible	Not Applicable
<b>TREATMENT FOR SUBSTANCE ABUSE</b>		
Outpatient	70%, after deductible	Not Applicable
Inpatient	70%, after deductible	Not Applicable
<b>Prescription drugs*</b>	\$7 copay for generic and 50% brand up to a maximum of \$125, subject to deductible	Not Applicable

\* In addition, a mail-order service is available allowing you to order up to a 90-day supply of covered maintenance medications for two generic copayments and the brand coinsurance amount indicated above. Maintenance medications are prescribed for long-term treatment of a chronic health condition, e.g. arthritis, diabetes, heart disorders, high blood pressure, etc. This benefit can save you time and money. (Excludes Out-of-Network Mail Orders)

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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.amerhealthnj.com/precert> or call the phone number that is listed on the back of your identification card.