AmeriHealth New Jersey EPO

EPO $1,500/100% with HSA

AmeriHealth EPO, our popular Exclusive Provider Organization, gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing care through AmeriHealth EPO's expansive network of hospitals, doctors and specialists.

With AmeriHealth EPO...

- You do not need to enroll with a primary care physician
- You never need a referral

Benefit	In-Network	Not Applicable
BENEFIT PERIOD[+]	Calendar Year	Calendar Year
DEDUCTIBLE		
Single	$1,500	Not Applicable
Family	$3,000	Not Applicable
AFTER DEDUCTIBLE, PLAN PAYS	100%	Not Applicable
OUT-OF-POCKET MAXIMUM[1]		
Single	$3,000	Not Applicable
Family	$6,000	Not Applicable
LIFETIME MAXIMUM	Unlimited	Not Applicable
DOCTOR'S OFFICE VISITS		
Primary Care Services	100%, after deductible	Not Applicable
Specialist Services	100%, after deductible	Not Applicable
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, NO deductible	Not Applicable
PEDIATRIC IMMUNIZATIONS	100%, NO deductible	Not Applicable
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per calendar year for women of any age*	100%, NO deductible	Not Applicable
MAMMOGRAM	100%, NO deductible	Not Applicable
OUTPATIENT LABORATORY/PATHOLOGY	100%, after deductible	Not Applicable

\+ A calendar year benefit period begins on January 1 and ends on December 31.

1 Includes deductible, coinsurance and copayments, when applicable.

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

amerihealthnj.com

Benefit	In-Network	Not Applicable
MATERNITY		
First OB visit	100%, NO deductible	Not Applicable
Hospital	100%, after deductible	Not Applicable
INPATIENT HOSPITAL SERVICES		
Facility	100%, after deductible	Not Applicable
Physician/Surgeon	100%, after deductible	Not Applicable
INPATIENT HOSPITAL DAYS	Unlimited	Not Applicable
OUTPATIENT SURGERY		
Facility	100%, after deductible	Not Applicable
Physician/Surgeon	100%, after deductible	Not Applicable
EMERGENCY ROOM	100%, after deductible	Covered at In-network level
URGENT CARE CENTER	100%, after deductible	Covered at In-network level
AMBULANCE		
Emergency	100%, after deductible	Covered at In-network level
Non-emergency	100%, after deductible	Not Applicable
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	100%, after deductible	Not Applicable
MRI/MRA/CT/PET Scans	100%, after deductible	Not Applicable
THERAPY SERVICES		
Physical, Occupational and Speech 60 visits per calendar year (combined)	100%, after deductible	Not Applicable
Cardiac Rehabilitation 36 visits per calendar year	100%, after deductible	Not Applicable
Pulmonary Rehabilitation 12 visits per calendar year	100%, after deductible	Not Applicable
Orthoptic/Pleoptic 8 sessions lifetime maximum	100%, after deductible	Not Applicable
CHIROPRACTIC CARE *30 visits per calendar year*	100%, after deductible	Not Applicable
CHEMO/RADIATION/DIALYSIS THERAPY	100%, after deductible	Not Applicable
OUTPATIENT PRIVATE DUTY NURSING *360 hours per calendar year*	100%, after deductible	Not Applicable
SKILLED NURSING FACILITY *120 days per calendar year*	100%, after deductible	Not Applicable
HOSPICE AND HOME HEALTH CARE	100%, after deductible	Not Applicable
DURABLE MEDICAL EQUIPMENT	100%, after deductible	Not Applicable

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Benefit	In-Network	Not Applicable
PROSTHETICS	100%, after deductible	Not Applicable
MENTAL ILLNESS CARE		
Outpatient	100%, after deductible	Not Applicable
Inpatient	100%, after deductible	Not Applicable
TREATMENT FOR SUBSTANCE ABUSE		
Outpatient	100%, after deductible	Not Applicable
Inpatient	100%, after deductible	Not Applicable
Prescription drugs*	$7 copay for generic, $15 brand/non-formulary, subject to deductible	Not Applicable

* In addition, covered medications for chronic conditions (such as blood pressure medications) may be provided through our convenient mail order service allowing you to order up to a 90-day supply. You will pay two times the generic or brand copayment for a formulary drug or two times the non-formulary brand copayment for covered non-formulary drugs. This benefit can save you time and money. (Excludes Out-of-Network Mail Orders)

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

What Is Not Covered?

- Services not medically necessary
- Services or supplies which are experimental or investigative except routine costs associated with clinical trials
- Hearing aids, except as stated for dependent children, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Alternative Therapies/complementary medicine
- Dental care, including dental implants or dentures, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy and hippotherapy
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotic appliances or as required for the prevention of complications associated with diabetes
- Cranial prostheses including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Service or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Vision care

This summary represents only a partial listing of the benefits and exclusions of the AmeriHealth EPO Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your benefit booklet carefully for a complete listing of the terms, limitations and exclusions of the program. If you need more information, please call **1-888-YOUR-AH1(1-888-968-7241)**.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to **http://www.amerihealthnj.com/precert** or call the phone number that is listed on the back of your identification card.

Enrollment / Change Form (For all plans including NJ Small Group Employer Benefits Program)

12830

1 Plan Selection

1A Standard Plans (Indicate co-pay amount and deductible)					1B					
PPO 10		HDHP EPO								

2 Subscriber/Member Enrollment or Change - Employee Must Complete in Full

- **New Application**: ☐ New Hire ☐ Open Enrollment ☐ Life Event Change. Complete all information and sign form.
- **Information Change**: Provide your Identification Number below and indicate the change(s) you are making. Complete Appropriate section(s) and sign at bottom of form. I.D. # _____
- **Change**: ☐ Address ☐ Last Name ☐ Primary Care Office ☐ Rehire
- **Dependent Membership Change**: ☐ Add Dependent — If adding spouse, indicate marriage date __/__/__ ☐ Delete Dependent
- **Other Change**: ☐ COBRA ☐ Conversion ☐ 18 mos. eff. date: __/__/__ ☐ 29 mos. eff. date: __/__/__ ☐ 36 mos. eff. date: __/__/__
- **Terminate Contract**: ☐ Terminated Employment ☐ Full-time to Part-time ☐ Deceased, date: __/__/__ ☐ Open Enrollment

3 Subscriber Information

NOTE: Please complete this section in its entirety, whether you are a new applicant or are making a change

Social Security Number	Last Name	First Name	Middle Initial	Sex	Date of Birth month / day / year
				☐ M ☐ F	/ /

Street Address	City	State	Zip Code

Telephone Number (including area code)	Employment Status	Marital Status	Previous Health Insurer
Home: ( ) - Work: ( ) -	☐ Active ☐ COBRA ☐ Retiree	☐ single ☐ married ☐ divorced ☐ separated	

3A Group/Employer Information

Your **Group Administrator** must complete this section. This form cannot be processed without this information.
☐ Check if National Account

Group Number	Group Name
	Haddon T p BOE
Account Number	**Group Address**

Employer Signature and Date

Date of Hire ___/___/___	Date Coverage/Change is Eff.
Payroll/Work Location	Location Name/Phone #

3B Complete this section for HMO or POS Only

Primary Care Office Name	If Current Physician Check This Box ☐	Primary Care Office 10 Digit HMO Identification Number

4 Dependent Information

Please provide all information for each person to be covered.

Last Name	First Name	Middle Initial	Sex (M/F)	Date of Birth Month/day/year	Social Security Number	4A For HMO/POS Only: Primary Care Office Name	4A For HMO/POS Only: Primary Care Office Number (If current Physician, check box at right.)	4B If Disabled Please Attach Verification
Spouse							☐	
Child							☐	☐ Yes ☐ No
Child							☐	☐ Yes ☐ No
Child							☐	☐ Yes ☐ No

4C

If you have listed any dependents in the Dependent Information Section, you must answer the question below.

Do any of the dependents listed in this section live at another address?

☐ Yes ☐ No

If yes, who and what address?

If any dependent's last name is different from yours, eplain the circumstances.

Please use the reverese side.

5 Other Insurance Information

To be sure that you receive all the benefits to which you are entitled, you must complete the following.

5A

5B Are you or any of your dependents currently receiving Medicare benefits? ☐ Yes ☐ No If yes, please give name of recipient.

	Part A (Y/N)	Effective Date	Part B (Y/N)	Effective Date	Medicare Claim #
Self					
Spouse					
Child					

5C When you become effective with your policy, will any persons listed on this enrollment form be covered by any other health insurance policy. ☐ Yes ☐ No

If yes, please give name and policy number of insurance carrier and type of benefits.

Ins. Co. Name _____

Policy Number _____

Policy Holder _____

Type of benefits: ☐ Health ☐ RX ☐ Dental ☐ Vision

Who is covered by this policy? List names of those covered.

(1) _____

(2) _____

(3) _____

(4) _____

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Signature of Employee _____ Date Signed _____

*Print as clear as possible in all areas.