

EMPLOYER PLAN SELECTION FORM

(Check appropriate boxes in each Step)

Please send forms to:
Concord Management Resources
P.O. Box 5487
Somerset, NJ 08875
Phone: 833-MEWANOW (833-639-2669)
Fax: 833-MEWAFAX (833-639-2329)
Email: mewarenewals@concordmgt.com

GROUP NAME: _____ ACCOUNT #: _____ EFFECTIVE DATE: _____

CONTACT NAME: _____ EMAIL: _____ PHONE: _____

STEP 1: WAITING PERIOD FOR NEW HIRES

- 1st of the month following date of hire
- 1st of the month following 30 days
- 1st of the month following 60 days

STEP 2: WAITING PERIOD FOR REHIRES

- 1st of the month following date of hire
- 1st of the month following 30 days
- 1st of the month following 60 days

STEP 3: OCA IS THE COBRA ADMINISTRATOR FOR THE PLAN AT NO COST TO EMPLOYER

- OCA
- Other _____

STEP 4: SELECT MEDICAL PLANS

You can offer 1 or a combination of Plans

STEP 5: SELECT PRESCRIPTION PLANS

You can offer one (1) or more Rx options per Medical Plan Offered

SELECT	PLAN	MEDICAL PLAN NAME	RX 1	RX 2	RX 3	RX 4	RX 5	RX 6
<input type="checkbox"/>	Plan A	Open Access POS Plan Plus				N/A	N/A	
<input type="checkbox"/>	Plan B	Open Access POS Network Plan				N/A	N/A	
<input type="checkbox"/>	Plan D	Facility High Deductible Plan				N/A	N/A	
<input type="checkbox"/>	Plan F	Network Only High Plan				N/A	N/A	
<input type="checkbox"/>	Plan G	Open Access POS Network Basic Plan				N/A	N/A	
<input type="checkbox"/>	Plan H	Network Only Base Plan				N/A	N/A	
<input type="checkbox"/>	Plan J	Network Only Basic Plan				N/A	N/A	
<input type="checkbox"/>	Plan K	Network Only High Deductible Plan				N/A	N/A	
<input type="checkbox"/>	Plan L	High Deductible Low Plan				N/A	N/A	
<input type="checkbox"/>	Plan M	Aetna Whole Health – Network Only (Gold) Plan				N/A	N/A	
<input type="checkbox"/>	Plan N	Aetna Whole Health – High Deductible H.S.A (Silver Plan)*	N/A	N/A	N/A			N/A
<input type="checkbox"/>	Plan O	Network Only 70% Plan				N/A	N/A	
<input type="checkbox"/>	Plan P	High Deductible 70% Plan				N/A	N/A	
<input type="checkbox"/>	Plan R	H.S.A. Compatible Plan*	N/A	N/A	N/A			N/A
<input type="checkbox"/>	Plan S	H.S.A Compatible High Plan*	N/A	N/A	N/A			N/A
<input type="checkbox"/>	Plan T	Network Only Plan				N/A	N/A	
<input type="checkbox"/>	Plan U	High Deductible Network Only Plan				N/A	N/A	
<input type="checkbox"/>	Plan V	High Deductible Catastrophic Plan				N/A	N/A	
<input type="checkbox"/>	Plan W	H.S.A Compatible Low Plan*	N/A	N/A	N/A			N/A
<input type="checkbox"/>	Plan X	Aetna Whole Health Network Only High (Silver) Plan				N/A	N/A	
<input type="checkbox"/>	Plan Y	Aetna Whole Health Network Only (Bronze) Plan				N/A	N/A	
<input type="checkbox"/>	Plan Z	Aetna Whole Health Network Only Low (Silver) Plan				N/A	N/A	

* These plans may be aligned with a **Health Savings Account (HSA)**. The MHPNJ MEWA does not administer HSA Accounts.

Rx Option 1
Retail: \$15/\$35/\$50
Mail: \$35/\$82.50/\$120

Rx Option 2
Retail: \$30/\$50/\$80
Mail: \$70/\$120/\$195

Rx Option 3
Retail: \$15 Generic /50% Brand (Min/Max Apply)
Mail: \$37.50 Generic /50% Brand (Min/Max Apply)

Rx Option 4
Member must meet Ded.
Retail: \$15/\$35/\$50
Mail: \$35/\$82.50/\$120

Rx Option 5
Member must meet Ded.
Retail: \$15 Generic /50% Brand (Min/Max Apply)
Mail: \$37.50 Generic /50% Brand (Min/Max Apply)

Rx Option 6
No Rx Coverage (3% is added to Medical Rates)

STEP 6 – SELECT DENTAL PLAN OPTIONS

The Dental Plan is only offered with enrollment in the medical plan. There is an additional charge for this option. You can select both Delta Dental and the Guardian Dental Options.

No Dental

Delta Dental Premier
 Delta Dental Base PPO

Guardian PPO Dental Plan
 Guardian DHMO Dental Plan

*STEP 7 – FSA/HRA

If administered by OCA please indicate below. There is an additional charge for this service.

No HRA/FSA
 Flexible Spending Account (FSA)
 Health Reimbursement Account (HRA)

I acknowledge that all my enrolled employees meet all of the MHPNJ Underwriting Guidelines. I further acknowledge that I must provide waivers for all employees waiving coverage. The information I am providing, attached to this Employer Plan Selection Form, is accurate and represents **all** changes/terminations/additions to my eligible members. Any requests or discrepancies that arise after the processing of the attached documents may not be eligible for coverage until the next open enrollment period (for changes/additions).

*In order to elect FSA and HRA you must contact OCA Benefits to enroll and set up your group. For additional information please contact 833-MEWANOW (833-639-2669).

STEP 8: EMPLOYER SIGNATURE: _____ DATE: _____