2020 Benefits Guide

Welcome to
TeleSearch
2020 Open Enrollment!

TeleSearch is offering you and your eligible family members a comprehensive and valuable benefits program. These various plans are described in this Open Enrollment Guide. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

These plans will be implemented on December 1, 2020

the peterman group
Insurance and risk management solutions

TeleSearch
Group Medical Benefit and Rate Summary
Effective Date: December 1, 2020

Insurance Carrier	AmeriHealth
Plan Type	SEH Silver HMO Local Value $50 / $75
In Network	
Referrals	Yes
Primary/Specialist	$50 / $75
Deductible (Ind/Family)	$2,500 / $5,00
Inpatient Hospital	50% (After Ded)
Outpatient Surgery	50% (After Ded)
Xray	$50
Complex Imaging (MRI)	$100
Lab	$0
Vision / Ped Dental	Not Covered
Urgent Care / ER	$85 (No Ded) / $100 (After Ded)
Out of Pocket Max (Ind/Fam)	$8,150 / $16,300
Lifetime Maximum	Unlimited
Out of Network	
Deductible	N/A
Coinsurance	N/A
Out of Pocket Max (Ind/Fam)	N/A
Lifetime Maximum	N/A
Prescription	
Deductible	Integrated with Medical Deductible for Brand
Generic	$15
Brand/Non-Form/Specialty	50% to $125 Max (After Ded)
Mail Order (90 Day Supply)	$30 / 50% to $250 Max (After Ded)

Created on : 10/07/2020

Age-Band Rates

Rates effective from 12/01/2020 through 11/30/2021

SEH Silver HMO Local Value $50/$75 - CY $15/50% up to $125 max

Region: C

Age Bands (In Years)	Non-Tobacco User	Tobacco User	Age Bands (In Years)	Non-Tobacco User	Tobacco User
0	$237.19	$237.19	33	$413.60	$413.60
01	$237.19	$237.19	34	$417.33	$417.33
02	$237.19	$237.19	35	$419.19	$419.19
03	$237.19	$237.19	36	$421.05	$421.05
04	$237.19	$237.19	37	$422.60	$422.60
05	$237.19	$237.19	38	$424.46	$424.46
06	$237.19	$237.19	39	$428.18	$428.18
07	$237.19	$237.19	40	$431.90	$431.90
08	$237.19	$237.19	41	$437.17	$437.17
09	$237.19	$237.19	42	$442.44	$442.44
10	$237.19	$237.19	43	$449.57	$449.57
11	$237.19	$237.19	44	$458.25	$458.25
12	$237.19	$237.19	45	$468.48	$468.48
13	$237.19	$237.19	46	$480.58	$480.58
14	$237.19	$237.19	47	$493.91	$493.91
15	$258.27	$258.27	48	$508.79	$508.79
16	$266.33	$266.33	49	$523.36	$523.36
17	$274.39	$274.39	50	$539.79	$539.79
18	$283.07	$283.07	51	$555.61	$555.61
19	$291.76	$291.76	52	$572.66	$572.66
20	$300.75	$300.75	53	$589.71	$589.71

21	$387.56	$387.56
22	$387.56	$387.56
23	$387.56	$387.56
24	$387.56	$387.56
25	$387.56	$387.56
26	$387.56	$387.56
27	$387.56	$387.56
28	$387.56	$387.56
29	$395.31	$395.31
30	$399.03	$399.03
31	$404.61	$404.61
32	$410.19	$410.19
54	$608.01	$608.01
55	$625.99	$625.99
56	$644.90	$644.90
57	$664.12	$664.12
58	$683.97	$683.97
59	$706.91	$706.91
60	$706.91	$706.91
61	$706.91	$706.91
62	$706.91	$706.91
63	$706.91	$706.91
64+	$706.91	$706.91

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Referred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50/Visit. Deductible does not apply.	Not covered.	Telemedicine is a covered benefit: See your benefit booklet for coverage level at www.amerihealthnj.com/SGBooklet.
	Specialist visit	$75/Visit. Deductible does not apply.	Not covered.	PCP referral required for certain services. Telemedicine is a covered benefit: See your benefit booklet for coverage level at www.amerihealthnj.com/SGBooklet.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $50/Visit. Deductible does not apply. Blood Work: No charge. Deductible does not apply.	Not covered.	Referral required for certain services.
	Imaging (CT/PET scans, MRIs)	$100/Scan. Deductible does not apply.	Not covered.	Prior authorization is required. *See section "using services that require preapproval".
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http:// www.amerihealthnj.com/ valueformulary.	Generic Drugs	Retail/Mail Order (1-30 days supply) $15/Fill. Mail Order (31-90 days supply) $30/Fill. Deductible does not apply.	Not covered.	Prior authorization may be required on some drugs. Covers up to a 90 day supply.
	Preferred Drugs	Retail/Mail Order (1-30 days supply) 50% coinsurance ($125 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($250 max/fill).	Not covered.	Prior authorization may be required on some drugs. Covers up to a 90 day supply.
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) 50% coinsurance ($125 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($250 max/fill).	Not covered.	Prior authorization may be required on some drugs. Covers up to a 90 day supply.

*For more information about limitations and exceptions, see plan or policy document at www.amerihealthnj.com/SGBooklet.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Referred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty Drugs	Retail/Mail Order (1-30 days supply) 50% coinsurance ($125 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($250 max/fill).	Not covered.	This applies to oral or injectable self-administered Specialty Drugs which are covered under the Prescription Drug Plan. Covers up to a 90 day supply. Prior authorization and/or dispensing limits may apply. Other Specialty Drugs and infusion therapy drugs may be covered under your medical benefits plan as stated within your Policy and/or Drug Rider information. A complete list of drugs requiring Prior authorization is available, *see section "Using services that require preapproval".
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance.	Not covered.	Prior authorization is required for certain services. *See section "using services that require preapproval".
	Physician/surgeon fees	50% coinsurance.	Not covered.	
If you need immediate medical attention	Emergency room care	$100/Visit.	Covered at In-Network level.	None
	Emergency medical transportation	50% coinsurance.	Covered at In-Network level.	
	Urgent care	$85/Visit. Deductible does not apply.	Covered at In-Network level.	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance.	Not covered.	Prior authorization is required. *See section "using services that require preapproval".
	Physician/surgeon fees	50% coinsurance.	Not covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$70/Visit. Deductible does not apply.	Not covered.	Telemedicine is a covered benefit. See your benefit booklet for coverage level at www.amerihealthnj.com/SGBooklet.
	Inpatient services	50% coinsurance.	Not covered.	Prior authorization may be required. *See section "using services that require preapproval".

*For more information about limitations and exceptions, see plan or policy document at www.amerihealthnj.com/SGBooklet.

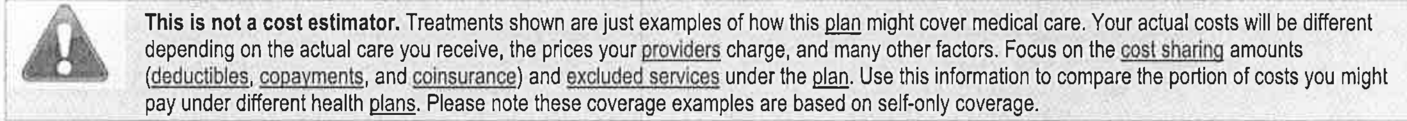
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Referred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge. Deductible does not apply.	Not covered.	Cost sharing does not apply for preventive services. Depending on the type of services a copayment and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	50% coinsurance.	Not covered.	
	Childbirth/delivery facility services	50% coinsurance.	Not covered.	Prior notification requested.
If you need help recovering or have other special health needs	Home health care	50% coinsurance.	Not covered.	Prior authorization is required. *See section "using services that require preapproval". 60 Visit(s)/Plan Year.
	Rehabilitation services	$70/Visit. Deductible does not apply.	Not covered.	PCP referral required. Physical Therapy and Occupational Therapy: 30 visits (combined)/Plan Year; Speech Therapy and Cognitive Therapy: 30 visits (combined)/Plan Year.
	Habilitation services	$70/Visit. Deductible does not apply.	Not covered.	PCP referral required. Physical Therapy and Occupational Therapy: 30 visits (combined)/Plan Year; Speech Therapy and Cognitive Therapy: 30 visits (combined)/Plan Year. Visit limits do not apply for the treatment of Autism.
	Skilled nursing care	50% coinsurance.	Not covered.	Prior authorization is required. *See section "using services that require preapproval".
	Durable medical equipment	50% coinsurance.	Not covered.	Prior authorization is required for selected items. *See section "using services that require preapproval".
	Hospice services	50% coinsurance.	Not covered.	Prior authorization is required. *See section "using services that require preapproval".
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered.	This benefit is administered by Davis Vision. Pediatric Vision; 1 exam(s)/Plan Year.
	Children's glasses	No charge. Deductible does not apply.	Not covered.	This benefit is administered by Davis Vision. Lenses and Hardware are covered once/Plan Year. Limit includes 1 pair(s) of frames from the select Davis Vision collection. There is a $150 allowance for non-collection frames.
	Children's dental check-up	Not covered.	Not covered.	None

*For more information about limitations and exceptions, see plan or policy document at www.amerihealthnj.com/SGBooklet.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

——To see examples of how this plan might cover costs for a sample medical situation, see the next section.——

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$90
Coinsurance	$4,500
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$7,100**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$800
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,660**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 888-YOUR-AH1 (TTY: 711)

The plan would be responsible for the other costs of these EXAMPLE covered services.

TeleSearch

2020-2021 Enrollment Change Form
Plan Year December 1, 2020 through November 30, 2021

DIRECTIONS:

1. Complete Sections 1 through 5. If you are waiving any lines of coverage, please be sure to check off the appropriate box.
2. Sign and Date the form.
3. Please return completed Enrollment form to HR Department within 48 hours of receipt.

Please note that if you fail to provide notification within 31 days of a qualified life event change, you may not be able to enroll yourself or your dependents or change your current elections until next open enrollment period.

1. Employee Information *Please Provide all requested information. Check here if change of address ☐*				
Full Name:		*Social Security Number:*	*Marital Status*	
Address:		*Date of Birth:*	*Gender:*	*Date of Hire:*
City:	*State:*	*Zip:*		*Effective Date:*
Email Address:	*Phone Number:*	*Occupation*		

2. Type of Enrollment *Please check all that apply.*				
☐	New Hire Enrollment	☐	Birth or Adoption of Child	Date:
☐	Open Enrollment	☐	Divorce / Legal Separation	Date:
☐	Address or Name Change	☐	Spouse Lost or Gained Coverage	Date:
☐	Other *(Please indicate)*	☐	Marriage	Date:

3. Coverage Options *Please check one box for each benefit. Rates are based on age, located in this guide*

Carrier	Plan Name	Waive	EE Only	EE +Child	EE + Children	EE + Spouse	EE + Family
AmeriHealth	SEH Silver HMO	☐ $0.00	☐ $	☐ $	☐ $	☐ $	☐ $
United Concordia	PPO	☐ $0.00	☐ $	☐ $	☐ $	☐ $	☐ $

Have you or a dependent used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use?	☐ Yes	☐ No
Please write name of the tobacco user:		
If Yes, are you participating in a tobacco cessation program	☐ Yes	☐ No

available only if enrolling a child dependent

4. Dependent Coverage Options

Please provide all information and check all boxes that apply.

Add	Delete	Dependent Full Name	Social Security #	Relationship	Birth Date	Gender	Medical	Dental
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐

5. Primary Care Physician (PCP) Election

Required if enrolling in the HMO plan(s). Check here if PCP change ☐

	PCP Name	PCP Phone	PCP Address	PCP ID
Employee:			* *	
Spouse:			* *	
Child:			* *	
Child:			* *	
Child:			* *	

I hereby declare that the information that I provide on this form is accurate and complete. I wish to participate in the benefit plan(s) that I have selected above, and I authorize my employer to deduct the necessary contributions from my paycheck. I understand that Social Security benefits may be reduced as certain pay deductions are being taken on a pre-tax basis. Further, my employer reserves that right to change the contributions at any time for the benefits they offer.

X ______________________________
Employee Signature

X ______________
Date

Please complete this form Sign/Date and Deliver to:
Karrie Rank

Federal regulations prohibit you from changing your enrollment or your elected salary reduction amount during the Plan Year. The only exception is in the event you experience a change in family status called a Qualifying Life Event. A Qualifying Life Event refers to: marriage, divorce, the death of a spouse or dependent, the birth or adoption of a child, termination or commencement of employment for your spouse, the changing of a part-time or full-time status for you or your spouse or taking an unpaid medical leave of absence by either you or your spouse. The beneficiary designation that you have made with the most recent calendar date will be considered your beneficiary designation. If you have not named a beneficiary, your Term Life Benefit will be payable to your estate.

Any coverage's that you elected which are subject to Evidence of Insurability (EOI) will not become effective until approved by the insurance carrier. Payroll deductions for the coverage amount pending EOI review will not begin until the review process is complete, and the coverage amounts are approved. If approved, the effective date of coverage will be indicated in written confirmation from the carrier. Similarly, if any of your elections add dependents to the plan and documentation (such as full-time student verification) is required by the carrier, the election will not take effect until such documentation is provided. Lastly, all amounts elected and/or approved are limited by the benefit maximums of each respective plan.