

Important Notice

Regarding the Pre-existing Condition Exclusion in this Coverage

About the pre-existing condition exclusion

The coverage in which you are enrolling includes a pre-existing condition exclusion. Under this exclusion, you or your dependents will have no coverage for pre-existing conditions for up to six months, if you are enrolled through a New Jersey group, or 12 months if enrolled through a Delaware group.

A pre-existing condition is an illness or injury which manifests itself in the six months before coverage by AmeriHealth is effective and for which you received, or were advised by a provider to receive, medical care, treatment or took drugs or, advice, care or treatment in the six months before coverage begins.

If you have any questions or comments now or in the future, please call AmeriHealth Member Services.

Exceptions to the pre-existing condition exclusion

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Small Employer Health plan provides exceptions and limits to pre-existing condition exclusions.

Your pre-existing condition exclusion period can be reduced if you had coverage prior to enrolling with this health plan. You may receive credit for any comprehensive medical coverage in which you were enrolled, as long as you were covered at some time during the three months prior to the effective date of coverage with AmeriHealth.

To receive credit for prior coverage in which you - or a family member - was enrolled, you must fill out the form provided and attach information, such as a Certification of Coverage to your enrollment form. If you believe you or any family member have prior coverage but you do not have a Certification, speak to your Group Leader. You may obtain a Certification of Coverage and submit this at a later date, or AmeriHealth will accept other information while assisting you to obtain a Certification of Coverage from your prior carrier(s). AmeriHealth is not required to credit you for coverage prior to a significant break in coverage.

- After reviewing your enrollment form and attached materials AmeriHealth will provide you with a notice if you are determined to be subject to a pre-existing condition exclusion.

Maternity benefits are not subject to pre-existing condition exclusion. The term "Maternity Benefits" includes prenatal care.

Newborn children, and children placed for adoption are not subject to pre-existing condition exclusions as long as they are enrolled within 30 days following the date of birth, or placement for adoption. If your child was born or adopted since July 1, 1997 and has been continuously covered (with no break in coverage of more than 63 days), note that on the form provided.



Pre-Ex Check-Off Form
IMPORTANT!

The coverage in which you are enrolling has a pre-existing condition exclusion. A notice is provided in this kit which explains the pre-existing condition exclusion. If you did not receive a copy of the notice, or if you have any questions after reviewing this document, please contact your Group Leader or the Insurance Agent assisting your group.

It is possible the pre-existing condition exclusion does not apply to you. Please read the following and check off which of these describes your situation, and to indicate what documents you are submitting to expedite AmeriHealth's determination of whether you can get a waiver of the pre-existing condition exclusion.

You or your family members (spouse or child) have not had any health coverage within the last 3 months.

If this describes you, please submit your application form to AmeriHealth. You will be subject to a pre-existing condition exclusion.

You, or any family member (spouse or child), have had health coverage within the last 3 months. If this describes you, please fill out the appropriate areas below and submit this form and the attachments with your application form to AmeriHealth.

_____ I do have a Certificate(s) of Coverage for myself or a family member;

_____ I do not have a Certificate(s) of Coverage, so I am submitting:

A letter listing the insurers or HMOs with whom I previously had coverage (it can be more than one) and when the coverage was in effect.

AND

A copy of a document that shows I did have prior coverage. (This can be a copy of an ID card, a bill, or any other document on official letterhead which provides evidence of prior coverage.)

******RETURN THIS FORM WITH YOUR APPLICATION******

I understand AmeriHealth is entitled, by law, to verify, with prior carrier(s), any information regarding prior coverage which I have provided. I will assist AmeriHealth in this regard if asked to do so. Providing false or misleading information for the purpose of obtaining coverage is against the law and could result in criminal or civil penalties.

Signature _____ *Date* _____

