AmeriHealth

Medical Benefit Highlights

EPO $30/$50 $1,000 $500/Day

AmeriHealth New Jersey EPO, our popular Exclusive Provider Organization, gives you freedom of choice by allowing you to choose health care providers from within our expansive network of hospitals, doctors and specialists.
With AmeriHealth New Jersey EPO...

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

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$1,000/$2,000	Not covered
Out-of-Pocket Maximum (Embedded)[2] Individual/Family	$3,500/$7,000	Not covered
Coinsurance	50%	Not covered
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	Not covered
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$30 no deductible	Not covered
Telemedicine Visit	$30 no deductible	Not covered
Specialist		
Office Visit	$50 no deductible	Not covered
Telemedicine Visit	$50 no deductible	Not covered
Retail Health Clinic Visit	$30 no deductible	Not covered
Telemedicine (through Teladoc)[3]	No charge no deductible	Not covered
Urgent Care Visit	$75 no deductible	Covered at In-Network level
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (60 visits/year)[4]	$50 no deductible	Not covered
Occupational Therapy (60 visits/year)[4]	$50 no deductible	Not covered
Speech Therapy (60 visits/year)[4]	$50 no deductible	Not covered
Cognitive Therapy	$50 no deductible	Not covered
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room (copay not waived if admitted)	$100 no deductible	Covered at In-Network level
Emergency Ambulance	50% after deductible	Covered at In-Network level
Non-Emergency Ambulance	50% after deductible	Not covered

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Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services	$500/Day; max of 5 copays per admission after deductible	Not covered
Maternity Hospital Services	$500/Day; max of 5 copays per admission after deductible	Not covered
Inpatient Professional Services (includes Maternity)	No charge after deductible	Not covered

Outpatient Surgery	In-Network	Out-of-Network
Freestanding	$300 after deductible	Not covered
Hospital Based	$300 after deductible	Not covered
Outpatient Professional Services	No charge after deductible	Not covered

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	$50 after deductible	Not covered
Routine Radiology (X-Ray)		
Freestanding	$50 after deductible	Not covered
Hospital Based	$50 after deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$100 after deductible	Not covered
Hospital Based	$100 after deductible	Not covered

Outpatient Lab and Pathology	In-Network	Out-of-Network
Outpatient Lab and Pathology	No charge no deductible	Not covered

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year)	$30 no deductible	Not covered
Acupuncture (18 visits/year)	$30 no deductible	Not covered
Standard Injectables	$50 no deductible	Not covered
Allergy Injections	$50 no deductible	Not covered
Biotech/Specialty Injectables	$50 no deductible	Not covered
Chemotherapy	50% after deductible	Not covered
Dialysis	50% after deductible	Not covered
Skilled Nursing Facility (120 days/year)	$500/Day; max of 5 copays per admission after deductible	Not covered
Home Health	50% after deductible	Not covered
Hospice	50% after deductible	Not covered
Private Duty Nursing (360 hours/year)	50% after deductible	Not covered
Durable Medical Equipment (DME)	50% after deductible	Not covered
Mental Health – Outpatient (includes substance abuse)		
Office Visit	$50 no deductible	Not covered
Telemedicine Visit	$50 no deductible	Not covered

Mental Health – Inpatient (includes substance abuse)	$500/Day; max of 5 copays per admission after deductible	Not covered
Nutritional Counseling (6 visits/year)[5]	No charge no deductible	Not covered

1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

3 Services include Teledermatology and Telebehavioral Health.

4 Physical Therapy, Occupational Therapy, and Speech Therapy combined visit limit.

5 Cost share may vary depending on place of service or network status of provider.

This summary represents only a partial listing of benefits and exclusions of the Medical 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 contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.amerihealthnj.com/LGBooklet** or call **1-888-YOUR-AH1** (TTY: 711).

Benefits may be changed by AmeriHealth New Jersey to comply with applicable federal/state laws and regulations.

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.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Telugu: శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగాలభిస్తాయి. 1-800-275-2583 (TTY: 711) కు కాల్ చేయండి.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Taglines as of 12/31/2022

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.