KBenefits, LLC
Insurance Specialists

Christopher S. Kudryk
732-333-1976 office
732-444-5971 e-fax
chris@kbenefits.com
kbenefits.com

2019 Amerihealth of NJ – effective Jan 1st, 2019

Amerihealth 2019	Bronze EPO HSA Advantage $25/$50	Bronze EPO HSA Hospital Advantage $50/$75	Silver EPO Advantage $25/$50
	Tier1 / Tier 2	Tier1 / Tier 2	Tier1 / Tier 2
Deductible - (Individual)	$3,000 deductible	$3,000 deductible	$2,500 deductible
Out of Pocket Max - (Indiv)	$6,750 max	$6,750 max	$7,500 max
Referrals Required?	No Referrals Required	No Referrals Required	No Referrals Required
Preventive Care	No Charge	No Charge	No Charge
Primary Care Physician Visit	$25 copay after ded / 50% after ded	$50 copay after ded / 50% after ded	$25 copay / 50% afterded
Specialist Visit	$50 copay after ded / 50% after ded	$75 copay after ded / 50% after ded	$50 copay / 50% afterded
Chiro/PT/SpeechTherapy	30% after ded	50% after ded	20% after ded
Urgent Care	30% after ded	50% after ded	20% after ded
Emergency Room	30% after ded / 50% after ded	50% after ded	20% after ded / 50% after ded
Lab	50% after ded	50% after ded	No Charge
Xrays / Adv Radiology	50% after ded	50% after ded	50% after ded
Inpatient Hospital	30% after ded / 50% after ded	$500 per day (5) after ded / 50% after ded	20% after ded / 50% after ded
Inpatient Surgery	30% after ded / 50% after ded	50% after ded	20% after ded / 50% after ded
Outpatient Facility	30% after ded / 50% after ded	20% after ded / 50% after ded	20% after ded / 50% after ded
Outpatient Surgery	30% after ded / 50% after ded	20% after ded / 50% after ded	20% after ded / 50% after ded
Durable Medical Equipment	50% after ded	50% after ded	50% after ded
Home Health Care	50% after ded	50% after ded	20% after ded / 50% after ded
Skilled Nursing Hospice	30% after ded	50% after ded	20% after ded / 50% after ded
Prescriptions Retail (30 day supply):	Deductible then 50% up to $125 maximum	Deductible then 50% up to $125 maximum	$10 Generic / 50% Name Brand up to $125 maximum
Pediatric Vision: Eye Glasses (Lenses/Frames) or Contact Lenses (Covered once every 12 months)	No Charge/ No Charge	No Charge/ No Charge	No Charge/ No Charge
Pediatric Vision: Routine Eye Exam (Covered once every 12 months)	No Charge/ No Charge	No Charge/No Charge	No Charge/ No Charge

- Does not include pediatric dental

Christopher S. Kudryk
732-333-1976 office
732-444-5971 e-fax
chris@kbenefits.com
kbenefits.com

2019 Amerihealth of NJ – effective Jan 1st, 2019

Amerihealth 2019	**Silver HMO Local Value $50/$75**	
Deductible - (Individual)	$2,500 deductible	
Out of Pocket Max - (Indiv)	$7,400 max	
Referrals Required?	**Referrals Required**	
Preventive Care	No Charge	
Primary Care Physician Visit	$50 copay	
Specialist Visit	$75 copay	
Chiro/PT/SpeechTherapy	$75 copay	
Urgent Care	$85 copay	
Emergency Room	$100 after ded	
Lab	No Charge	
Xrays / Adv Radiology (mri,cat)	$50 copay/ $100 copay	
Inpatient Hospital	50% after ded	
Inpatient Surgery	50% after ded	
Outpatient Facility	50% after ded	
Outpatient Surgery	50% after ded	
Durable Medical Equipment	50%after ded	
Home Health Care	50% after ded	
Skilled Nursing Hospice	50% after ded	
Prescriptions Retail (30 day supply):	**$10 Generic / 50% Name Brand up to $125 maximum**	
Pediatric Vision: Eye Glasses (Lenses/Frames) or Contact Lenses (Covered once every 12 months)	No Charge/ No Charge	
Pediatric Vision: Routine Eye Exam (Covered once every 12 months)	No Charge/ No Charge	

- Does not include pediatric dental