AmeriHealth PPO

PPO 10

Haddon Twp. BOE

AmeriHealth PPO, our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You maximize your coverage by having care provided by the area's hospitals and thousands of doctors and specialists who participate in the AmeriHealth PPO network. Of course, with AmeriHealth PPO, you have the freedom to select providers who do not participate in the AmeriHealth PPO network. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

With AmeriHealth PPO...

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

Benefit	In-Network	Out-of-Network[1]
Benefit Period+	Calendar Year	Calendar Year
Deductible		
Individual	$0	$250
Family	$0	$500
After Deductible, Plan Pays	100%	80%
Out-of-Pocket Limit[2]		
Individual	$1,000	$1,000
Family	$2,000	$2,000
Lifetime Maximum	Unlimited	Unlimited
Doctor's Office Visits		
Primary Care Services	$10 Copayment	80%, after deductible
Specialist Services	$10 Copayment	80%, after deductible
Preventive Care for Adults and Children	100%	80%, NO deductible
Pediatric Immunizations	100%	80%, NO deductible

1 Out-of-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 out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

2 Includes deductible, coinsurance and copayments, when applicable

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

For more information about AmeriHealth PPO please call our Customer Service Representatives at 1-800-275-2583, or visit the AmeriHealth website at www.amerihealth.com

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
www.amerihealth.com

02/14 - NJ - 51+ PPO 10 in Area
125382

Benefit	In-Network	Out-of-Network[1]
Routine Gynecological Exam/Pap 1 per calendar year for women of any age[4]	100%	80%, NO deductible
Mammogram	100%	80%, NO deductible
Maternity		
First OB Visit	$10 Copayment	80%, after deductible
Hospital	100%	80%, after deductible
Inpatient Hospital Services		
Facility	100%	80%, after deductible
Physician/Surgeon	100%	80%, after deductible
Inpatient Hospital Days	365	70
Outpatient Surgery		
Facility	100%	80%, after deductible
Physician/Surgeon	100%	80%, after deductible
Emergency Room	$25 Copayment (waived if admitted)	$25 Copayment (waived if admitted) NO deductible
Urgent Care Center	$10 Copayment	80%, after deductible
Ambulance		
Emergency	100%	100%, NO deductible
Non-Emergency	100%	80%, after deductible
Outpatient Laboratory	100%	80%, after deductible
Outpatient X-Ray/Radiology		
Routine Radiology/Diagnostic	100%	80%, after deductible
MRI/MRA, CT, PET Scans	100%	80%, after deductible
Therapy Services		
Physical, Speech and Occupational	$15 Copayment	80%, after deductible
Cardiac Rehabilitation 36 visits per calendar year[4]	$15 Copayment	80%, after deductible
Pulmonary Rehabilitation 12 visits per calendar year[4]	$15 Copayment	80%, after deductible
Respiratory Therapy	$15 Copayment	80%, after deductible
Restorative Services, Including Chiropractic Care (30 visits per calendar year)[4] Orthoptic/Pleoptic Therapy limited to 8 sessions lifetime maximum[4]	$15 Copayment	80%, after deductible

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4 Combined in/out-of-network.

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Benefit	In-Network	Out-of-Network[1]
Chemo/Radiation and Renal Dialysis Therapy	100%	80%, after deductible
Outpatient Private Duty Nursing	100%	80%, after deductible
Skilled Nursing Facility	100%	80%, after deductible
Hospice and Home Health Care	100%	80%, after deductible
Durable Medical Equipment and Prosthetics	100%	80%, after deductible
Outpatient Diabetic Education	100%	80%, after deductible
Mental Illness Care		
Outpatient	$10 Copayment	80%, after deductible
Inpatient	100%	80%, after deductible
Treatment for Substance Abuse		
Outpatient	$10 Copayment	80%, after deductible
Inpatient	100%	80%, after deductible

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What Is Not Covered?

- Services not medically necessary
- Services not billed and performed by a provider properly licensed and qualified to render the medically appropriate and/or necessary treatment, service or supply
- Cosmetic services/supplies
- Routine foot care
- Foot orthotics, except for orthotic appliances or as required for the prevention of complications associated with diabetes
- Dental care, including dental implants, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Vision care
- Military or occupational injuries or illness
- Benefits payable by the government, Medicare or through motor vehicle insurance
- Charges in excess of benefit maximums or allowable charges as set forth in the group contract
- Services or supplies which are experimental or investigative except routine costs associated with qualifying clinical trials
- Inpatient private duty nursing
- Alternative Therapies/complementary medicine
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices, except as stated for dependent children
- Immunizations required for employment or travel
- Maintenance of chronic conditions

This summary represents only a partial listing of the benefits and exclusions of the PPO 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. This managed care plan may not cover all of your health care expenses. Read your benefit booklet carefully to determine which health care services are covered. If you need more information please call 1-800-855-4000.

For Care Provided Out-of-Network

Services That Require Pre-Authorization

- INPATIENT SERVICES
  - All Inpatient Admission
  - Acute Rehabilitation
  - Skilled Nursing Facility
  - Inpatient Hospice
- OUTPATIENT FACILITY/OFFICE SERVICES (regardless of place of service)
  - Ambulance
  - Dental services as a result of accidental injury
  - PET Scans
  - Echocardiography
  - Hysterectomy
  - Cataract surgery
  - Cochlear implant surgery (all settings)
  - Nasal surgery for submucous resection and septoplasty
  - Transplants (except cornea)
  - Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)
  - Durable medical equipment (all rentals and items over $500 billed amount, including repairs and replacements), except for oxygen, diabetic supplies, and unit dose medication for nebulizers
  - Home health care
  - Hyperbaric oxygen therapy
  - Obesity surgery
  - Day rehabilitation programs
  - Uvulopalatopharyngoplasty (including laser-assisted) (UPPP or UP3)
  - Infusion therapy in a home setting
  - Infusion therapy drugs in an outpatient facility or in an office setting for the following: Abraxane®, Alpha 1 inhibitors (Aralast, NP, Glassia, Prolastin®C, Zemaira®), Aldurazyme®, Alimta®, Ampligen®, Aredia®, Arzerra®, Avastin®,Benlysta®, Boniva®, C1 esterase inhibitors (Berineter®, Cinryze®), Ceredase®, Cerezyme®, Elaprase®, Eloxatin®, Enzyme replacement (Lumizyme®, Replagal®, Uplyso®, VPRIV®), Erbitux®, Fabrazyme®, Flolan®, Folotyn®, Halaven, Hemophilia fators, Herceptin®DM1, Istodax®, IVIG, Jevtana®, Myozyme®, Nulojix®, Orencia®, Psoriasis/rheumatoid arthritis (Actemra®), Provenge®, Remodulin®, Remicade®, Rituximab, Soliris®, Temodar®, Tysabri®, Yervoy.
  - Injectable medications: Avastin® (except for certain ophthalmological conditions), Botox®, Hyaluronate agents, Kalbitor®, Lucentis®, Macugen®, Makena, Mozobil®, Omapro, Prolia®, Stelara® Synagis®, Xgeva and Xolair®
  - Orthotic devices all rentals on (items over $500 billed amount, including repairs and replacements. Preapproval is not required for orthotic appliances)
  - Private duty nursing
  - Prosthetic devices (items over $500 billed amount, including repairs and replacements. Preapproval is not required for ostomy supplies or prosthetic appliances.)
  - Routine costs associated with qualifying clinical trials
- ALL HOME CARE SERVICES (including infusion therapy in the home)
- MATERNITY ADMISSION AND BIRTHING CENTER (prenotification requested only)
- ELECTIVE (non-emergency) AMBULANCE TRANSPORT
- RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES
  - Blepharoplasty/ptsosis repair
  - Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
  - Canthopexy/canthoplasty
  - Cervicoplasty
  - Chemical peels
  - Dermabrasion
  - Excision of excessive skin and/or subcutaneous tissue
  - Genetically and bio-engineered skin substitutes for wound care
  - Hair transplant
  - Injectable dermal fillers
  - Keloid removal
  - Labiaplasty
  - Lipectomy/liposuction, or any other excess fat removal procedure
  - Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies
  - Otoplasty
  - Rhinoplasty
  - Rhytidectomy
  - Scar revision
  - Skin closures, including skin grafts, skin flaps, tissue grafts
  - Sex reassignment surgery
  - Surgical treatment of gynecomastia
  - Surgery for varicose veins, including perforators and sclerotherapy
  - Subcutaneous Mastectomy for Gynecomastia
- MENTAL ILLNESS CARE/TREATMENT FOR SUBSTANCE ABUSE
  - Inpatient Mental Illness Care/Inpatient Substance Abuse Treatment
  - Partial Inpatient/Intensive Outpatient Mental Illness Care/Partial Inpatient/Intensive Outpatient Substance Abuse Treatment
- SERVICES BY A NON-PARTICIPATING PHYSICIAN/PROVIDER FOR NON-EMERGENCY SERVICES

AmeriHealth PPO network providers will obtain pre-authorization for you, if it is required for the service provided. You are not required to obtain pre-authorization when you are treated in an AmeriHealth PPO network hospital or facility, or by an AmeriHealth PPO network doctor. Members are not responsible for financial penalties because an AmeriHealth PPO network provider does not obtain prior approval.

When an AmeriHealth PPO member receives services outside of the network, the obligation to obtain pre-authorization is with the member. If the out-of-network provider recommends one of the services listed above, you must obtain pre-authorization by calling the precertification telephone number listed on the back of your ID card. For Pet Scans, call AIM at the telephone number listed on the back of your ID card.

If services are received outside of the AmeriHealth PPO network without pre-authorization, benefits will be reduced by $1,000, but in no event more than 50% of the benefit amount for inpatient services or treatment and 20% for outpatient services or treatment.

Pre-authorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the pre-authorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request. If you need more information please call 1-800-855-4000.

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 (M / F)	Date of Birth month / day / year
				☐ M ☐ F	/ /

Street Address | City | State | Zip Code

Telephone Number (including area code) Home: ( ) - Work: ( ) -

Employment Status: ☐ Active ☐ COBR ☐ Retiree

Marital Status: ☐ single ☐ married ☐ divorced ☐ separated

Previous Health Insurer

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: Primary Care Office Number (If current Physician, check box at right.)	4B If Disabled Please Attach Verification	4C
Spouse					☐		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.
Child					☐	☐ Yes ☐ No	
Child					☐	☐ Yes ☐ No	
Child					☐	☐ Yes ☐ No	

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.