AmeriHealth NEW JERSEY

Please Mail To:
AmeriHealth Insurance Company
P.O. BOX 41574
Philidelphia, PA 19101-1574

IHC High Deductible Health Plans – Declaration Of Understanding

This declaration is issued pursuant to Section 18 of PL 2005, c 248, as it pertains to high deductible health plans for which qualified medical expenses are paid using health savings accounts (HSAs). (Section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223)).

This declaration provides a brief description of the important features of the Policy. This declaration is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both the Policyholder and the Carrier. It is, therefore, important to read the Policy carefully!

The Policy delivered to you is a high deductible health plan, meant to be used in conjunction with a health savings account (HSA). It provides coverage to Covered Persons for primary and preventive care services, daily hospital room and board, miscellaneous hospital services, surgical services, inhospital medical services and supplies, out-of-hospital care and prescription drugs. Before the Carrier pays benefits for Covered Charges, a Cash Deductible, which is a specified amount, must be met by each Covered Person and/or Family each Calendar year. The Cash Deductible will not apply to Preventive Care Services. When this Cash Deductible is met the Carrier will provide coverage for Covered Charges, less any applicable Copayment or Coinsurance amounts that each Covered Person must pay, until the Policy's applicable Maximum Out-of-Pocket amount is reached for the Calendar Year. The Maximum Out-of-Pocket is a maximum that is placed on the amount of out-of-pocket expenses which the Covered Person and/or Family are required to pay each Calendar Year. The Maximum Out-of-Pocket is a specific dollar amount of expense incurred by a Covered Person and/or Family for Covered Charges, including prescription drugs. The Maximum Out-of-Pocket expense includes any applicable Copayments, Coinsurance amounts and Cash Deductible. Once the applicable Maximum Out-of-Pocket amount(s) is/are reached, the Carrier will pay 100% of the Covered Charges for Covered Charges incurred during the balance of the Calendar Year, subject to any applicable limits as shown in the Schedule of Insurance section of the Policy.

The HSA funds may be used to pay for expenses classified as "qualified medical expenses" under federal tax law. These expenses include Copayments, Cash Deductible and Coinsurance.

Please review the definitions of "Coinsurance", "Copayment", "Covered Charge", "Covered Person", "Cash Deductible", "Maximum Out of Pocket" and other terms applicable to the Policy's benefit design in the Definitions section of the Policy.

Covered Persons will not be required to submit claim forms. Providers will submit claims on the Covered Person's behalf. Additional claim information is outlined in the Claims Provision section of the Policy.

I hereby agree that I have read and understand the contents of the "Declaration of Understanding" as stated above.

Signed by:_____ Date:_____

INSTRUCTIONS FOR ENROLLING IN A BANCORP HSA:

1. Complete this application (see other side) and give it to your Benefits Administrator or Independent Broker.
2. If all information is complete, Bancorp will send you a welcome package of information.
3. Complete and sign the signature card form included in the Bancorp welcome package and return the signature card to Bancorp in the business reply envelope enclosed with your Bancorp welcome package.

ELIGIBILITY:

1. You are enrolled in an HSA-qualified High Deductible Health Insurance Plan (HDHP) that meets the minimum annual deductible for single coverage or for family coverage as determined by the Department of the Treasury (go to www.ustreas.gov to see current minimum deductibles).
2. You are not covered by another health insurance plan, as either an individual, spouse or a dependent other than another High Deductible Health Plan, or a plan providing specific, limited coverage.
   Examples of allowable coverage include:
   a. Dental, vision, disability and long-term care insurance, or auto insurance
   b. Insurance for a specified disease or illness, or
   c. Insurance that pays a fixed amount per day (or other period of hospitalization)
3. You are not eligible for, or enrolled in Medicare
4. You cannot be claimed as a dependent on someone else's tax return

HEALTH SAVINGS ACCOUNT (HSA) BENEFITS:

- Tax-free interest or other earnings on your assets
- A tax deduction for the contributions you make. You are eligible for a deduction even if you don't itemize your tax deductions on Internal Revenue Service (IRS) Form 1040.
- Opportunity to build funds for your medical care needs. Your contributions remain in your HSA from year-to-year until you use them.

Please consult a tax advisor for guidance and comprehensive information about HSAs and other tax-related issues as well as eligibility requirements, definitions of qualified medical expenses, and mid-year contribution amounts.

The most current information on HSAs is provided by the United States Department of the Treasury at **http://www. ustreas. gov**

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Health Savings Account (HSA) Enrollment Request for The Ban corp Bank (Bancorp)

AmeriHealth has a preferred relationship with The Bancorp Bank to provide HSA services.
Please complete this form to open an Health Savings Account with The Bancorp Bank.

Instructions:

1. To avoid processing delays, please complete all fields on the application. The shaded field is the only optional field; all other fields are required.
2. Give completed form to your Benefits Administrator or Independent Broker.
3. Please do not submit check contributions with this form.

SECTION 1. HEALTH PLAN INFORMATION

Group Number *(completed by your Administrator)* _____

SECTION 2. EMPLOYEE INFORMATION

Name (First, Middle, Last):	Birthdate:	SSN:
Email Address:		
Address-Street:	City,State	Zip Code
Address-2:	City,State	Zip Code
Home Phone:	Evening Phone *(Optional)*	

SECTION 3. SIGNATURE AND VERIFICATION

Yes, please send my enrollment information to **The Bancorp Bank** to enroll me in a Bancorp HSA.

Signature:_____ Date: _____

IMPORTANT: We cannot process this application without your signature.

Please read before signing above

I understand the eligibility requirements for deposits made to my Health Savings Account (HSA) and state that I qualify to make deposits to this account.

I assume complete responsibility tor:

1. Determining my eligibility for an HSA each year I make a contribution.
2. Ensuring all contributions made to my account are within the limits set forth by the tax laws.
3. Any tax consequences of contributions (including rollover contributions) and distributions.