

Ventnor City Board of Education

AmeriHealth Plans

	PPO \$5		EHP (Educators Health Plan)		GSHP (Garden State Health Plan)	
	In-Network	Out-of-Network	In-Network	*Out-of-Network	In-Network	*Out-of-Network
	Calendar Year 90th FAIR Health		Calendar Year 200% of CMS		NEW JERSEY COVERAGE ONLY	
Benefit Period						
Out of Network Reimbursement						
Annual Deductible						
Individual Family	\$0 \$0	\$100 \$250	\$0 \$0	\$350 \$700	\$0 \$0	\$350 \$700
Coinsurance	100%	30%	10% (on selected services)	30%	10% (on selected services)	30%
Out of Pocket Maximum						
Individual Family	\$400 \$800	\$2,000 \$5,000	\$500 \$1,000	\$2,000 \$5,000	\$500 \$1,000	\$2,000 \$5,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Office Visit	\$5	70% after deductible	\$10	70% after deductible	\$10	70% after deductible
Specialist Office Visit	\$5	70% after deductible	\$15	70% after deductible	\$15	70% after deductible
Preventative Care For Adults and Children	100% (no copayment)	70% after deductible	100% (no copayment)	70% after deductible	100% (no copayment)	70% after deductible
Emergency Room	\$25 copay (copay waived if admitted)	\$25 copay (copay waived if admitted)	\$100 copay (copay waived if admitted)	\$100 copay (copay waived if admitted)	\$100 copay (copay waived if admitted)	\$100 copay (copay waived if admitted)
Urgent Care Center	\$5 copay	70% after deductible	\$15	70% after deductible	\$15	70% after deductible
Ambulance Services	100%	70% after deductible	90%	70% after deductible	90%	70% after deductible
Chiropractic Service	\$5 copay	70% after deductible	\$15	70% after deductible	\$15	70% after deductible
Physical Therapy	30 visit max, per calendar year, combined in and out of network	70% after deductible	30 visit max, per calendar year, combined in and out of network	70% after deductible max allowance per visit up to \$52	30 visit max, per calendar year, combined in and out of network	70% after deductible max allowance per visit up to \$52
Acupuncture	\$5 copay	70% after deductible	\$15	70% after deductible max allowance per visit up to \$60	\$15	70% after deductible max allowance per visit up to \$60
Durable Medical Equipment	100%	70% after deductible	90%	70% after deductible	90%	70% after deductible

Comparison is for illustrative purposes only. Written plan document supersedes any errors on this illustration.

***out of network reimbursement is set at 200% of CMS for the EHP**

Out-of-network providers may bill you for differences between the R&C, which is the amount paid by carrier, and the provider's actual charge. This amount may be significant. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.