TeleSearch

2022 -2023 Enrollment Change Form
Plan Year December 1, 2022 through November 30, 2023

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. Medical age-based rates are listed in guide*

Carrier	Plan Name	Waive		EE Only		EE +Child		EE + Children		EE + Spouse		EE + Family	
AmeriHealth	EPO Value Plus	☐	$0.00	☐	$386.46	☐	$748.46	☐	$748.46	☐	$908.36	☐	$1,340.14

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*

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
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐

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.

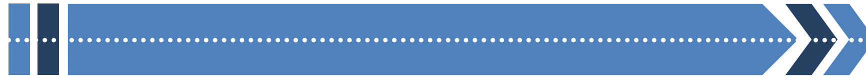
X____ X____________________

Employee Signature *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.



the peterman group
insurance and risk management solutions

TeleSearch
Group Medical Benefit and Rate Summary
Effective Date: December 1, 2022

Insurance Carrier	AmeriHealth
Plan Type	**EPO Value Plus $30 / $50 $1,500 $7 / $50% / $125**
In Network	
Referrals	No
Primary / Specialist	$30 / $50
TeleMedicine	$0
Wellness Visits	$0
Deductible (Ind/Family)	$1,500 / $3,000
Inpatient Hospital	30% (After Deductible)
Outpatient Surgery	30% (After Deductible)
Xray	30% (After Deductible)
Complex Imaging (MRI)	30% (After Deductible)
Lab	$0
Vision / Ped Dental	N/A
Urgent Care / ER	$50 / $100
Out of Pocket Max (Ind/Fam)	$3,000 / $6,000
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	$0
Generic	$7
Brand / Non-Form / Specialty	50% up to $125 Max
Mail Order (90 Day Supply)	$14 / 50% up to $250 Max
Total Monthly Premium	
Employee	$386.46
Employee + Child(ren)	$748.46
Employee + Spouse	$908.36
Family	$1,340.14

BENEFITS AT A GLANCE

EPO $30/$50 $1,500 $25/$50/$75 RX

Please read the important information at the end of this Benefits at a Glance.

This summary shows the Coinsurance percentage the Plan pays for various services. All payments are based on the Plan's allowance for the services performed.

Benefit	IN NETWORK	OUT OF NETWORK[1]
BENEFIT PERIOD	Calendar year*	Calendar year*
DEDUCTIBLE (EMBEDDED)[2 3]		
▪ Individual	$1,500	$0
▪ Family	$3,000	$0
OUT OF POCKET MAXIMUM (EMBEDDED)[4 5]		
▪ Individual	$3,000	$0
▪ Family	$6,000	$0
LIFETIME MAXIMUM	Unlimited	Unlimited
PREVENTIVE SERVICES		
▪ Preventive Services	100%	Not Covered
▪ Adult Immunizations	100%	Not Covered
▪ Pediatric Immunizations	100%	Not Covered
OUTPATIENT MEDICAL SERVICES		
▪ Primary Office Visit/Consultation	$30 copay / 100%	Not Covered
▪ Specialist Office Visit/Consultation	$50 copay / 100%	Not Covered

Benefit	IN NETWORK	OUT OF NETWORK[1]
URGENT CARE		
▪ Urgent Care	$50 copay / 100%	$50 copay / 100%
RETAIL CLINIC (MINUTE CLINIC)	$30 copay / 100%	Not Covered
TELEMEDICINE		
▪ Telemedicine	100%	Not Covered
▪ Telemedicine MDLive Behavioral Health	100%	Not Covered
▪ Telemedicine MDLive Dermatology	100%	Not Covered
THERAPY/COUNSELING SERVICES		
▪ Physical Therapy [6] 60 Visits per year(IN NETWORK)	$50 copay / 100%	Not Covered
▪ Occupational Therapy [6] 60 Visits per year(IN NETWORK)	$50 copay / 100%	Not Covered
▪ Speech Therapy[6] 60 Visits per year(IN NETWORK)	$50 copay / 100%	Not Covered
▪ Cardiac Rehabilitation 36 Visits per year(IN NETWORK)	$50 copay / 100%	Not Covered
▪ Pulmonary Therapy 12 Visits per year(IN NETWORK)	$50 copay / 100%	Not Covered
▪ Orthoptic/Pleoptic Therapy (Vision Therapy) 8 Sessions per year(IN NETWORK)	$50 copay / 100%	Not Covered
EMERGENCY MEDICAL FACILITY		
▪ Emergency Medical [7]	$100 copay / 100%	$100 copay / 100%
▪ Non Emergency	$100 copay / 100%	$100 copay / 100%
AMBULANCE SERVICES		
▪ Emergency Ambulance	70% after deductible	70% after deductible
▪ Non-Emergency Ambulance	70% after deductible	Not Covered
INPATIENT MEDICAL SERVICES		
▪ Inpatient Hospital Services	70% after deductible	Not Covered
▪ Inpatient Professional Services	70% after deductible	Not Covered
OUTPATIENT SURGICAL PROCEDURES		
▪ Outpatient Surgical Procedures	70% after deductible	Not Covered
▪ Short Procedure Facility	70% after deductible	Not Covered
DIAGNOSTIC TESTING OUTPATIENT		
▪ Diagnostic Medical	100%	Not Covered
▪ Simple Radiology	70% after deductible	Not Covered
▪ Advanced Radiology	70% after deductible	Not Covered
▪ Lab and Pathology	100%	Not Covered

Benefit	IN NETWORK	OUT OF NETWORK[1]
MATERNITY CARE		
▪ Initial Prenatal Care Visit	$50 copay / 100%	Not Covered
▪ Subsequent Prenatal Care Visit	100%	Not Covered
CRANIAL PROSTHESIS - WIG/HAIRPIECE	Not Covered	Not Covered
CHIROPRACTIC SERVICES		
▪ Chiropractic Services 30 Visits per year(IN NETWORK)	$50 copay / 100%	Not Covered
ALLERGY TESTS	$50 copay / 100%	Not Covered
ALLERGY INJECTIONS	$50 copay / 100%	Not Covered
NUTRITIONAL COUNSELING 6 Visits per year(IN NETWORK)	100%	Not Covered
DIALYSIS/HEMODIALYSIS	70% after deductible	Not Covered
PRIVATE DUTY NURSING	70% after deductible	Not Covered
SKILLED NURSING FACILITY 120 Days per year(IN NETWORK)	70% after deductible	Not Covered
HOME HEALTH CARE 60 Visits per year(IN NETWORK)	70% after deductible	Not Covered
INPATIENT HOSPICE CARE	70% after deductible	Not Covered
HOME INFUSION THERAPY	70% after deductible	Not Covered
DURABLE MEDICAL EQUIPMENT	50% after deductible	Not Covered
ORTHOTICS/PROSTHETICS DEVICES	50% after deductible	Not Covered
OUTPATIENT MENTAL NERVOUS		
▪ Psychotherapy Office Visit/Consultation	$50 copay / 100%	Not Covered
▪ Psychotherapy Visit	70% after deductible	Not Covered
DIABETIC SERVICES		
▪ Diabetic Education	$30 copay / 100%	Not Covered
▪ Diabetic Equipment	50% after deductible	Not Covered
▪ Diabetic Supplies	50% after deductible	Not Covered

AmeriHealth New Jersey
Fixed-Funding Mandate Guide

Effective 9/1/2022

Mandate Coverage

This quick reference guide indicates if the following current mandates are covered under the AmeriHealth New Jersey Fixed-Funding portfolio.

Note: The AmeriHealth New Jersey — EPO HSA 0%/0% $1,500 $7/50%/$125 Rx plan covers all mandates.

Mandate	AmeriHealth New Jersey
Breastfeeding support mandate	Included
Childhood immunizations and blood lead screening	Included
Civil unions	Included
Colorectal cancer screening	Included
ACA contraceptive mandate	Included
Diabetic education and supplies	Included
Domestic partners (cover same-sex dependents and their children)	Included
ER mandate (HCQA)	Included
Infant formula/enteral formula/medical food	Included
Mammograms (Including 3D mammography)	Included
Newborn — 60-day coverage	Included
Nutritional supplements	Included
Pap smears	Included
Prostate cancer screening	Included
Treatment of mental health & substance use disorder treatment	Included

Mandate	AmeriHealth New Jersey
Autism (including early intervention services, diagnosis, speech therapy, physical therapy, occupational therapy, labs, or applied behavioral analysis as it relates to autism)	Excluded
Autologous bone marrow transplant	Excluded
Bariatric surgery	Excluded
Continuation of benefits for dependents upon death of insured	Excluded
Continuation of coverage due to total disability of employee or member	Excluded
Coverage of handicapped children beyond termination age	Excluded
Dependent health benefits: Extension of benefits to age 31	Excluded
Donated human breast milk	Excluded
Health wellness promotion	Excluded
Hearing aids	Excluded
Infertility treatment (including diagnosis, testing, and treatment)	Excluded
Inherited metabolic disorders	Excluded
Mail-order pharmacy cost shares and supply quantity	Excluded
OON Consumer Protection, Transparency, Cost Containment & Accountability Act	Excluded
Oral contraceptives — 6 month coverage supply	Excluded
Prosthetics/Orthotics mandated appliances	Excluded
TMJ surgery	Excluded
Wilms' tumor	Excluded

© 2022 AmeriHealth