AmeriHealth PPO

SEH PPO HDHP $2,000/90% Summary of Benefits

Benefit	Network	Non-Network[1]
Benefit Period[+]	Calendar Year	Calendar Year
Deductible		
Single	$2,000	$5,000
Family	$4,000	$10,000
After Deductible, Plan Pays	90%	60%
Out-of-Pocket Maximum[2]		
Single	$5,000	$10,000
Family	$10,000	$20,000
Lifetime Maximum	Unlimited	Unlimited
Physician Visit	90%, subject to deductible	60%, subject to deductible
Preventive Care (exam, related tests and X-rays, immunizations, Pap smears, mammography, and screening tests)	Covered 100%	Covered 100% No deductible to a maximum benefit of $750 per covered person per calendar year from birth until end of calendar year after 1st birthday. $500 calendar year maximum for all others
Outpatient Diagnostic and X-Ray Services	90%, subject to deductible	60%, subject to deductible
Laboratory	90%, subject to deductible	60%, subject to deductible
Maternity - 1st visit	90%, subject to deductible	60%, subject to deductible
Maternity - Hospital	90%, subject to deductible	60%, subject to deductible
Hospital Inpatient	90%, subject to deductible	60%, subject to deductible
Emergency Room	90%, subject to deductible	Covered at in-network level
Emergency Follow up	90%, subject to deductible	60%, subject to deductible
Outpatient Surgery	90%, subject to deductible	60%, subject to deductible
Assistant Surgeon	90%, subject to deductible	60%, subject to deductible
Anesthesia	90%, subject to deductible	60%, subject to deductible
Therapeutic Manipulation 30 visits per calendar year[3]	90%, subject to deductible	60%, subject to deductible

1 Non-Network Providers may bill you for differences between the Plan allowance, which is the amount paid by AmeriHealth, and the Provider's actual charge. This amount may be significant. It is important to note that all percentages for Non-Network services are a percentage of the Plan allowance, not the Provider's actual charge.

2 Includes deductible, copayments, and coinsurance, when applicable

3 Combined Network/Non-Network.

Single deductible and Out-Of-Pocket Maximum apply when an individual is enrolled without dependents. Family deductible and Out-Of-Pocket Maximum apply when an individual and one or more dependents are enrolled. Prior to benefits being paid, the entire family deductible must be met.

Deductible and/or Out-Of-Pocket Maximum may be adjusted annually for inflation.

+ A calendar year benefit period begins Jan. 1 and ends Dec. 31.

This summary is intended to highlight the benefits available to you. For additional information, including all benefits, exclusions, and limitations, please refer to your benefit booklet.

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

www.amerihealth.com

08/11 - NJ - 2-50 NJ SEH PPO HDHP 2,000/90%
ID#13948

Benefit	Network	Non-Network[1]
Speech and Cognitive Therapy combined 30 visits per calendar year[3]	90%, subject to deductible	60%, subject to deductible
Occupational and Physical Therapy combined 30 visits per calendar year[3]	90%, subject to deductible	60%, subject to deductible
Inpatient Extended Care or Rehab Center 120 days per calendar year[3]	90%, subject to deductible	60%, subject to deductible
Home Health Care	90%, subject to deductible	60%, subject to deductible
Hospice Care	90%, subject to deductible	60%, subject to deductible
Substance Abuse		
Inpatient	90%, subject to deductible	60%, subject to deductible
Outpatient	90%, subject to deductible	60%, subject to deductible
Mental Illness		
Inpatient	90%, subject to deductible	60%, subject to deductible
Outpatient	90%, subject to deductible	60%, subject to deductible
Durable Medical Equipment	90%, subject to deductible	60%, subject to deductible $2,500 benefit maximum per calendar year
Blood	90%, subject to deductible	60%, subject to deductible
Ambulance	90%, subject to deductible	60%, subject to deductible
Prescription Drugs	$7 generic formulary copayment/$35 brand formulary copayment/$50 non-formulary copayment, subject to deductible	60%, subject to deductible

1 Non-Network Providers may bill you for differences between the Plan allowance, which is the amount paid by AmeriHealth, and the Provider's actual charge. This amount may be significant. It is important to note that all percentages for Non-Network services are a percentage of the Plan allowance, not the Provider's actual charge.

3 Combined Network/Non-Network.

Single deductible and Out-Of-Pocket Maximum apply when an individual is enrolled without dependents. Family deductible and Out-Of-Pocket Maximum apply when an individual and one or more dependents are enrolled. Prior to benefits being paid, the entire family deductible must be met.

Deductible and/or Out-Of-Pocket Maximum may be adjusted annually for inflation.

This summary is intended to highlight the benefits available to you. For additional information, including all benefits, exclusions, and limitations, please refer to your benefit booklet.

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