Members HealthPlan NJ

Designed for You.

# APRIL 2021 RENEWAL PACKAGE

Dear Benefits Administrator:

2020 has certainly been a unique and challenging time for our employers and members. We understand that you may be experiencing changes in your business and industry. It is important for you to know that MHPNJ is here to support you during these unprecedented times. More now than ever, we appreciate your partnership, cooperation and patience while we work towards a new normal and continue to ensure MHPNJ remains a strong health plan for our members.

The COVID-19 pandemic health crisis has impacted the entire health insurance market in ways that we cannot yet fully measure. We continue to closely monitor all data related to the virus and identify ways we can provide assistance and clinical support to members and their health care providers. We have been pleased to promote Teledoc and other tools to guide members and their families to use from the safety of their homes.

As a member owned self-insured MEWA Health Plan it is vital that we continuously evaluate the claims experience, the competitiveness and all market conditions to ensure the plan maintains its history of financial strength. The plan has recently made some changes that may or may not impact your renewal and healthcare fees.

IMPORTANT: The plan is currently implementing a 5.5% COVID-19 surcharge on all healthcare fees charged as a result of significantly increased costs resulting from increased testing and services related to COVID-19. This measure will go into effect on February 1, 2021. The COVID-19 surcharge will be calculated on your total monthly healthcare fees and will be added to your invoice each month and could be adjusted at any time if needed. This is in addition to the monthly totals.

## RENEWAL CHANGE IMPACTS

- **MHPNJ has changed from a 4 Tier Rx Rating methodology to an age/gender rating methodology.**
  - Employers will continue to receive a 4 Tier Medical and Rx Rate; however, the rates will vary based on your groups specific demographics (age/gender/tier)
- **MHPNJ has implemented a geographical rating methodology based on employer zip code**
  - This geographical factor is incorporated into your final rates
- **Census Changes – An employer group may also experience health care fee changes due to census changes. These changes can be related to the following circumstances.**
  - Group Average Age Change (increase or decrease)
  - Individual Employee(s) Age Band Change
  - Shift in Individual Employee(s) tier (EE, EECH, ES, FAM)
  - Shift in overall member demographics (Male/Female Ratio)
  - Employer Zip Code Change

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# APRIL 2021 RENEWAL INFORMATION

MHPNJ is a customer focused plan that strives to improve the quality of services for every member and dependent. Our partnership with Aetna provides our members with an integrated and holistic member service and clinical support model that will help to assist your employees and their families in their journey towards better health.

## EFFECTIVE APRIL 1, 2021 MEDICAL CHANGES:

MHPNJ is consistently evaluating ways to add value to our clients, keep our rates competitive, and offer generous plan designs. The following changes may impact your current plans, so please read carefully:

### Maximum Out-of-Pocket (MOOP) amounts by plan are amended as follows:

- Plans B, G, H, L, O, P, T, U, & V, the MOOP will be changed to the ACA max $8,550/$17,100 (In-Network) / $17,100/ $34,200 (Out-of-Network if applicable).
- Plans N and W the MOOP will be changed to the HSA max $7,000/$14,000 (In-Network & Out-of-Network if applicable).
- Plan R the MOOP will be changed to the HSA max $7,000/$14,000 (In-Network)/$17,100/$34,200 (Out-of-Network)
- Plans M, X, Y, and Z, Tier 2: MOOP will be changed to the ACA max $8,550/$17,100.
- Refer to the Benefit Summaries for details.

## EFFECTIVE JANUARY 1, 2021 PHARMACY AND UNDERWRITING CHANGES

### MHPNJ transitioned pharmacy management services from Express Scripts to Aetna, utilizing Aetna's pharmacy network and formulary.

- The Plan has updated its maintenance network and members can fill maintenance medications through Aetna RX Home Delivery or CVS Pharmacy. (Refer to the Prescription Summary for details)

### Underwriting Guideline changes are as follows:

- **Eligible Employers** - A group is eligible to participate in Members Health Plan NJ for coverage if they have at least two (2) Eligible Employees (one of which must be provided a W-2 and that W-2 employee must be enrolled in the health plan). Employer must be located in New Jersey.
- **Ineligible Employees** – **ADDED:** An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse are not considered employees of the Policyholder.
- **Tax Documentation** - Group with 6-50 Eligible Employees do not require tax documentation. The Plan requires a completed certification.

***Please refer to the Plans detailed Underwriting Guidelines for additional definitions and clarification.***

### As these changes may or may not impact you, we also want to share some Important facts to help you understand how we remain a competitive alternative to other health benefit programs:

- MHPNJ continues to offer a 4 Tier Rate Option where other carriers in the market provide ACA rates based on the specific employee and dependent census data
- MHPNJ does not medically underwrite or ask for employers or employers to complete medical questionnaires
- MHPNJ allows employers to offer one plan or a combination of several medical and prescription drug plan designs to meet the needs of their employees
- MHPNJ is a non-profit member owned plan
- MHPNJ partnered with Aetna to provide our members with solutions and features that are only offered to large employers and national clients

## RENEWAL PROCESS:

- SIMPLIFIED the renewal process for you and your employees
- Added a renewal option that will allow you to renew "AS IS"

## RENEWAL DATES:

- Renewal paperwork needs to be returned no later than 3/15/2021 to avoid disruption to your employees medical, pharmacy and dental coverage.
    - *Members with renewal plan changes may not receive NEW ID cards prior to 4/1/2021 if the renewal paperwork has not been received by 3/15/2021.*

The information on the following pages will outline any changes made for your renewal period. Please review the information carefully. You must complete and submit the appropriate paperwork to renew your group.

We have a dedicated team ready to assist you during open enrollment. Please feel free to contact us at 1-833-MEWANOW (1-833-639-2669) or mewarenewals@concordmgt.com if you have any questions.

Sincerely,
Members Health Plan NJ

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# HEALTH PLAN ADVANTAGES

Plan Designs and Options

## 22 Benefit Plan Designs

**Employers Can offer 1 or all 22 Benefit Plan Designs**

- Variety of High Value, High Deductible and Value Based Network Plans.
- 7 Open Access in Network/Out of Network Plans
- 10 Open Access Network Only Plans
- 4 HSA Compatible Plans
- National Network available on All Plans

## 5 Value Based Network Plans (AWH)

**Members will have access to 5 Value Based Network Plans (M, N, X, Y & Z)**

- Plans utilize (NJ) Aetna Whole Health℠- New Jersey- Aetna Select Multi-Tier.
- A more comprehensive state-wide Value Based Network includes 27 hospitals, 3,400+ Primary Care Doctors, 21,000+ Specialists and 175+ Urgent Care Facilities
- National Network available on All Value Based Network Plans

## 6 Prescription Plan Options Offered Through Aetna

**We are excited to provide an integrated medical and prescription benefit for our members. There are 6 Prescription benefit plan options. Additional details are listed on the Prescription Benefit Summary. If you have any questions, please contact your Broker or Broker Relationship Manager (BRM).**

- RX1 - Retail $15/$50/$75, Mail Order: $35/$125/$187.50 Copay Plan, Specialty (Retail & Mail): 30%
- RX2: Retail $25/$75/$100, Mail Order: $60/$187.50/$250 Copay Plan, Specialty (Retail & Mail): 30%
- RX3: Retail $15 Copay for Generic/Brand 50% Copay (Min $25/Max $500), Mail Order: $37.50 Copay for Generic/Brand 50% Copay (Min $62.50/Max$1,250), Specialty (Retail & Mail): 50%
- RX4: Retail $15/$50/$75 after Deductible, Mail Order: $35/$125/$187.50 after Deductible, Specialty (Retail & Mail): 30%, after Ded
- RX5: Retail $15 Copay after Ded for Generic/Brand 50% Copay after Ded (Min $25/Max $500), Mail Order: $37.50 Copay after Ded for Generic/Brand 50% Copay after Ded (Min $62.50/Max $1,250), Specialty (Retail & Mail): 50%, after Ded
- RX6: No Prescription Selection (Medical Rates will increase by 3%)

## 4 Dental Plan Options

**Members will have access to the same 4 Dental Plan Options**

- Delta Dental Premier Plan
- Delta Dental Base Plan
- Guardian PPO Plan
- Guardian DHMO Plan

## COBRA/HRA/FSA/DCA

**Employers continue to have the benefit of OCA as the Administrator for HRA/FSA/DCA and COBRA**

- COBRA/NJ Continuation is covered at no additional cost under the Plan
- HRA/FSA/DCA is available all employers at a set up and renewal fee of $250 per year. No monthly admin fees

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# HEALTH PLAN ADVANTAGES

## The Benefits of the Aetna Platform

**PROVIDER NETWORK ACCESS**

**Members have access to three (3) Comprehensive Provider Networks with Aetna**

- **Aetna Select℠ Open Access**
  - Offered with Network Only Plans F, H, J, K, O, S, T, U, V and W
- **Aetna Choice® POS II Open Access**
  - Offered with In/Out Network Plans A, B, D, G, L, P and R
- **(NJ) Aetna Whole Health℠- New Jersey- Aetna Select Multi-Tier**
  - Offered with Value Based Plans M, N, X, Y and Z

**ENHANCED MEMBER EXPERIENCE**

**The Aetna Platform offers members a greater variety of programs, plans and tools including:**

- **Aetna One Advocate (A1A)**
  This program provides members with a single, trusted advisor when they need one. Designed to ease members' burdens of managing their health and their benefits, our members have a dedicated advocate who reaches out to members about their health and whom members can reach directly as well. The dedicated team collects, reviews and connects information end to end to help our members access care and get the most from their benefit plans.
- **Telemedicine Program (Teladoc)**
  Use Teladoc anytime, anywhere for non-emergency conditions like the flu, bronchitis, stress, psoriasis, and more. Just visit Teladoc.com/Aetna or call 1-**855-TELADOC (835-2362)** to set up your account.
- **24/7 Informed Health Line**
  Whether you're looking for general information or have a specific health concern, the Informed Health Line is a 24-hour hotline for employees. Just call **1-800-556-1555** and select the option to speak to a nurse (TTY: Dial 711 and ask the operator).
- **Urgent Care**
  In urgent situations you may find you save time and money by going to an In-Network Urgent Care Center instead of the Emergency Room. In most cases you pay a copayment which will often be lower than the copayment or coinsurance for an Emergency Room Visit.
- **Member Website**
  Members will need to register and create an account on Aetna's website **www.aetna.com.** Members will have access to a variety of tools and services, which includes finding providers and facilities, see coverage and costs, manage claims, view explanations of benefits (EOBs), view medical ID card
- **Member Mobile Experience**
  You can download the Aetna app on Google Play or the Apple App Store. Members will be able to view benefits, dependent(s) information, search providers and access products available to you as a member accessing the Aetna platform.
- **Stay Healthy Programs**
  Members will be able to receive discounts on health products and services from eye care to fitness and weight management. Members will also be able to access their health assessment, health record and personalized health and wellness programs. Members will also be able to get helpful information about procedures, conditions and treatments.

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# EMPLOYER RESOURCES

## Important Benefit Administrator Information

### Employer/Employee Online Enrollment Platform

Members Health Plan NJ is pleased to provide online administrative access to benefit administrators and brokers via Jet Insure, our enrollment platform. Benefit administrators and brokers can manage the group 24/7, 7 days a week.

- Enroll/Terminate
- Employees Make
- Demographic Changes
  Renew Online
- Print/View Employee Roster

Webinar

To gain access to the Enrollment Platform, join us for a brief webinar that will show you how to manage the day to day activity for your group.

- Webinars are held every Thursday from 11am – 12 noon EST. To register, send an email with your name and group name to: **PortalAssistance@concordmgt.com**
- Webinar Information
  Dial:1-773-231-9226
  Meeting ID: 148 944 0215
  https://meetings.ringcentral.com/teleconference

### Employer Billing/Invoices

paperless billing

Invoices are sent via email to the employers administrative billing email address. Please confirm we have the current contact information and email address for the person responsible for administration and billing.

- **Questions related to accessing your electronic invoice:**
  Email: PortalAssistance@concordmgt.com
  Phone: 833-MEWANOW (833-639-2669) Option 4
- **Questions related to your invoice, billing or credit card payment:**
  Email: MEWABilling@concordmgt.com
  Phone: 833-MEWANOW (833-639-2669) Option 5

**Paying by Check via Regular Mail:**
**Checks payable to: Members Health Plan NJ**
APEMT/Members Health Plan NJ
P.O. Box 412491
Boston, MA 02241-2491

**Paying by Check via Overnight Mail:**
**Checks payable to: Members Health Plan NJ**
APEMT/Members Health Plan NJ
Bank of America Lockbox Services - Lockbox #412491
MA5-527-02-072 Morrissey Blvd.
Dorchester, MA 02125

**Paying by Direct Debit:**
The payment will be deducted on or about the 10th business day of every month

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# WHAT YOU NEED TO KNOW

## Important Health Plan Information

### Employer Contacts/Information

- Employers can call **(833) MEWANOW (833-639-2669)** to speak a Members Health Plan NJ representative. Employers can also send your completed paperwork or email questions to **MEWArenewals@concordmgt.com** Employers can visit **www.MembersHealthPlanNJ.com** for additional plan information.
    - View or print Summary Plan Documents (SPD)
    - View or print Summary of Benefits & Coverage (SBC's)
    - View or print Medical, Dental and Prescription Summaries

### Member Contacts/Information - Aetna One Advocate (A1A)

- Members have access to a care focused, value driven, high tech customer service model that is staffed by highly trained advocates dedicated to our membership.
- Members can call **1-833-98APEMT (1-833-982-7368)** for both Medical and Pharmacy benefit information
    - Hours of operation:
        - Monday through Friday 8am to 8pm EST and Saturday 8am to 4pm EST

### ID Cards

- Enrolled members will receive a combined Medical/Prescription (if selected) Card from Aetna, and Dental Card (if selected) from either Guardian or Delta Dental ONLY IF MAKING A PLAN CHANGE
- The Plan must be notified of any discrepancies with benefits, coverage, ID Cards and invoices within 30 days after the renewal effective date of coverage.

### COBRA/NJ Continuation/Age 31

- OCA Benefit Services (OCA) is the COBRA/NJ Continuation/Age 31 administrator for Members Health Plan NJ. OCA administers these services at no additional cost to the employer.
- If you currently have a COBRA administrator and chose to continue to use them, you must let us know.

### HRA/FSA/DCA

- OCA Benefit Services (OCA) administrators Health Reimbursement Account (HRA), Flexible Spending Account (FSA) and Dependent Care Account (DCA) for the Employers of Members Health Plan NJ. OCA administers these services for an annual set-up and renewal fee of $250.00. No additional monthly fee is being charged.
- If you are interested in the HRA/FSA/DCA program, please contact OCA at **1-609-514-0777.**

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# EMPLOYER RENEWAL SUBMISSION & DISCLAIMERS

## Important Benefit Administrator Information

### Step 1 – Select Renewal Option

☐ **OPTION 1 – RENEW "AS IS"**
By selecting this option, I agree to renew "AS IS" with no changes to current waiting period, rehire waiting period, COBRA/HRA/FSA, current medical, prescription and/or dental plans. I understand that all employer plan options will remain the same for the 2021 renewal and employees will renew with their current plans. (Refer to the Renewal Checklist for required paperwork).

☐ **OPTION 2 – RENEW WITH CHANGES**
By selecting this option, I am electing to make employer plan changes (Refer to the Renewal Checklist for required paperwork).

### Step 2 - Complete Employer Certification (Groups 2-50 eligible) include all eligible employees, date of hire, date of birth, occupation, full time or part time status and home zip codes – (See Attached)

### Step 3 – Attach a group census with Eligible Employees. The census must include all eligible employees, date of hire, date of birth, occupation, full time or part time status and home zip codes.
### (Groups of 51+ please include all eligible Full Time Employees and Waivers)

### Step 4 – Read and Sign

## Renewal Disclaimers and Eligibility Verification

- An Eligible Employer must have at least two (2) Eligible Employees working at least 24 hours or more
  - One (1) Eligible Employee be provided a W-2 and that W-2 employee must be enrolled in the health plan) and must be listed on the most recent quarterly wage and tax statement (QWTS/WR-30) and employee must have worked 13 weeks in each of the last two quarters.
- All currently enrolled employees meet the definition of eligible employee set forth in the Underwriting Guidelines
- Employer meets participation requirements
  - 75% for Small Group 2-50 Eligible Employees
  - 50% for Large group 51+ Eligible Employees
- Eligible Employer is domiciled in New Jersey with at least 75% of eligible employees residing in New Jersey
- Employer remains in good standing and is a member of one of the Plans sponsoring Associations. (Non-renewal will result in health plan termination.

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# EMPLOYER RENEWAL SUBMISSION & DISCLAIMERS

## Important Benefit Administrator Information

- Groups are eligible through their association with the IPA of North Jersey, Trinitas Hospital Medical Staff, Mountainside IPA, Vista IPA, Northwest Physician Organization, Inc. and The Medical & Dental Staff of Hackensack Meridian Health, CentraState Medical Center.
  - The employer must be a member of their local IPA (if there is one).
- Groups are Eligible through their affiliation with Employers Association of New Jersey (EANJ)
- Groups are Eligible through their affiliation with Medical Society of New Jersey (MSNJ)
- Groups are Eligible through their affiliation with New Jersey Chamber of Commerce (NJCC)

- The Plan reserves the right to rerate the group if the enrolled census changes +/- 10%
- The Plan has the authority to make final determination of eligibility based on submission.
- The Plan reserves the right to request documentation, and payroll documentation at any time.

**Please read and sign the attached proposal agreement below. You must return both pages to the Health Plan.**

*I acknowledge and certify that I as the employer meets all renewal disclaimers and eligibility guidelines stated above.*

*I acknowledge receipt and approve the proposal and attached rates as outlined. Health Care Fees are effective from April 1st, 2021 through March 31, 2022 (12-month Contract Period), provided my group meets eligibility requirements listed in the Plans Underwriting Guidelines. Rates are final unless there is a change to my final enrollment; enrollment changes by more than 10% during the year or for reasons outlined in my contract rates may be adjusted throughout the year.*

*I authorize commissions to be paid to the General Agent and/or the Broker of Record and understand that I am solely responsible for contracting with the broker of record and that the Health Plan or Third-Party Administrator is not party to such relationships for this purpose.*

*I understand that the plan has a 5.5% COVID-19 surcharge on all healthcare fees charged as a result of significantly increased costs resulting from increased testing and services related to COVID-19. This measure will go into effect on February 1, 2021. I further understand that the COVID-19 surcharge will be calculated on my total monthly healthcare fees and will be added to my invoice each month and could be adjusted at any time if needed. This is in addition to the monthly totals.*

Authorized Name & Title: _____

Authorized Signature: _____ Date: _____

## Step 5 – Submit Paperwork

### Renewal Submission Requirements

- Renewal Group Paperwork must be submitted by 3/15/2021 in order, to confirm coverage is effective 4/1/2021.
- Employees can make plan changes within the guidelines of the renewal options. (Please submit Enrollment spreadsheet with employee changes or renewal plan selection)
- Send in any updates to employee's address, phone number and email address. ID Cards will be sent to employee home address
- All documents relevant to Renewal Option selected (Refer to renewal checklist)
  - Return Signed Rates
  - Return Page 1 and 2 of the Renewal submission and Disclaimer Form

# RENEWAL PAPERWORK CHECKLIST

## IF OPTION 1 SELECTED
## Employer Renewing **"AS IS"**

- ☐ Signed Rates
- ☐ Employer Certification (Groups 2-50).
  - Groups with 2-5 eligible employees must provide 2 Quarters of the WR30
- ☐ Groups 51+ Census include FT, PT, Waivers
- ☐ Signed Employer Renewal Submission and Disclaimers (2 Pages)
- ☐ Completed Enrollment Spreadsheet
- ☐ Benefit Enrollment Forms for new employee(s), terminated employee(s), employee demographic changes (if applicable)
- ☐ Waiver Forms for Employees waiving/refusing coverage (if applicable) or letter on company letterhead listing employees with valid waivers include carrier name. List

## IF OPTION 2 SELECTED
## Employer Renewing **WITH** Changes

- ☐ Signed Rates
- ☐ Employer Certification (Groups 2-50).
  - Groups with 2-5 eligible employees must provide 2 Quarters of the WR30
- ☐ Groups 51+ Census include FT, PT, Waivers
- ☐ Signed Employer Renewal Submission and Disclaimers (2 Pages)
- ☐ Employer Plan Selection Form
- ☐ Completed Employee Spreadsheet
- ☐ Benefit Enrollment Forms for new employee(s), terminated employee(s), employee demographic changes (If applicable)
- ☐ Waiver Forms for Employees waiving/refusing coverage (if applicable) or letter on company letterhead listing employees with valid waivers include carrier name. List of employees refusing.

## APRIL RENEWAL
## Instructions & Descriptions

*Complete all required renewal documents using the checklist appropriate for your renewal option selected and/or employer size. All required forms are located on the Member Health Plan NJ website www.membershealthplannj.com*

### Signed Rates (Option 1 & 2)
The Rate Page attached to the quote must be signed and returned

### Employer Certification (Groups 2-50) (Option1 &2)

### Groups with 2-5 eligible employees
Must provide 2 Quarters of the WR30 refer to the underwriting guidelines for details on tax document requirements.

### Signed Employer Renewal Submission and Disclaimers (2 Pages) (Option 1 &2)

### Enrollment Spreadsheet (Option 1 & 2)
The spreadsheet provides current employee plan elections and is used to provide employee renewal plan selections

### Benefit Enrollment Form (Option 1 & 2)
Used for adding, terminating and changing employee demographic information

### Waiver Form (Option 1 & 2)
Used for an employee who is waiving/refusing coverage or letter on company letterhead listing employees with valid waivers include policy holder, policy/carrier name and refusal reason. List of employees refusing.

### Employee Census (Option 1 & 2)
Groups 51+ please list of all part time and full-time employees including gender, employee home zip code, date of hire, date of birth and hours worked per week, and waivers.

## SUBMIT RENEWAL PAPERWORK TO:

Members HealthPlan NJ

c/o Concord Management Resources
P.O. Box 5487
Somerset, NJ 08875
**Email: MEWArenewals@concordmgt.com**
**Fax: 833-MEWAFAX (833-639-2329)**

**Additional Questions Please Call**
**833-MEWANOW (833-639-2669)**

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# 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: 4/1/2021**

**CONTACT NAME:**_____ **EMAIL:**_____ **PHONE:**_____

## ONLY COMPLETE THIS FORM IF YOU ARE MAKING PLAN CHANGES

**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 the information I am providing, attached to this Employer Plan Selection Form, is accurate and represents **all** changes/terminations/additions to my enrolled or eligible members for this renewal period. 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:**_____

Members HealthPlan NJ

Designed for You.

# EMPLOYER CERTIFICATION

| **Practice Name and Address**: | **Telephone**: | **Renewal Date**: / / |
|---|---|---|
| | **Fax**: | |
| | **Account #:** **(if a current customer):** | |

Please indicate your office's individual waiting period before medical coverage can begin. Select only one for each.
**New Hire**: _ 1st of the month following date of hire; _ 1st of the month following 30 days; _ 1st of the month following 60 days
**Rehire:** _ of the month following date of hire; _ 1st of the month following 30 days; _ 1st of the month following 60 days If any class of employee waiting period is waived, please list classes below *(Example: Medical coverage begins immediately for "Physicians – No Waiting Period"):*_____

## FOR EMPLOYERS WITH MULTIPLE SITES

**If you have more than one site (office), other than the address above, please list out your multiple sites and total employees at each site:**

| Site (Office) Location (City/State) | | Number of Employees in each site | | | |
|---|---|---|---|---|---|
| **CITY** | **STATE** | Full-time | Part-time | Retired | Other |
| | | | | | |
| | | | | | |

## TOTAL EMPLOYEE CALCULATION

**Total Employees**

**A** **Total # Full-Time Eligible Employees* (Refer to Underwriting Guidelines)** _____ **(A)**

**B** **Total # Part-time Employees (Refer to Underwriting Guidelines)** _____ **(B)**
*(does not include Per Diem employees)*

**C** **Total # Employees (A+ B):** ═══ **(A+B)**

**Total Benefit Eligible Employees** ***(Based on "A" Total above)***

**Total # Eligible Employees applying/enrolling for health benefits coverage.** _____

**Total # Eligible Employees waiving health benefits coverage with other coverage**
*through a spouse, other than individual coverage; or any other Health Benefits Plan offered by the employer.* _____

**Total # Eligible employees waiving health benefits coverage without other coverage**
*through a spouse, other than individual coverage; or any other Health Benefits Plan offered by the employer.* _____

**Federal Law – Eligible Employees** ***(Based on "C" Total above – Includes Part-Time)***

**Is your firm subject to the requirements of the federal COBRA law?** ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

**Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)?** ☐ Yes ☐ No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year.)

* An **Eligible Employee** as defined in the Underwriting Guidelines.

## CERTIFICATION AS A SMALL EMPLOYER (IF APPLICABLE), IN THE STATE OF NEW JERSEY

**"Small Employer"** means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed an average of at least two, but not more than 50, Eligible Employees on business days during the preceding Calendar Year, and
- employs at least two Eligible Employees on the first day of the Plan Year, and
- the majority of the Eligible Employees are employed in New Jersey.

*Continue onto back page*

If you're total in **part A** on the previous page is **between 2-50**, you qualify as a Small Employer and must check the boxes **D and F** and sign below. If you're total in **part A** on the previous page is **greater than 50 or equal to 1**, check boxes **E and F** and sign below.

**D** ☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

**OR**

**E** ☐ **I certify that I do not qualify as a Small Employer in the State of New Jersey, based on the previous definition.**

**AND**

**F** ☐ **I certify that the information provided the Members Health Plan NJ is true and complete**. I understand that if the above information is not complete or is not provided in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

Signature of Officer, Partner or Owner:_____ Title:_____ Date:_____

Print Name of Officer, Partner or Owner: _____

Signature of Witness:_____ Date:_____

**Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties, as well as termination of all health coverage.**

## EMPLOYEE CENSUS INFORMATION

**Please include the following persons in the following list:**

a) employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis and are paid by the employer on a regular basis, whether or not they are eligible to be covered.

b) employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

***Please use the following letters to indicate Status:***

**O: Owner, partner or officer**
**F: Full-time employee**
**P: Part-time employee**
**D: Totally Disabled employee**
**W: Waiving Coverage (has coverage through spouse, Medicare or other source)**
**I: Independent Contractor**
**T: Temporary employee**
**Y: Per Diem employee**
**C: Continuation of Coverage under State or Federal law**
**X: Does not want Coverage**

| Employee Name & Title (Example: John Smith -Doctor) | Date of Birth (mo,dy,yr) | Gender (M,F) | Date of Hire (mo,dy,yr) | Type of coverage (Single, EE/Child(ren), EE/Spouse ,Family) | Hours Worked per week | Status (F,P,D,W ,I,T,C,X, Y) | Employee Home Zip Code |
|---|---|---|---|---|---|---|---|
| **PLEASE ATTACH A COPY OF CURRENT CENSUS TO INCLUDE ALL ELIGIBLE EMPLOYEES, PART TIME AND WAIVERS** | | | | | | | |
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**If additional space is needed, attach a separate sheet.**

1) Please note that you can offer multiple plans alongside this plan and therefore can request a quote for 1 or more plans.

**Call us if you have any questions at 833-MEWANOW (833-639-2669).**

Members HealthPlan NJ

Designed for You.

**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: mewaenrollment@concordmgt.com

# HEALTH BENEFIT WAIVER OF COVERAGE

This benefit waiver is available to employees who are regularly scheduled to work a minimum of 24 hours or more every week. Upon renewal of the Group Health Plan, employees may elect to continue to waive out or enroll in the benefit program during the open enrollment period or at any time upon a qualifying event as defined in the Plan's Summary Plan Description Document.

## WAIVER

I_____voluntarily agree to waive coverage under the health benefits offered by_____. I understand the above explanation of my rights to waive benefits or enroll in the benefit program offered.

I realize that I can enroll in the group health plan being offered at this time but have chosen not to participate. I also understand that hereafter I may apply for coverage only during the open enrollment period of the Group Health Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description Document.

**Choose one of the below options that apply:**

- ☐ I knowingly do not have any type of health (medical, vision & prescription drug) benefits and do not wish to participate in the Group Health Plan being offered.
- ☐ I am enrolled in a Group Health Plan sponsored by my spouse's employer
- ☐ I am enrolled in a Group Health Plan sponsored by another organization
- ☐ I am covered under Medicare
- ☐ Other reasons (please explain)_____

**I certify that I am covered by the following health insurance plan:**

Name of Policy Holder: _____

Name of Health Insurance Plan/Carrier: _____

Policy Number: _____

Company or Group Sponsor: _____

*(Please attach a copy of Insurance Card if Information is not Provided Above)*

_____

Employee Signature Date

_____

Employer Signature Date

**Account #:** _____

To be completed by Plan Administrator

Prepared By: Concord Management Resources
V.10.20