

# AmeriHealth New Jersey EPO

## Tier 1 Advantage High Option

Tier 1 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 Tier 1 Advantage facilities have the lowest out of pocket costs. Members can also use Value Network facilities in the second tier and experience higher out of pocket costs. The Tier 1 Advantage plan 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 Tier 1 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 <sup>+</sup>	Tier 2 <sup>**</sup>
<b>BENEFIT PERIOD<sup>+</sup></b>	Calendar Year	Calendar Year
<b>DEDUCTIBLE<sup>1</sup></b>		
Single	\$1,500	\$1,500
Family	\$3,000	\$3,000
<b>AFTER DEDUCTIBLE, PLAN PAYS</b>	70%, except where otherwise noted	70%, except where otherwise noted
<b>OUT-OF-POCKET MAXIMUM<sup>1</sup></b> Includes deductible, coinsurance and copayments when applicable.		
Single	\$4,000	\$4,000
Family	\$8,000	\$8,000
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>DOCTOR'S OFFICE VISITS</b>		
Primary Care Services	\$30 copay, NO deductible	\$30 copay, NO deductible
Specialist Services	\$50 copay, NO deductible	\$50 copay, NO deductible
<b>PREVENTIVE CARE FOR ADULTS AND CHILDREN</b>	100%, NO deductible	100%, NO deductible
<b>PEDIATRIC IMMUNIZATIONS</b>	100%, NO deductible	100%, NO deductible
<b>ROUTINE GYNECOLOGICAL EXAM/PAP</b> <i>1 per calendar year for women of any age</i>	100%, NO deductible	100%, NO deductible
<b>MAMMOGRAM</b>	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 Advantage Network consists of Tier 1 Advantage facilities and AmeriHealth New Jersey Value Network professional providers

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

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

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.



**AmeriHealth**  
**NEW JERSEY**

AmeriHealth Insurance Company of New Jersey  
[amerihealthnj.com](http://amerihealthnj.com)

<b>Benefit</b>	<b>Tier 1<sup>*</sup></b>	<b>Tier 2<sup>**</sup></b>
<b>OUTPATIENT LABORATORY/PATHOLOGY</b>	70%, after deductible	70%, after deductible
<b>MATERNITY</b>		
First OB visit	\$30 copay, NO deductible	\$30 copay, NO deductible
Hospital	90%, after deductible	60%, after deductible
<b>INPATIENT HOSPITAL SERVICES</b>		
Facility	90%, after deductible	60%, after deductible
Physician/Surgeon	90%, after deductible	60%, after deductible
<b>INPATIENT HOSPITAL DAYS</b>	Unlimited	Unlimited
<b>OUTPATIENT SURGERY</b>		
Facility	90%, after deductible	60%, after deductible
Physician/Surgeon	90%, after deductible	60%, after deductible
<b>EMERGENCY ROOM</b>	90%, after deductible	60%, after deductible
<b>URGENT CARE CENTER</b>	\$75 copay, after deductible	\$75 copay, after deductible
<b>AMBULANCE</b>		
Emergency	70%, after deductible	70%, after deductible
Non-emergency	70%, after deductible	70%, after deductible
<b>OUTPATIENT X-RAY/RADIOLOGY</b>		
Routine Radiology/Diagnostic	70%, after deductible	70%, after deductible
MRI/MRA/CT/PET Scans <sup>***</sup>	70%, after deductible	70%, after deductible
<b>THERAPY SERVICES</b>		
Physical, Occupational and Speech <sup>1</sup> 60 visits per calendar year (combined)	\$50 copay, after deductible	\$50 copay, after deductible
Cardiac Rehabilitation <sup>1</sup> 36 visits per calendar year	\$50 copay, after deductible	\$50 copay, after deductible
Pulmonary Rehabilitation <sup>1</sup> 12 visits per calendar year	\$50 copay, after deductible	\$50 copay, after deductible
Orthoptic/Pleoptic <sup>1</sup> 8 sessions lifetime maximum	\$50 copay, after deductible	\$50 copay, after deductible
<b>CHIROPRACTIC CARE<sup>1</sup></b> 30 visits per calendar year	\$50 copay, after deductible	\$50 copay, after deductible
<b>CHEMO/RADIATION/DIALYSIS THERAPY</b>	70%, after deductible	70%, after deductible

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<sup>\*\*\*</sup> Subject to preapproval

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Benefit	Tier 1 <sup>*</sup>	Tier 2 <sup>**</sup>
<b>OUTPATIENT PRIVATE DUTY NURSING<sup>***</sup></b> 360 hours per calendar year <sup>1</sup>	70%, after deductible	70%, after deductible
<b>SKILLED NURSING FACILITY<sup>***</sup></b> 120 days per calendar year	70%, after deductible	70%, after deductible
<b>HOSPICE AND HOME HEALTH CARE<sup>***</sup></b>	70%, after deductible	70%, after deductible
<b>DURABLE MEDICAL EQUIPMENT</b>	50%, after deductible	50%, after deductible
<b>PROSTHETIC/ORTHOTIC DEVICES</b>	50%, after deductible	50%, after deductible
<b>OUTPATIENT DIABETIC EDUCATION</b>	100%, NO deductible	100%, NO deductible
<b>MENTAL ILLNESS CARE</b>		
Outpatient	\$50 copay, NO deductible	\$50 copay, NO deductible
Inpatient	90%, after deductible	90%, after deductible
<b>TREATMENT FOR SUBSTANCE ABUSE</b>		
Outpatient	\$50 copay, NO deductible	\$50 copay, NO deductible
Inpatient	90%, after deductible	90%, after 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.amerhealthnj.com/precert> or call the phone number that is listed on the back of your identification card.