Members HealthPlan NJ
Designed for You.

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
❑	Plan A	Open Access POS Plan Plus				N/A	N/A	
❑	Plan B	Open Access POS Network Plan				N/A	N/A	
❑	Plan D	Facility High Deductible Plan				N/A	N/A	
❑	Plan F	Network Only High Plan				N/A	N/A	
❑	Plan G	Open Access POS Plan Basic				N/A	N/A	
❑	Plan H	Network Only Base Plan				N/A	N/A	
❑	Plan J	Network Only Basic Plan				N/A	N/A	
❑	Plan K	Network Only High Deductible Plan				N/A	N/A	
❑	Plan L	High Deductible Low Plan				N/A	N/A	
❑	Plan M	Aetna Whole Health – Network Only (Gold) Plan				N/A	N/A	
❑	Plan N	Aetna Whole Health – High Deductible H.S.A. (Silver Plan) *	N/A	N/A	N/A			N/A
❑	Plan O	Network Only 70% Plan				N/A	N/A	
❑	Plan P	High Deductible 70% Plan				N/A	N/A	
❑	Plan R	H.S.A. Compatible Plan*	N/A	N/A	N/A			N/A
❑	Plan S	H.S.A. Compatible High Plan*	N/A	N/A	N/A			N/A
❑	Plan T	Network Only Plan				N/A	N/A	
❑	Plan U	High Deductible Network Only Plan				N/A	N/A	
❑	Plan V	High Deductible Catastrophic Plan				N/A	N/A	
❑	Plan W	H.S.A. Compatible Low Option Plan*	N/A	N/A	N/A			N/A
❑	Plan X	Aetna Whole Health - Network Only High (Silver) Plan				N/A	N/A	
❑	Plan Y	Aetna Whole Health - Network Only (Bronze) Plan				N/A	N/A	
❑	Plan Z	Aetna Whole Health - Network Only Low (Silver) Plan				N/A	N/A	

Rx Option 1
Retail: $15/$50/$75
Mail: $35/$125/$187.50
Specialty: 30%

Rx Option 2
Retail: $25/$75/$100
Mail: $60/$187.50/$250
Specialty: 30%

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

Rx Option 4
Member must meet Ded.
Retail: $15/$50/$75
Mail: $35/$125/$187.50
Specialty: 30%

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

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

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

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:**______________