TeleSearch
Group Medical Benefit and Rate Summary
Effective Date: December 1, 2017

Insurance Carrier	Amerihealth
Plan Type	Silver HMO Local Value $50/$75 PY
In Network	
Referrals	Yes
Tier	N/A
Primary/Specialist	$50 / $75
Wellness Visits	$0
Deductible (Ind/Family)	$2,000 / $4,000
Inpatient Hospital Copay	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 / $100 (After Ded)
Out of Pocket Maximum	$6,850/$13,700
Lifetime Maximum	Unlimited
Out of Network	
Deductible	N/A
Coinsurance	N/A
Out of Pocket Maximum	N/A
Lifetime Maximum	N/A
Prescription	
Deductible	$0
Generic	50% to $125 Max
Brand/Non-Form	50% to $125 Max
Mail Order	50%

Created on : 11/13/2017

Age-Band Rates

Rates effective from 12/01/2017 through 11/30/2018

SEH Silver HMO Local Value $50/$75 - CY
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 - 20	$227.73	$227.73	43	$440.28	$440.28
21	$379.55	$379.55	44	$448.78	$448.78
22	$379.55	$379.55	45	$458.80	$458.80
23	$379.55	$379.55	46	$470.65	$470.65
24	$379.55	$379.55	47	$483.70	$483.70
25	$379.55	$379.55	48	$498.28	$498.28
26	$379.55	$379.55	49	$512.55	$512.55
27	$379.55	$379.55	50	$528.64	$528.64
28	$379.55	$379.55	51	$544.13	$544.13
29	$387.14	$387.14	52	$560.83	$560.83
30	$390.79	$390.79	53	$577.53	$577.53
31	$396.25	$396.25	54	$595.44	$595.44
32	$401.72	$401.72	55	$613.05	$613.05
33	$405.06	$405.06	56	$631.58	$631.58
34	$408.70	$408.70	57	$650.40	$650.40
35	$410.53	$410.53	58	$669.84	$669.84
36	$412.35	$412.35	59	$692.31	$692.31
37	$413.87	$413.87	60	$692.31	$692.31
38	$415.69	$415.69	61	$692.31	$692.31
39	$419.33	$419.33	62	$692.31	$692.31
40	$422.97	$422.97	63	$692.31	$692.31

41	$428.14	$428.14	64+	$692.31	$692.31
42	$433.30	$433.30			

Healthy Chompers Child Plus Adult Preventive (child and adult plan)
Healthy Chompers Child (pediatric plan)

DENTAL BENEFITS SUMMARIES

Small Group (2-50)

Network: **Alliance**

	Age 0-18*	Age 19+
Contract Year Deductible per Member:	$350	$0
Annual Maximum Payable per Member:	N/A	$1000
Out of Pocket (OOP) Maximum Covering 1 Child: *Applies to In-Network Services Only*	$350	N/A
Out of Pocket (OOP) Maximum Covering 2 or More Children: *Applies to In-Network Services Only*	$700	N/A

***This plan meets the minimum essential health benefit requirements for pediatric oral health as required under the federal Affordable Care Act. Child's age is determined by the effective date of the policy or as of the enrollment date, whichever is later.**
These benefits are available to children through the end of the contract year that they turn 19.

Covered Services	Age 0-18**			Age 19+		
	Waiting Period	Policy Pays	After Deductible	Waiting Period	Policy Pays	After Deductible
Oral Evaluations (Exams)	None	90%	N/A	None	100%	N/A
Radiographs (All X-Rays)	None	50%	N/A	None	100%	N/A
Prophylaxis (Cleanings)	None	90%	N/A	None	100%	N/A
Fluoride Treatments	None	50%	N/A	None	Services are not Covered. Discounts apply at most provider offices*	N/A
Palliative Treatment (Emergency)	None	50%	N/A	None		N/A
Sealants	None	50%	N/A	None		N/A
Space Maintainers	None	50%	Yes	None		N/A
Amalgam Restorations (Metal Fillings)	None	50%	Yes	None		N/A
Resin-based Composite Restorations Anterior (White Fillings)	None	50%	Yes	None		N/A
Crowns, Inlays, Onlays	None	50%	Yes	None		N/A
Crown Repair	None	50%	Yes	None		N/A
Endodontic Therapy (Root Canals, etc.) and Other Endodontic Services	None	50%	Yes	None		N/A
Surgical Periodontics, Non-Surgical Periodontics and Prosthetics (Complete or Fixed Partial Dentures)	None	50%	Yes	None		N/A
Periodontal Maintenance	None	50%	Yes	None		N/A
Adjustments and Repairs of Prosthetics	None	50%	Yes	None		N/A
Other Prosthetic Services	None	50%	Yes	None		N/A
Maxillofacial Prosthetics	None	50%	N/A	None		N/A
Implant Services	12 Months	50%	Yes	None		N/A
Simple Extractions	None	50%	Yes	None		N/A
Surgical Extractions	None	50%	Yes	None		N/A
Oral Surgery	None	50%	Yes	None		N/A
General Anesthesia, Nitrous Oxide and/or IV Sedation	None	50%	Yes	None		N/A
Consultations	None	90%	N/A	None		N/A
Medically Necessary Orthodontics	12 Months	50%	N/A	None		N/A

Exclusions and limitations apply. Please see plan details and documents.

*Discounts may apply. Network dentists may elect to discount non-covered services. Consult our online provider directory (Find A Dentist) to search for a dentist. Dentists with a black box (■) next to their name accept negotiated rates for non-covered services. Discounts vary by service and region with average savings of 30%.

**The Policy will cover eligible services, when performed in-network and once OOP Max is met, at 100%.

A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality.

Important Regulatory Disclosure: Dental plans are administered by United Concordia Companies, Inc., and underwritten by United Concordia Life and Health Insurance Company. For information about which companies are licensed in your state, visit the "Disclaimers" link at www.UnitedConcordia.com. Administrative and claims offices located at 4401 Deer Path Road, Harrisburg, PA 17110 (1-888-483-9930).

These policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your account representative for specific provisions and details of availability.

***Benefits are eligible for children 0-18 in either plan. The Healthy Chompers Child plan is pediatric only and does not offer any benefit for adults.**

UnitedConcordia.com

PREMIUM RATES

Essex, Hudson, Union, Bergen, Passaic, Monmouth, Morris, Sussex, Warren, Hunterdon, Middlesex and Somerset	Burling, Camden, Mercer, Atlantic, Cape May, Ocean, Salem, Cumberland, Gloucester
Premium Rate per Enrolled Member for the Healthy Chompers Child Plan*	
$26.45 for 0 through18 $0 for 19+	**$26.19 for 0 through 18 $0 for 19+**
Premium Rate per Enrollment Member for the Healthy Chompers Child Plus Adult Preventive Plan	
$17.29	**$17.39**

FOR PRODUCER USE ONLY

United Concordia Life and Health Insurance Company is a Qualified Health Plan issuer in the

Silver HMO Value $50/$75

Coverage for: FAMILY| **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.amerihealthnj.com/SGBooklet or by calling 1-888-YOUR-AH1 (TTY:711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-YOUR-AH1 (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 person/ $4,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,850 person / $13,700 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.amerihealthnj.com/provider_finder or call 1-888-YOUR-AH1 (TTY:711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		a Referred Provider	an Out Of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 Copayment (copay)/visit, Deductible does not apply	Not Covered	None.
	Specialist visit	$75 copay/visit, Deductible does not apply	Not Covered	PCP referral required for certain services.
	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)	$50 copay/test, Deductible does not apply (X-Ray)/No Charge, Deductible does not apply (Blood Work)	Not Covered	Referral required for certain services.
	Imaging (CT/PET scans, MRIs)	$100 copay/test, 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 www.amerihealthnj.com/formulary	Generic	50% (1-30 days supply/Retail & Mail) Maximum (max) $125; 50% (31-90/Mail) max $250, per prescription fill, Deductible does not apply	Not Covered	Prior authorization may be required on some drugs. Covers up to a 90 day supply.
	Preferred Drug	50% (1-30 days supply/Retail & Mail) max $125; 50% (31-90/Mail) max $250, per prescription fill, Deductible does not apply	Not Covered	Prior authorization may be required on some drugs. Covers up to a 90 day supply.
	Non-Preferred Drugs	50% (1-30 days supply/Retail & Mail) max $125; 50% (31-90/Mail) max $250, per prescription fill, Deductible does not apply	Not Covered	Prior authorization may be required on some drugs. Covers up to a 90 day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		a Referred Provider	an Out Of Network Provider	
	Specialty drugs	50% (1-30 days supply/Retail & Mail) max $125; 50% (31-90/Mail) max $250, per prescription fill, Deductible does not apply	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%	Not Covered	Prior authorization is required for certain services. *See section "using services that require preapproval".
	Physician/surgeon fees	50%	Not Covered	Prior authorization is required for certain services. *See section "using services that require preapproval".
If you need immediate medical attention	Emergency room care	$100 copay/visit	Covered at in-network level	None.
	Emergency medical transportation	50%	Covered at in-network level	None.
	Urgent care	$85 copay/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 physicians office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	50%	Not Covered	Prior authorization is required. *See section "using services that require preapproval".
	Physician/surgeon fees	50%	Not Covered	Prior authorization is required. *See section "using services that require preapproval".
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay/visit, Deductible does not apply	Not Covered	None.
	Inpatient services	50%	Not Covered	Prior authorization may be required. *See section "using services that require preapproval".
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%	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.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		a Referred Provider	an Out Of Network Provider	
	Childbirth/delivery facility services	50%	Not Covered	Prior notification requested.
If you need help recovering or have other special health needs	Home health care	50%	Not Covered	Prior authorization is required. *See section "using services that require preapproval". 60 visits per calendar year.
	Rehabilitation services	$50 copay/visit, Deductible does not apply	Not Covered	PCP referral required. Physical Therapy/ Occupational Therapy: 30 visits (combined) per calendar year; Speech Therapy/Cognitive Therapy: 30 visits (combined) per calendar year.
	Habilitation services	$50 copay/visit, Deductible does not apply	Not Covered	PCP referral required. Physical Therapy/ Occupational Therapy: 30 visits (combined) per calendar year; Speech Therapy/Cognitive Therapy: 30 visits (combined) per calendar year. Visit limits do not apply for Treatment of Autism.
	Skilled nursing care	50%	Not Covered	Prior authorization is required. *See section "using services that require preapproval".
	Durable medical equipment	50%	Not Covered	Prior authorization is required for selected items. *See section "using services that require preapproval".
	Hospice services	50%	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	Pediatric Vision; Once every calendar year.
	Children's glasses	No Charge, Deductible does not apply	Not Covered	Pediatric Vision; Once every calendar year.
	Children's dental check-up	Not Covered	Not Covered	None.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental care (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine Eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (covered for members age 15 and younger)
- Infertility Treatment (limited to artificial insemination; requires pre approval)
- Private-duty nursing (covered under Home Health Care)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the plan call 888-YOUR-AH1 (TTY:711), or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, you should contact your State Insurance regulator regarding possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan . For more information about your rights, this notice, or assistance, contact: New Jersey Department of Banking and Insurance - (609) 292-7272; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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** $2,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 50%
- **Other coinsurance** 0%

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	**$2,000**
Copayments	**$50**
Coinsurance	**$5,800**
What isn't covered	
Limits or exclusions	**$10**
The total Peg would pay is	**$6,860**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $2,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 50%
- **Other coinsurance** 0%

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	**$0**
Copayments	**$500**
Coinsurance	**$3,000**
What isn't covered	
Limits or exclusions	**$60**
The total Joe would pay is	**$3,560**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $2,000
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 50%
- **Other coinsurance** 0%

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: 1-888-YOUR-AH1 (TTY:711)

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

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Please Mail To:
AmeriHealth New Jersey
259 Prospect Plains Road, Building M,
Cranbury, NJ 08512

AmeriHealth New Jersey Small Group Member Coverage Application

AmeriHealth NEW JERSEY	Group Information – to be completed by Employer:		
AmeriHealth New Jersey	Group Name:	Group Number:	Class Code:

A. Type of Activity – To be completed by Applicant. *Refer to instructions before completing this form. Print clearly.*

	Activity – Check all that apply	Date of Event	Date of Hire/Reason for Change
ADD	☐ Enrollment of a new Subscriber	__/__/__	Date: __/__/__ Reason: ____
	☐ Add Spouse	__/__/__	Date: __/__/__ Reason: ____
	☐ Add Civil Union Partner	__/__/__	Date: __/__/__ Reason: ____
	☐ Add Domestic Partner	__/__/__	Date: __/__/__ Reason: ____
	☐ Add Dependent Child	__/__/__	Date: __/__/__ Reason: ____
	☐ Add Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*	__/__/__	Date: __/__/__ Reason: ____
REMOVE	☐ Employee Withdrawal/Termination	__/__/__	Date: __/__/__ Reason: ____
	☐ Remove Spouse	__/__/__	Date: __/__/__ Reason: ____
	☐ Civil Union Partner	__/__/__	Date: __/__/__ Reason: ____
	☐ Remove Domestic Partner	__/__/__	Date: __/__/__ Reason: ____
	☐ Remove Dependent Child	__/__/__	Date: __/__/__ Reason: ____
	☐ Remove Over-Age Child as a Dependent Under 31	__/__/__	Date: __/__/__ Reason: ____
OTHER CHANGES	☐ Name Change	__/__/__	____
	☐ Change Plan	__/__/__	____
	☐ Other	__/__/__	____
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist **See list of Triggering Events in Instructions*	__/__/__	____

COVERAGE CONTINUATION

☐ For Employee	☐ Total Disability* ☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 29	Date of Loss of Coverage: __/__/__	Qualifying Event #: ____ **	Date of Qualifying Event: __/__/__
Billing: ☐ Group ☐ Home (Section B)				***Attach proof of disability**	
☐ For Spouse/Civil Union Partner*	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage: __/__/__	Qualifying Event #: ____ **	Date of Qualifying Event: __/__/__	
Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ Section E			***Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.**		
☐ For Dependent/ Over-age Child	☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage: __/__/__	Qualifying Event #: ____ **	Date of Qualifying Event: __/__/__
☐ Dependent Under 31	Qualifying Event #: ____ **	Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ Section F			

****Qualifying event #s: see list in Instructions. ***Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section J.**

B. Employee Information – To be completed by the Employee

Name (Last, First, MI):	SSN:	Birthdate (mm/dd/yyyy)	Sex: ☐ M ☐ F

HOME

Street/Apt: ____
Street/Apt: ____
City, State, Zip Code: ____
Phone: ____ Email: ____

WORK

Employer Name: ____
Address: ____
City, State, Zip Code: ____
Phone: ____ Email: ____
Employment Date: ____ Hours worked per week: ____

50196

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ACTIVITY	☐ Add ☐ Remove ☐ Continuation ☐ Other Change – *If a name change, indicate prior name:*		
	Primary Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:
	Ob/Gyn Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:
	Dentist Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:

Other Health Coverage? ☐ Yes ☐ No If yes: Payer Name: ______ Policy #: ______ Medicare ID#, if any: ______	Other Rx Coverage? ☐ Yes ☐ No If yes: Payer Name: ______ Policy #: ______ Medicare ID#, if any: ______
C. Plan Option – to be completed by the Employee	Medical Plan Name:

D. Other Individuals Covered – to be completed by the Employee *Identify individuals other than yourself for whom you are adding/changing removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability if necessary.*

1.Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L:______ F:______ MI:	Name (last, first, MI) L:______ F:______ MI:	Name (last, first, MI) L:______ F:______ MI:	Name (last, first, MI) L:______ F:______ MI:
Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number:	Social Security Number:	Social Security Number:	Social Security Number:
Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______
Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: ______ Policy #: ______ Medicare ID #: ______
Primary Care Provider: NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No
Ob/Gyn Office NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No ☐ NA
Dentist Office NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: ______ Address: ______ ______ ______ Current Patient? ☐ Yes ☐ No

Employed? ☐ Yes ☐ No *If yes, complete Section E1*	If last name is different from Employee's, please explain: ________________	If last name is different from Employee's, please explain: ________________	If last name is different from Employee's, please explain: ________________
Home or billing address same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by Employee. *If not applicable, please mark as "NA."*

1.	Employer Name:________ Employer Address:________ City, State, Zip Code:________ Phone:________
2.a	Street/Apt:________ Street/Apt:________ City, State, Zip Code:________
2.b	Please explain why the address is different:________

F. Additional Child Information – to be completed by Employee. *Provide information below about children listed in Section D,* ***if*** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):________ Street/Apt:________ Street/Apt:________ City, State, Zip Code:________ Reason:________	Name(s):________ Street/Apt:________ Street/Apt:________ City, State, Zip Code:________ Reason:________

G. Race/Ethnicity – to be completed by Employee at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:
☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature:	Date:___/___/___

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election

Signature:	Date:___/___/___

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer. In addition, the Employer consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No

Employer Representative:	Date:___/___/___
Representative's Title:	

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (9 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI or PCP ID number from the provider directory on www.amerihealthnj.com or by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI or PCP ID number. You should confirm the correct NPI or PCP ID number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events

COBRA and NJSGC

- C1. Termination of job or reduction in hours
- C2. Employee enrollment in Medicare (COBRA only)
- C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
- C4. Death of employee
- C5. Loss of dependent child status under the plan
- C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

- D1. Loss of dependent status and otherwise eligible
- D2. Reestablish eligibility: residency
- D3. Reestablish eligibility: nonresident full-time student
- D4. Reestablish eligibility: change in marital status
- D5. Reestablish eligibility: change in parental status
- D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT – APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give AmeriHealth New Jersey, or any consumer reporting agency acting on behalf of AmeriHealth New Jersey, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that AmeriHealth New Jersey has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree AmeriHealth New Jersey will provide coverage in accordance with the terms of the contract for the group plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

MISREPRESENTATIONS

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

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