

AmeriHealth EPO

SEH EPO \$30/50% 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 two separate covered persons)	\$5,000	Not applicable
After deductible plan pays	50%	Not applicable
Out-of-pocket maximum ¹ Individual/Family	\$5,000/\$10,000	Not applicable
Lifetime maximum	Unlimited	Not applicable
Physician visit	\$30 copay	Not applicable
Specialist visit	50%, subject to deductible	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	50%, subject to deductible	Not applicable
Laboratory	100%, No deductible	Not applicable
Maternity	\$30 copay (first OB visit)	Not applicable
Maternity-hospital	50%, subject to deductible	Not applicable
Hospital inpatient	50%, subject to deductible	Not applicable
Emergency room	50%, subject to deductible	Covered at in-network level
Outpatient surgery	50%, subject to deductible	Not applicable
Assistant surgeon	50%, subject to deductible	Not applicable
Anesthesia	50%, subject to deductible	Not applicable
Chiropractic care	50%, subject to deductible	Not applicable
Speech and cognitive therapy combined 30 visits per calendar year	50%, subject to deductible	Not applicable
Occupational and physical therapy combined 30 visits per calendar year	50%, subject to deductible	Not applicable

¹ Includes deductible, copayments, and coinsurance, when applicable.

⁺ A calendar year benefit period begins January 1 and ends 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
Inpatient extended care or rehab center 120 days per calendar year	50%, subject to deductible	Not applicable
Home health care	50%, subject to deductible	Not applicable
Hospice care	50%, subject to deductible	Not applicable
Treatment for mental illness or substance abuse (including alcohol abuse)		
Inpatient	50%, subject to deductible	Not applicable
Outpatient	50%, subject to deductible	Not applicable
Durable medical equipment	50%, subject to deductible	Not applicable
Blood	50%, subject to deductible	Not applicable
Ambulance	50%, subject to deductible	Not applicable

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