Black Horse Pike Regional School Disctrict

BHPR SD	Current Plan		Current Plan		NJEHP	
	AmeriHealth PPO $15		AmeriHealth PPO $20		NJEHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Deductibles	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	None	$500	None	$500	N/A	$350
Family	None	$1,000	None	$1,000	N/A	$700
After deductible, plan pays	100%	70% after deductible	100% after deductible	80% after deductible	100% or; 90% after deductible when applied to Emergency Medical Transportation care and durable medical equipment but capped at $800 / $2,000	70% after deductible
Out of Pocket Limit**						
Individual	$2,000	$2,000	$2,000	$2,000	$500	$2,000
Family	$4,000	$4,000	$4,000	$4,000	$1,000	$5,000
Primary Care Physician Selection	**Not Required**	**Not Applicable**	**Not Required**	**Not applicable**	**Not Required**	**Not applicable**
Preventive Care						
Routine Adult Physician Exams/Immunizations	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	70% after deductible
Routine Well Child Exams/Immunizations	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	70% after deductible
Routine Gynecological Care Exams	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	70% after deductible
Routine Mammograms	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	70% after deductible
Physician's Office Visit						
Primary Care Services	$15 copay	70% after deductible	$20 copay	80% after deductible	$10 copay	70% after deductible
After Office Hours/Home	$25 copay	70% after deductible	$30 copay	80% after deductible	$10 copay	70% after deductible
Specialist Services	$25 copay	70% after deductible	$30 copay	80% after deductible	$15 copay	70% after deductible
Maternity OB Visit	$25 copay- 1st visit; then 100%	70% after deductible	$30 copay- 1st visit; then 100%	80% after deductible	$10 copay - 1st visit only	70% after deductible
Outpatient Diagnostic Procedures						
Diagnostic Laboratory	100%	70% after deductible	100%	80% after deductible	100%	70% after deductible
Diagnostic X-ray	100%	70% after deductible	100%	80% after deductible	100%	70% after deductible

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	AmeriHealth PPO $15		AmeriHealth PPO $20		NJEHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Medical Care						
Urgent Care	$25 copay	70% after deductible	$30 copay	80% after deductible	$15 copay	70% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Emergency Room	$25 copay, waived if admitted	$25 copay, waived if admitted	$35 copay, waived if admitted	$35 copay, waived if admitted	$125 copay, waived if admitted	70% after deductible
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hospital Care						
Inpatient Coverage	100%	70% after deductible	100%	100%	100%	70% after deductible
Services Subject To Deductible						
Orthotics	100%, No deductible	70% after deductible	100%,	80% after deductible	90% after deductible	70% after deductible
Prosthetics	100%, No deductible	70% after deductible	100%,	80% after deductible	90% after deductible	70% after deductible
Durable Medical Equipment	100%, No deductible	70% after deductible	100%,	80% after deductible	90% after deductible	70% after deductible
Outpatient Surgery	100%, No deductible	70% after deductible	100%,	100% No deductible	100%	70% after deductible
Mental Health Services **Alcohol/Drug Abuse Services**	Same as any other illness; benefit depends on place of service		Same as any other illness; benefit depends on place of service		Same as any other illness; benefit depends on place of service	
Other Services						
Skilled Nursing Facility	100%	70% after deductible	100%	100% No deductible	100%	70% after deductible
					120 Days per calendar year	
Outpatient Rehabilitation Therapy (includes speech, physical, and occupational therapy)	$25 copay	70% after deductible	$30 copay	100%, no deductible	$15 copay	70% after deductible
	Medical Necessity Review		Medical Necissity Review		30 visit limit per therapy per calendar year, subject to medical necessity	
Chiropractic Care	$25 copay	70% after deductible	$25 copay	80% after deductible	$15 copay	70% after deductible
	Medical Necessity Review		20 visits per calendar year, subject to medical necessity		Subject to medical necessity	

All Benefits Subject to Medical Necessity. This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Please refer to your benefit booklet for more information.

Rates			
Single	$870	$878	$857
Parent + Child(ren)	$1,285	$1,295	$1,264
H/W	$1,938	$1,954	$1,907
Family	$2,257	$2,273	$2,218