

Individual Health Coverage (IHC)

HMO Monthly Rates



Effective March 1, 2010

IHC Basic Plan Rates

Age	Single		Parent & Child/ Children		Couple (Rate based on the age of the older adult)			Family (Rate based on the age of the older adult)		
	Male	Female	Male Parent	Female Parent	Male/ Female	Male/ Male	Female/ Female	Male/ Female	Male/ Male	Female/ Female
0-24	\$184	\$334	\$588	\$738	\$518	\$368	\$668	\$922	\$772	\$1,072
25-29	\$184	\$402	\$588	\$805	\$586	\$368	\$804	\$990	\$772	\$1,207
30-34	\$202	\$378	\$606	\$782	\$580	\$404	\$756	\$984	\$808	\$1,160
35-39	\$238	\$349	\$641	\$753	\$587	\$476	\$698	\$990	\$879	\$1,102
40-44	\$267	\$364	\$670	\$768	\$631	\$534	\$728	\$1,034	\$937	\$1,132
45-49	\$316	\$380	\$719	\$784	\$696	\$632	\$760	\$1,099	\$1,035	\$1,164
50-54	\$436	\$434	\$840	\$838	\$870	\$872	\$868	\$1,274	\$1,276	\$1,272
55-59	\$601	\$562	\$1,005	\$965	\$1,163	\$1,202	\$1,124	\$1,567	\$1,606	\$1,527
60-64	\$644	\$642	\$1,048	\$1,046	\$1,286	\$1,288	\$1,284	\$1,690	\$1,692	\$1,688
65-69	\$644	\$644	\$1,048	\$1,048	\$1,288	\$1,288	\$1,288	\$1,692	\$1,692	\$1,692
70+	\$644	\$644	\$1,048	\$1,048	\$1,288	\$1,288	\$1,288	\$1,692	\$1,692	\$1,692

IHC Preferred Plan Rates

Age	Single		Parent & Child/ Children		Couple (Rate based on the age of the older adult)			Family (Rate based on the age of the older adult)		
	Male	Female	Male Parent	Female Parent	Male/ Female	Male/ Male	Female/ Female	Male/ Female	Male/ Male	Female/ Female
0-24	\$274	\$500	\$875	\$1,100	\$774	\$548	\$1,000	\$1,375	\$1,149	\$1,600
25-29	\$287	\$600	\$887	\$1,200	\$887	\$574	\$1,200	\$1,487	\$1,174	\$1,800
30-34	\$303	\$563	\$903	\$1,163	\$866	\$606	\$1,126	\$1,466	\$1,206	\$1,726
35-39	\$355	\$522	\$955	\$1,122	\$877	\$710	\$1,044	\$1,477	\$1,310	\$1,644
40-44	\$397	\$543	\$998	\$1,144	\$940	\$794	\$1,086	\$1,541	\$1,395	\$1,687
45-49	\$470	\$568	\$1,070	\$1,168	\$1,038	\$940	\$1,136	\$1,638	\$1,540	\$1,736
50-54	\$650	\$646	\$1,251	\$1,246	\$1,296	\$1,300	\$1,292	\$1,897	\$1,901	\$1,892
55-59	\$898	\$837	\$1,498	\$1,437	\$1,735	\$1,796	\$1,674	\$2,335	\$2,396	\$2,274
60-64	\$959	\$959	\$1,560	\$1,559	\$1,918	\$1,918	\$1,918	\$2,519	\$2,519	\$2,518
65-69	\$959	\$959	\$1,560	\$1,560	\$1,918	\$1,918	\$1,918	\$2,519	\$2,519	\$2,519
70+	\$959	\$959	\$1,560	\$1,560	\$1,918	\$1,918	\$1,918	\$2,519	\$2,519	\$2,519

How to determine the age for IHC rates:

- For new policies, age is calculated based on the subscriber's age as of the last day of the month preceding the effective date of the policy.
- For the "Couple" and the "Family" tiers, the rate is based on the age of the older adult.
- Under most circumstances, changes from one age band to another for affected policyholders will take place on March 1 (or on March 15 for policies originally effective on the 15th of a month). In this case, the age is calculated based on the subscriber's age as of February 28.

IHC Standard Plan Rates

Benefit Plan	Single	Parent & Child/ Children	Couple	Family
IHC 50	\$738	\$1,343	\$1,476	\$2,081
IHC 30/50	\$839	\$1,527	\$1,678	\$2,366
IHC 30	\$883	\$1,607	\$1,766	\$2,490
IHC 15	\$1,491	\$2,714	\$2,982	\$4,205

For more details, please visit www.amerihealth.com or email the IHC sales team at ihc@amerihealth.com.

Individual Health Coverage (IHC)

PPO Monthly Rates



Effective September 1, 2009

IHC PPO \$25/\$50/70%

Age	Single	Parent & Child/Children	Couple (Rate based on the age of the older adult)	Family (Rate based on the age of the older adult)
0-24	\$240.69	\$613.69	\$481.38	\$854.38
25-29	\$272.00	\$645.00	\$544.01	\$917.01
30-34	\$325.06	\$698.06	\$650.12	\$1,023.12
35-39	\$352.10	\$725.10	\$704.21	\$1,077.21
40-44	\$365.30	\$738.30	\$730.61	\$1,103.61
45-49	\$383.19	\$756.19	\$766.38	\$1,139.38
50-54	\$437.75	\$810.75	\$875.51	\$1,248.51
55-59	\$505.55	\$878.55	\$1,011.09	\$1,384.09
60-64	\$604.30	\$977.30	\$1,208.60	\$1,581.60
65-69	\$604.30	\$977.30	\$1,208.60	\$1,581.60
70+	\$604.30	\$977.30	\$1,208.60	\$1,581.60

IHC PPO \$30/\$50/90%

Age	Single	Parent & Child/Children	Couple (Rate based on the age of the older adult)	Family (Rate based on the age of the older adult)
0-24	\$293.80	\$748.80	\$587.59	\$1,042.59
25-29	\$332.02	\$787.02	\$664.04	\$1,119.04
30-34	\$396.78	\$851.78	\$793.56	\$1,248.56
35-39	\$429.80	\$884.80	\$859.59	\$1,314.59
40-44	\$445.91	\$900.91	\$891.82	\$1,346.82
45-49	\$467.74	\$922.74	\$935.48	\$1,390.48
50-54	\$534.34	\$989.34	\$1,068.69	\$1,523.69
55-59	\$617.09	\$1,072.09	\$1,234.18	\$1,689.18
60-64	\$737.64	\$1,192.64	\$1,475.28	\$1,930.28
65-69	\$737.64	\$1,192.64	\$1,475.28	\$1,930.28
70+	\$737.64	\$1,192.64	\$1,475.28	\$1,930.28

How to determine the age for IHC rates:

- For new policies, age is calculated based on the subscriber's age as of the last day of the month preceding the effective date of the policy.
- For the "Couple" and the "Family" tiers, the rate is based on the age of the older adult.
- Under most circumstances, changes from one age band to another for affected policyholders will take place on March 1 (or on March 15 for policies originally effective on the 15th of a month). In this case, the age is calculated based on the subscriber's age as of February 28.

For more details, please visit www.amerihealth.com or contact me today to discuss which plan best suits your needs.

Frank White: (732) 726-6803
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AmeriHealth PPO

Individual Summary of Benefits
IHC \$25/\$50/70%



Benefit	Network	Non network ¹
Individual deductible	\$2,500	\$7,500
Family deductible (must be satisfied by at least two separate covered persons)	\$5,000	\$15,000
After deductible plan pays	70%	50%
Out-of-pocket maximum		
Individual	\$5,000	\$15,000
Family	\$10,000 ²	\$30,000 ³
Lifetime maximum	Unlimited	Unlimited
Physician visit	\$25 copay	50%, subject to deductible
Specialist visit	\$50 copay	50%, subject to deductible
Preventive Care: (exam, related tests and x-rays, immunizations, pap smears, mammography and screening tests)	Covered 100% to maximum benefit of \$750 per covered person per calendar-year from birth until 1st birthday. \$500 calendar-year maximum for all others. ⁴	Covered 100% to maximum benefit of \$750 per covered person per calendar-year from birth until 1st birthday. \$500 calendar-year maximum for all others. ⁴
Outpatient Diagnostic/Routine radiology	70%, subject to deductible	50%, subject to deductible
MRI/MRA, CT, PET scans	70%, subject to deductible	50%, subject to deductible
Laboratory	100%, no deductible (when provided by a network lab)	50%, subject to deductible
Maternity	\$25 copay first OB visit, Covered 100% after	50%, subject to deductible
Maternity - hospital	70%, subject to deductible	50%, subject to deductible
Hospital inpatient	70%, subject to deductible	50%, subject to deductible
Emergency room (copay waived if admitted)	\$100 copay	\$100 copay
Outpatient surgery	70%, subject to deductible	50%, subject to deductible
Spinal manipulation 30 visits per calendar year ⁴	\$50 copay	50%, 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 Network out-of-pocket maximum includes deductible, coinsurance, and copayments, when applicable.

3 Non network out-of-pocket maximum includes deductible, coinsurance and copayments.

4 Combined network/non network

This listing of benefits and services is only a summary. For a more detailed description of benefits, exclusions, and limitations, refer to the IHC contract.



AmeriHealth Insurance Company of New Jersey
www.amerhealth.com

Benefit	Network	Non network ¹
Physical occupational, speech, and cognitive therapy 30 visits per therapy, per calendar year ⁴	\$50 copay	50%, subject to deductible
Inpatient extended care or rehab center⁵ Combined 120 days per calendar year ⁴	70%, subject to deductible	50%, subject to deductible
Home health care⁵	70%, subject to deductible	50%, subject to deductible
Hospice care⁵	70%, subject to deductible	50%, subject to deductible
Non-biologically based mental illness and drug abuse services		
Inpatient Combined 30 days per calendar year ⁴	70%, subject to deductible	50%, subject to deductible
Outpatient Combined 20 visits per calendar year ⁴	\$50 copay	50%, subject to deductible
Alcohol abuse⁵		
Inpatient	70%, subject to deductible	50%, subject to deductible
Outpatient	\$50 copay	50%, subject to deductible
Biologically based mental illness		
Inpatient	70%, subject to deductible	50%, subject to deductible
Outpatient	\$50 copay	50%, subject to deductible
Durable medical equipment⁵	70%, subject to deductible	50%, subject to deductible
Blood	70%, subject to deductible	50%, subject to deductible
Ambulance	100%, no deductible	50%, subject to deductible
Prescription drug	50%, no deductible	50%, no deductible

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4 Combined network/non network

5 Subject to preapproval

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AmeriHealth PPO

Individual Summary of Benefits
IHC \$30/\$50/90%



Benefit	Network	Non network ¹
Individual deductible	\$2,500	\$5,000
Family deductible (must be satisfied by at least two separate covered persons)	\$5,000	\$10,000
After deductible plan pays	90%	70%
Out-of-pocket maximum Individual/Family	\$5,000/\$10,000 ²	\$10,000/\$20,000 ³
Lifetime maximum	Unlimited	Unlimited
Physician visit	\$30 copay	70%, subject to deductible
Specialist visit	\$50 copay	70%, subject to deductible
Preventive Care: (exam, related tests and x-rays, immunizations, pap smears, mammography and screening tests)	Covered 100% to maximum benefit of \$750 per covered person per calendar-year from birth until 1st birthday. \$500 calendar-year maximum for all others. ⁴	Covered 100% to maximum benefit of \$750 per covered person per calendar-year from birth until 1st birthday. \$500 calendar-year maximum for all others. ⁴
Outpatient Diagnostic/Routine radiology	90%, subject to deductible	70%, subject to deductible
MRI/MRA, CT, PET scans	90%, subject to deductible	70%, subject to deductible
Laboratory	100%, no deductible (when provided by a network lab)	70%, subject to deductible
Maternity	\$30 copay for first OB visit, covered 100% after	70%, subject to deductible
Maternity - hospital	90%, subject to deductible	70%, subject to deductible
Hospital inpatient	90%, subject to deductible	70%, subject to deductible
Emergency room (copay waived if admitted)	\$100 copay	\$100 copay
Outpatient surgery	90%, subject to deductible	70%, subject to deductible
Spinal manipulation 30 visits per calendar year ⁴	\$50 copay	70%, subject to deductible

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Inpatient	90%, subject to deductible	70%, subject to deductible
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Inpatient	90%, subject to deductible	70%, subject to deductible
Outpatient	\$50 copay	70%, subject to deductible
Durable medical equipment⁵	90%, subject to deductible	70%, subject to deductible
Blood	90%, subject to deductible	70%, subject to deductible
Ambulance	100%, no deductible	70%, subject to deductible
Prescription drugs	50%, no deductible	50%, no deductible

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4 Combined network/non network

5 Subject to preapproval

This listing of benefits and services is only a summary. For a more detailed description of benefits, exclusions, and limitations, refer to the IHC contract.

Individual Health Coverage (IHC)

HMO Plan Comparison



	IHC Preferred	IHC Basic	IHC 50	IHC 30/50	IHC 30	IHC 15
Primary Care Physician	\$30 copay	\$30 copay	\$50 copay	\$30 copay	\$30 copay	\$15 copay
Specialist Office Visits	\$30 copay	\$30 copay; plan pays a maximum of \$700 per calendar year	\$50 copay	\$50 copay	\$30 copay	\$15 copay
Outpatient X-ray and Laboratory Services	100%	100%	\$50 copay	\$50 copay	\$30 copay	\$15 copay
Well Baby/Child Care	\$30 copay	\$30 copay	\$50 copay	\$30 copay	\$30 copay	\$15 copay
Inpatient Hospital Services	\$500 copay/confinement, then covered at 100%	\$500 copay/confinement, then covered at 100%; maximum 90 days/calendar year	\$500 copay/day; maximum 5 days/admission; \$5,000 maximum copay/calendar year	\$300 copay/day; maximum 5 days/admission; \$3,000 maximum copay/calendar year	\$300 copay/day; maximum 5 days/admission; \$3,000 maximum copay/calendar year	\$150 copay/day; maximum 5 days/admission; \$1,500 maximum copay/calendar year
Prenatal Care	\$50 copay for initial visit, subsequent visits covered in full. Inpatient: see Inpatient Hospital Services	See Inpatient Hospital Services; first three prenatal visits covered as Specialists office visits. Delivery and newborn are covered; Prenatal (with the exception of first three office visits and postnatal not Covered)	\$50 copay for the initial visit	\$30 copay for the initial visit	\$25 copay for the initial visit; subsequent visits covered in full	\$25 copay for the initial visit; subsequent visits covered in full
Emergency Room	\$100 copay per visit	\$100 copay per visit	\$100 copay per visit*	\$100 copay per visit*	\$100 copay per visit*	\$100 copay per visit*
Outpatient and Ambulatory Surgery	\$250 copay per surgery, then 100%	\$250 copay per surgery, then 100%	Facility-\$100 copay; Practitioner-\$50 copay	Facility-\$100 copay; Practitioner-\$50 copay	Facility-\$30 copay; Practitioner-\$30 copay	Facility-\$15 copay; Practitioner-\$15 copay
Biologically Based Mental Illness	Outpatient: plan pays 70%; 30 visits/calendar year Inpatient:\$500 copay/confinement	Outpatient: plan pays 70%; 30 visits/calendar year Inpatient: \$500 copay/confinement; 90 days maximum/calendar year	Outpatient: \$50 copay Inpatient:\$500 copay/day; maximum 5 days/admission; \$5,000 maximum copay/year	Outpatient: \$50 copay Inpatient:\$300 copay/day; maximum 5 days/admission; \$3,000 maximum copay/year	Outpatient: \$30 copay Inpatient:\$250 copay/day; maximum 5 days/admission; \$3,000 maximum copay/year	Outpatient: \$15 copay Inpatient:\$150 copay/day; maximum 5 days/admission; \$1,500 maximum copay/year

See reverse side for more plan summaries details.

	IHC Preferred	IHC Basic	IHC 50	IHC 30/50	IHC 30	IHC 15
Non-Biologically Based Mental Illness	Not covered	Not covered	<u>Outpatient:</u> \$50 copay; maximum 20 visits/calendar year combined with substance abuse <u>Inpatient:</u> \$500 copay/day; maximum 5 days/admission; \$5,000 maximum copay/year combined with substance abuse	<u>Outpatient:</u> \$50 copay; maximum 20 visits/calendar year combined with substance abuse <u>Inpatient:</u> \$300 copay/day; maximum 5 days/admission; \$3,000 maximum copay/year combined with substance abuse	<u>Outpatient:</u> \$30 copay; maximum 20 visits/calendar year combined with substance abuse <u>Inpatient:</u> \$300 copay/day; maximum 5 days/admission; \$3,000 maximum copay/year combined with substance abuse	<u>Outpatient:</u> \$15 copay; maximum 20 visits/calendar year combined with substance abuse <u>Inpatient:</u> \$150 copay/day; maximum 5 days/admission; \$1,500 maximum copay/year combined with substance abuse
Substance Abuse	<u>Outpatient:</u> plan pays 70%; 30 visits/calendar year combined with alcohol abuse <u>Inpatient:</u> \$500 copay/confinement then pays 70%; 30 days maximum/calendar year combined with alcohol abuse	<u>Outpatient:</u> plan pays 70%; 30 visits/calendar year combined with alcohol abuse <u>Inpatient:</u> \$500 copay/confinement then pays 70%; 30 days maximum/calendar year combined with alcohol abuse	<u>Outpatient:</u> \$50 copay; 20 visits/calendar year combined with non-biologically based mental illness <u>Inpatient:</u> \$500 copay/day; maximum 5 days/admission; \$5,000 maximum copay/year combined with non-biologically based mental illness	<u>Outpatient:</u> \$50 copay; 20 visits/calendar year combined with non-biologically based mental illness <u>Inpatient:</u> \$300 copay/day; maximum 5 days/admission; \$3,000 maximum copay/year combined with non-biologically based mental illness	<u>Outpatient:</u> \$30 copay; 20 visits/calendar year combined with non-biologically based mental illness <u>Inpatient:</u> \$300 copay/day; maximum 5 days/admission; \$3,000 maximum copay/year combined with non-biologically based mental illness	<u>Outpatient:</u> \$15 copay; 20 visits/calendar year combined with non-biologically based mental illness <u>Inpatient:</u> \$150 copay/day; maximum 5 days/admission; \$1,500 maximum copay/year combined with non-biologically based mental illness
Alcohol Abuse	<u>Outpatient:</u> plan pays 70%; 30 visits/calendar year combined with substance abuse <u>Inpatient:</u> \$500 copay/confinement then pays 70%; 30 days maximum/calendar year combined with substance abuse	<u>Outpatient:</u> plan pays 70%; 30 visits/calendar year combined with substance abuse <u>Inpatient:</u> \$500 copay/confinement then pays 70%; 30 days maximum/calendar year combined with substance abuse	See biologically based mental illness	See biologically based mental illness	See biologically based mental illness	See biologically based mental illness
Pre-admission Testing	100%	100%	\$50 copay	\$50 copay	\$30 copay	\$15 copay
Prescription Drug	Plan pays 50% up to \$1,500 per person per year	Not covered	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

* Credited toward inpatient admission, if admission occurs within 24 hours of emergency.

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