BENEFITS AT A GLANCE

SOUTHERN NEW JERSEY HIF
003780 EVESHAM TOWNSHIP HDHP ACTIVE
EVESHAM TOWNSHIP HDHP PLAN

REQUESTED DATE OF SERVICE: 4/8/2025

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	$1,650	$1,650
▪ Family	$3,300	$3,300
OUT OF POCKET MAXIMUM (EMBEDDED)[4 5]		
▪ Individual	$2,500	$3,600
▪ Family	$5,000	$7,200
LIFETIME MAXIMUM	Unlimited	Unlimited
PREVENTIVE SERVICES		
▪ Preventive Services	100%	60% after deductible
▪ Adult Immunizations	100%	60% after deductible
▪ Pediatric Immunizations	100%	80% after deductible
▪ Annual Gynecological Exam	100%	60% after deductible
▪ Annual Pap Smear	100%	60% after deductible
▪ Mammogram	100%	60% after deductible
▪ Contraceptive Services	100%	60% after deductible

Benefit	IN NETWORK	OUT-OF-NETWORK[1]
OUTPATIENT MEDICAL SERVICES		
▪ Primary Office Visit/Consultation	80% after deductible	60% after deductible
▪ Specialist Office Visit/Consultation	80% after deductible	60% after deductible
URGENT CARE		
▪ Urgent Care	80% after deductible	60% after deductible
RETAIL CLINIC (MINUTE CLINIC)	80% after deductible	60% after deductible
TELEMEDICINE		
▪ Telemedicine	100%	Not Covered
▪ Telemedicine Dermatology	100%	Not Covered
▪ Telemedicine Behavioral Health	100%	Not Covered
THERAPY/COUNSELING SERVICES		
▪ Physical Therapy	80% after deductible	60% after deductible
▪ Occupational Therapy	80% after deductible	60% after deductible
▪ Speech Therapy	80% after deductible	60% after deductible
▪ Cardiac Rehabilitation	80% after deductible	60% after deductible
▪ Pulmonary Therapy	80% after deductible	60% after deductible
▪ Orthoptic/Pleoptic Therapy (Vision Therapy)	80% after deductible	60% after deductible
EMERGENCY MEDICAL FACILITY		
▪ Emergency Medical	80% after deductible	80% after deductible
▪ Non Emergency	80% after deductible	80% after deductible
AMBULANCE SERVICES		
▪ Emergency Ambulance	80% after deductible	80% after deductible
▪ Non-Emergency Ambulance	Not Covered	Not Covered
INPATIENT MEDICAL SERVICES		
▪ Inpatient Hospital Services	80% after deductible	60% after deductible
▪ Inpatient Professional Services	80% after deductible	60% after deductible
OUTPATIENT SURGICAL PROCEDURES		
▪ Outpatient Surgical Procedures	80% after deductible	60% after deductible
▪ Short Procedure Facility	80% after deductible	60% after deductible
DIAGNOSTIC TESTING OUTPATIENT		
▪ Diagnostic Medical	80% after deductible	60% after deductible
▪ Simple Radiology	80% after deductible	60% after deductible
▪ Advanced Radiology	80% after deductible	60% after deductible
▪ Lab and Pathology	80% after deductible	60% after deductible

Benefit	IN NETWORK	OUT-OF-NETWORK[1]
MATERNITY CARE		
▪ Initial Prenatal Care Visit	80% after deductible	60% after deductible
▪ Subsequent Prenatal Care Visit	80% after deductible	60% after deductible
CRANIAL PROSTHESIS - WIG/HAIRPIECE $500 per 24 Months[6]	80% after deductible	60% after deductible
CHIROPRACTIC SERVICES		
▪ Chiropractic Services 30 Visits per year[6]	80% after deductible	60% after deductible
ALLERGY TESTS	80% after deductible	60% after deductible
ALLERGY INJECTIONS	80% after deductible	60% after deductible
NUTRITIONAL COUNSELING 3 Visits per year(IN NETWORK)	100%	60% after deductible
DIALYSIS/HEMODIALYSIS	80% after deductible	60% after deductible
PRIVATE DUTY NURSING	80% after deductible	60% after deductible
SKILLED NURSING FACILITY 120 Days per year(IN NETWORK) 60 Days per year(OUT-OF-NETWORK)	80% after deductible	60% after deductible
HOME HEALTH CARE	80% after deductible	60% after deductible
INPATIENT HOSPICE CARE	80% after deductible	60% after deductible
HOME INFUSION THERAPY	80% after deductible	60% after deductible
DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible
ORTHOTICS/PROSTHETICS DEVICES	80% after deductible	60% after deductible
OUTPATIENT MENTAL NERVOUS		
▪ Psychotherapy Office Visit/Consultation	80% after deductible	60% after deductible
▪ Psychotherapy Visit	80% after deductible	60% after deductible
DIABETIC SERVICES		
▪ Diabetic Education 4 Visits per year(IN NETWORK)	100%	Not Covered
▪ Diabetic Equipment	80% after deductible	60% after deductible
▪ Diabetic Supplies	80% after deductible	60% after deductible
▪ Insulin Infusion Pumps	Not Covered	Not Covered

This summary represents only a partial listing of benefits and exclusions of the Group Health Plan described in this summary. Benefits and exclusions may be further defined by medical policy. As a result, this Group Health Plan may not cover all of your health care expenses. Read your member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the Group Health Plan. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ahatpa.com.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to www.ahatpa.com or call the phone number that is listed on the back of your identification card.

*A calendar year benefit period begins on the first day of the calendar year and ends on the last day of the calendar year. The deductible and out-of-pocket maximum amount starts at $0 at the beginning of each calendar year.

[1]It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.
[2]The in- and out-of-network deductibles accumulate separately.
[3]Each member contributes towards his or her own deductible. The deductible is considered met when he or she reaches the individual deductible or the family deductible is met.
[4]Out of pocket includes medical and prescription.
[5]Each member contributes towards his or her own out-of-pocket maximum. The out-of-pocket maximum is considered met when he or she reaches the individual out-of-pocket maximum or the family out-of-pocket maximum is met.
[6]Service limits combined across tiers.

Services that require precertification

Core precertification list effective: January 1, 2025

This applies to services performed on an elective, non-emergency basis. Because a service or item is subject to precertification, it does not guarantee coverage. The terms and conditions of your benefit plan must be reviewed to determine if any of these services or items are excluded. For your reference, we have published a list of medical codes for services that require precertification, which is available on our Medical Policy Portal.

Inpatient services

- Acute rehabilitation admissions
- Elective surgical and nonsurgical inpatient admissions
- Inpatient hospice admissions
- Long-term acute-care (LTAC) facility admissions
- Skilled nursing facility admissions

Procedures

- Cochlear implant surgery
- Obesity surgery

Reconstructive procedures and potentially cosmetic procedures

- Blepharoplasty/blepharoptosis repair
- Bone graft, genioplasty, and mentoplasty
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, and insertion or removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical peels
- Dermabrasion
- Excision of subcutaneous skin and/or subcutaneous tissue
- Gender-affirming interventions
- Genetically and bioengineered skin substitutes for wound care
- Gynecomastia
- Hair transplants
- Injectable dermal fillers
- Keloid removal
- Lipectomy, liposuction, or any other excess fat removal procedure
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar revision
- Skin closures including:
  - Skin grafts
  - Skin flaps
  - Tissue grafts
- Surgery for varicose veins, including perforators and sclerotherapy

Day rehabilitation programs

Elective (nonemergency) ground, air, and sea ambulance transportation

Outpatient private-duty nursing

Home-care services

- Enteral feeding therapy (tube feeding)
- Home health care
- Home infusion therapy

Prosthetics/orthoses

- Custom ankle-foot orthoses
- Custom knee-ankle-foot orthoses
- Custom knee braces
- Custom limb prosthetics including accessories/components
- Repair or replacement of all prosthetics/orthoses that require precertification

Select durable medical equipment (DME)

- Bone growth stimulators
  - Low-intensity ultrasound noninvasive bone growth stimulation
  - Other than spinal noninvasive electrical bone growth stimulation
- Bone-anchored (osseointegrated) hearing aids
  - Bone conduction hearing aids
  - Cochlear implants
- Dynamic adjustable and static progressive stretching devices (excludes CPMs)
- Electric, power, and motorized wheelchairs including custom accessories
- Insulin pumps
- Manual wheelchairs with the exception of those that are rented
- Negative pressure wound therapy
- Neuromuscular stimulators
- Power operated vehicles (POV)

Select durable medical equipment (DME) (continued)

- Pressure-reducing support surfaces including:
  - Air fluidized bed
  - Non-powered advanced pressure-reducing mattress
  - Powered air flotation bed (low air loss therapy)
  - Powered pressure-reducing mattress
- Push rim activated power assist devices
- Repair or replacement of all DME items that require precertification
- Speech generating devices

Medical foods

Hyperbaric oxygen therapy

Transplants

All transplant procedures, with the exception of corneal transplants

Mental health/serious mental illness/ substance abuse

- Mental health and serious mental illness treatment (inpatient/partial hospitalization programs/intensive outpatient programs)
- Repetitive transcranial magnetic stimulation (rTMS)
- Substance abuse treatment (inpatient/ partial hospitalization programs/ intensive outpatient programs)

Autism spectrum disorders

- Applied behavioral analysis (Precertification review for this service is provided by Magellan Healthcare, Inc., an independent company.)

Specialty drugs that require precertification

All listed brands and their generic equivalents require precertification. This list is subject to change.

See this list for information on Direct Ship.

Amyotrophic lateral sclerosis agents

- debamestrocel

Antineoplastic agents/chemotherapy

- Abraxane® (paclitaxel protein-bound particles)
- Adcetris® (brentuximab vedotin)
- Adstiladrin® (nadofaragene firadenovec)
- Alymsys® (bevacizumab) (except for ophthalmological conditions)
- Anktiva® (nogapendekin alfa-inbakicept)
- Avastin®† (bevacizumab) (except for ophthalmological conditions)
- Avzivi® (bevacizumab-tnjn)
- Blincyto® (blinatumomab)
- Cyramza® (ramucirumab)
- Darzalex® (daratumumab)
- Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)
- datapotamab deruxtecan*
- Elahere® (mirvetuximab soravtansine-gynx)
- Elrexfio™ (elranatamab-bcmm)
- Enhertu (fam-trastuzumab-deruxtecan-nxki)
- Epklinly™ (epicortimab-bysp)
- Erbitux® (cetuximab)
- glofitamab*
- Herceptin®† (trastuzumab)
- Herceptin Hylecta™ (trastuzumab)
- Hercessi™ (trastuzumab-strf)
- Herzuma® (trastuzumab-pkrb)
- Imjudo® (tremelimumab)
- Kadcyla® (ado-trastuzumab emtansinel)
- Kimmtrak® (tebentafusp-tebn)
- Kyprolis® (carfilzomib)
- Lunsumio™ (mosumetuzumab-axgb)
- Margenza™ (margetuximab)
- Monjuvi® (tafasitamab-cxix)
- odronextamab*
- Ogivri™ (trastuzumab-dkst)
- Ontruzant® (trastuzumab-dttb)
- Opdualag™ (nivolumab and relatlimab-rmbw)
- Padcev™ (enfortumab vedotin-ejfv)
- patritumab deruxtecan*
- Pemfexy™ (pemetrexed)
- Perjeta® (pertuzumab)
- Phesgo™ (pertuzumab/trastuzumab/hyaluronidase-zzxf)
- Polivy™ (polatuzumab vedotin-piiq)
- Poteligeo™ (mogamulizumab)
- Provenge® (sipuleucel-T)
- Riabni (rituximab-arrx)
- Rituxan®† (rituximab)
- Rituxan Hycela™ (rituximab/hyaluronidase human)
- Rybrevant (amivantamab-vmjw)
- Rylaze™ (asparaginase Erwinia chrysanthemi [recombinant]-rywn)
- Sarclisa (isatuximab-irfc)
- Taclantis* (paclitaxel injection concentrate for suspension)
- Talvey™ (talquetamab-tgvs)
- Tecvayli™ (teclistamab)
- Tivdak™ (tisotumab vedotin-tftv)
- trastuzumab-duocarmazine*
- Trodelvy™ (sacituzumab govitecan-hziy)
- Vegzelma® (bevacizumab-adcd) (except for ophthalmological conditions)
- Yervoy™ (ipilimumab)
- zanidatamab*
- zenocutuzumab*
- Zepzelca™ (lurbinectedin)
- Zynlonta (loncastuximab tesirine)

Anti-PD-1/PD-L1 human monoclonal antibodies*/chemotherapy

- Bavencio® (avelumab)
- balstilimab*
- camrelizumab*
- cosibelimab*
- Imfinzi™ (durvalumab)
- Jemperli (dostarlimab-gxly)
- Keytruda™ (pembrolizumab)
- Libtayo® (cemiplimab-rwlc)
- Loqtorzi® (toripalimab-tpzi)
- Opdivo® (nivolumab)
- penpulimab*
- Tecentriq™ (atezolizumab)
- Tevimbra® (tislelizumab-jsgr)
- Zynyz® (retifanlimab)

Bone-modifying agents

- Evenity® (romosozumab-aqqg)
- Jubbonti® (denosumab-bbdz)
- Prolia® (denosumab)
- Wyost® (denosumab-bbdz)
- Xgeva® (denosumab)

Botulinum toxin agents

- Botox® (onabotulinumtoxinA)

Chimeric antigen receptor (CAR-T) therapies/chemotherapy**

- Abecma (idecabtagene vicleucel)
- Breyanzi (lisocabtagene maraleucel)
- Carvykti™ (ciltacabtagene autoleucel)
- Kymriah™ (tisagenlecleucel)
- obecabtagene autotemcel*
- Tecartus™ (brexucabtagene autoleucel)
- Yescarta™ (axicabtagene ciloleucel)

Endocrine/metabolic agents

- Acthar H.P.® (corticotropin)
- Sandostatin® LAR (octreotide)/**chemotherapy**
- Somatuline® depot (lanreotide)/**chemotherapy**

Enzyme replacement agents**

- Aldurazyme® (laronidase)
- apadamtase alfa/cinaxadamtase alfa*
- Brineura™ (cerliponase alfa)
- Cerezyme® (imiglucerase)
- Elaprase® (idursulfase)
- Elelyso® (taliglucerase alfa)
- Elfabrio® (pegunigalsidase alfa)
- Fabrazyme® (agalsidase beta)
- Kanuma® (sebelipase alfa)
- Lamzede® (velmanase alfa-tycv)
- Lumizyme® (alglucosidase alfa)
- Mepsevii™ (vestronidase alfa-vjbk)
- Naglazyme® (galsulfase)
- Nexviazyme® (avalglucosidase alfa)
- Pombiliti™ (cipaglucosidase alfa-atga)
- Revcovi™ (elapegademase-lvlr)
- Vimizim™ (elosulfase alfa)
- VPRIV® (velaglucerase alfa)
- Xenpozyme® (olipudase alfa)

Gene replacement/gene editing therapy**

- Beqvez™ (fidanacogene elaparvovec)
- Casgevy (exagamglogene autotemcel)
- eladocagene exuparvovec*
- Elevidys (delandistrogene moxparvovec-rokl)
- Hemgenix® (etranacogene dezparvec)
- Lenmeldy™ (atidarsagene autotemcel)
- Luxturna™ (voretigene neparvovec-rzyl)
- Lyfgenia™ (lovotibeglogene autotemcel)
- marnetegragene autotemcel*
- prademagene zamikeracel*
- Roctavian® (valoctocogene roxaparvovec)
- Skysona™ (elivaldogene autotemcel)
- Vyjuvek® (beremagene geperpavec)
- Zolgensma® (onasemnogene abeparvovec-xioi)
- Zynteglo® (betibeglogene autotemcel)

Hemophilia/coagulation factors**

Hyaluronate acid products

- Cingal®
- Durolane®
- Euflexxa™
- Gel-One®
- Gelsyn-3™
- GenVisc 850®
- Hyalgan®
- Hymovis®
- Supartz®
- Synojoynt™
- Triluron™
- TriVisc™
- VISCO-3®

Immunological agents

- Actemra® IV (tocilizumab)
- Avsola™ (infliximab-axxq)
- Benlysta® IV (belimumab)
- Cosentyx® IV (secukinumab)
- Entyvio™ IV (vedolizumab)
- Ilumya™ (infliximab-dyyb)
- Inflectra™ (tildrakizumab-asmn)
- Infliximab (unbranded)
- Ixifi™ (infliximab-qbtx)
- Omvoh™ IV (mirikizumab)
- Orencia® IV (abatacept)
- Pyzchiva® IV (ustekinumab-ttwe)
- Remicade®† (infliximab)
- Renflexis™ (infliximab-abda)
- Saphnelo™ (anifrolumab)
- Selarsdi™ IV (ustekinumab-aekn)
- Simponi® Aria (golimumab for infusion)
- Skyrizi® IV (risankizumab-rzaa)
- Spevigo® (spesolimab)
- Stelara® IV (ustekinumab)
- Tofidence™ (tocilizumab-bavi)
- Tremfya® IV (guselkumab)
- Tyenne® IV (tocilizumab-aazg)
- Wezlana™ (ustekinumab-auub)

Intravenous immune globulin/subcutaneous immune globulin (IVIG/SCIG)**

Multiple sclerosis agents**

- Briumvi™ (ublituximab-xiiy)
- Lemtrada® (alemtuzumab)
- Ocrevus™ (ocrelizumab)
- Tyruko® (natalizumab-sztn)
- Tysabri® (natalizumab)

Myasthenia gravis agents**

- Rystiggo® (rozanolixizumab-noli)
- Vyvgart® (efgartigimod alfa-fcab)
- Vyvgart® Hytrulo (efgartigimod alfa-fcab and hyaluronidase-gvfc)

Neutropenia

- Fulphila™ (pegfilgrastim-jmbd)
- Fylnetra® (pegfilgrastim-pbbk)
- Granix® (tbo-filgrastim)
- Lapelga* (pegfilgrastim)
- Neupogen® (filgrastim)
- Nypozi™ (filgrastim-txid)
- Releuko™ (filgrastim-ayow)
- Rolvedon™ (eflapegrastim)
- Ryzneuta® (efbemalenograstim-alfa)
- Stimufend® (pegfilgrastim-fpgk)
- Udenyca™ (pegfilgrastim-cbqv)
- Udenyca™ OnBody (pegfilgrastim-cbqv)
- Ziextenzo® (pegfilgrastim-bmez)

Ophthalmic agents

- Ahzantive® (aflibercept-mrbb)
- Beovu® (brolucizumab-dbll)
- bevacizumab-vikg*
- Bmab-100*
- Byooviz™ (ranibizumab-nuna)
- Cimerli™ (ranibizumab-eqrn)
- Enzeevu™ (aflibercept-abzv)
- Eylea®† (aflibercept)
- Eylea® HD (aflibercept)
- Lucentis®† (ranibizumab)
- Opuviz™ (aflibercept-yszy)
- Pavblu™ (aflibercept-ayyh)
- revakinagene taroretcel*
- Susvimo™ (ranibizumab injection, port delivery system)
- Tepezza™ (teprotumumab-trbw)
- Vabysmo® (faricimab-svoa)
- Yesafili™ (aflibercept-jbvf)

Pulmonary arterial hypertension**

- Flolan® (epoprostenol GM)
- Remodulin® (treprostinil)
- Revatio® (sildenafil)
- Tyvaso® (treprostinil)
- Uptravi IV (selexipag)
- Veletri® (epoprostenol AS)
- Ventavis® (iloprost)

Respiratory agents

- Cinqair® (reslizumab)
- Synagis® (respiratory syncytial virus [RSV], monoclonal antibody, recombinant)
- Xolair® (omalizumab)

Respiratory enzymes (alpha-1 antitrypsin)**

- Aralast
- Glassia™
- Prolastin®
- Zemaira®

Tumor-infiltrating lymphocyte (TIL) and T-cell therapies

- Amtagvi™ (lifleucel)
- Imdelltra™ (tarlatamab-dlle)
- linvoseltamab*
- Tecelra® (afamitresgene autoleucel)

Miscellaneous therapeutic agents

- Adakveo® (crizanlizumab-tmca)
- Amvuttra™ (vutrisiran)
- Bkemv™ (eculizumab-aeeb)
- Cosela® (trilaciclib)
- Crysvita® (burosumab-twza)
- elamipretide*
- Enjaymo (sutimlimab-jome)
- Epysqli® (eculizumab-aagh)
- Evkeeza™ (evinacumab)
- Gamifant® (emapalumab-lzsg)
- Givlaari® (givosiran)
- Ilaris® (canakinumab)
- Injectafer® (ferric carboxymaltose injection)
- Krystexxa® (pegloticase)
- Leqvio® (inclisiran)
- Monoferric® (ferric derisomaltose)
- narsoplimab*
- Niktimvo™ (axatilimab-csfr)
- olezarsen*
- Onpattro™ (patisiran)
- Oxlumo® (lumasiran)
- Panhemitin® (hemin for injection)
- PiaSky® (crovalimab-akkz)
- Reblozyl® (luspatercept-aamt)
- Remune*
- Rethymic™ (allogeneic processed thymus tissue-agdc)
- Rytelo™ (imetelstat)
- Soliris®† (eculizumab)
- Spinraza™ (nusinersen)
- tablecleucel*
- Tzield™ (teplizumab)
- Ultomiris™ (ravulizumab-cwvz)
- Uplizna™ (inebilizumab)
- Veopoz™ (pozelimab-bbfg)
- Vyepti™ (eptinezumab-jjmr)
- Xiaflex® (collagenase clostridium histolyticum)

* Pending FDA approval.

** All drugs that can be classified under this header require precertification. This includes any unlisted brand or generic names or biosimilars, as well as new drugs that are approved by the FDA in that class during the course of the benefit year.

† Precertification requirements apply to all FDA-approved biosimilars to this reference product.

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