

AmeriHealth EPO

SEH EPO \$30/\$50/80% Summary of Benefits

Benefit	Network	Non-Network
Benefit period⁺	Calendar Year	Calendar Year
Individual Deductible	\$2,500	Not applicable
Family deductible (must be satisfied by 2 separate covered persons)	\$5,000	Not applicable
After deductible plan pays	80%	Not applicable
Out-of-pocket maximum¹ Individual/Family	\$5,950/\$11,900	Not applicable
Lifetime maximum	Unlimited	Not applicable
Physician visit	\$30 copay	Not applicable
Specialist visit	\$50 copay	Not applicable
Preventive care: (exam, related tests and X-rays, immunizations, Pap smears, mammography and screening tests)	100%, No deductible	Not applicable
Outpatient diagnostic and X-ray services	80%, subject to deductible	Not applicable
Laboratory	100%, No deductible	Not applicable
Maternity	\$30 copay (first OB visit)	Not applicable
Maternity-hospital	80%, subject to deductible	Not applicable
Hospital inpatient	80%, subject to deductible	Not applicable
Emergency room (copay waived if admitted)	\$100 copayment	Covered at in-network level
Outpatient surgery	80%, subject to deductible	Not applicable
Assistant surgeon	80%, subject to deductible	Not applicable
Anesthesia	80%, subject to deductible	Not applicable
Chiropractic care	80%, subject to deductible	Not applicable
Speech and cognitive therapy combined 30 visits per calendar year	80%, subject to deductible	Not applicable
Occupational and physical therapy combined 30 visits per calendar year	80%, subject to deductible	Not applicable
Inpatient extended care or rehab center 120 days per calendar year	80%, subject to deductible	Not applicable
Home health care	80%, subject to deductible	Not applicable
Hospice care	80%, subject to deductible	Not applicable

¹ Includes deductible, coinsurance and copayments, when applicable.

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

A Small Employer Health Benefits Buyer's Guide is available to small employers and can be obtained free of charge from AmeriHealth upon request. 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 Insurance Company of New Jersey
www.amerhealth.com

Benefit	Network	Non-Network
Treatment for mental illness or substance abuse (including alcohol abuse)		
Inpatient	80%, subject to deductible	Not applicable
Outpatient	\$50 copay	Not applicable
Durable medical equipment	80%, subject to deductible	Not applicable
Blood	80%, subject to deductible	Not applicable
Ambulance	80%, subject to deductible	Not applicable
Prescription drug	50%, No deductible	Not applicable

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