Clinton Township Board of Education
Medical Plan Comparison
eff. 11/1/2022

	SHIF/Aetna Educators Health Plan (EHP) (Open to all employees)	
	In-Network	Non-Network
Service Areas	**Aetna Choice POS II (Open Access)**	
Primary Care Physician (PCP) Referral Needed	**No**	
Annual Deductible		
Individual	$0	$350
Family	$0	$700
Coinsurance	100%; 90% on select services	70% of R&C [1]
Annual Out of Pocket Maximum (Includes Coinsurance and Copays)		
Individual	$500	$2,000
Family	$1,000	$5,000
Overall Annual Out of Pocket Maximum (Includes copay, coinsurance, and deductible)		
Individual	$500	$2,000
Family	$1,000	$5,000
Lifetime Maximum	Unlimited	
Hospital Inpatient Services (room and board; physician visits)	100%	70% after deductible
Emergency Room	100% after $125 copay waived if admitted	100% after $125 copay waived if admitted
Ambulance	90%; non-emergency condition excluded	70% after deductible; non-emergency condition excluded
Radiation/Chemotherapy Outpatient	100%	70% after deductible
X-Ray and Lab Tests	100%	70% after deductible
Home Health Care	100%	70% after deductible
	Requires Pre-approval	
Skilled Nursing Facility	100%	70% after deductible
	120 days per calendar year combined	
Private Duty Nursing (outpatient)	90%	70% after deductible
Hospice	100%	70% after deductible
	Requires Pre-approval	
Surgery/Anesthesia	100%	70% after deductible
Physician Office Visits [2]	$10 Copay (PCP) $15 Copay (Specialist)	70% after deductible
Annual Physical Exams	100%	Not Covered
Annual Well Child Care	100%	Not Covered
Immunizations (except if travel or job related)	100%	Not Covered; Well Child Immunizations: 70% after deductible (up to age 1)
Annual OB-Gyn Exam	100%	70% after deductible
Annual Mammogram (baseline and women over age 40)	100%	70% after deductible
Annual Prostate screening (men over 50)	100%	Not Covered

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	SHIF/Aetna Educators Health Plan (EHP)	
	In-Network	Non-Network
Maternity (including pre-natal)	$15 copay for 1st prenatal visit, then 100%	70% after deductible
Infertility services	$15 copay	70% after deductible
	Subject to limitations set by NJ Mandates	
Allergy Testing and Treatment	$15 copay	70% after deductible
Acupuncture	$15 copay	70% after deductible, limited to $60/visit
Chiropractic Care	$15 copay	70% after deductible, limited to $35/visit
	30 visits per calendar year	
Short Term Therapies (Physical, Cognitive, Occupational, Respiratory, Speech)	$15 copay	70% after deductible, limited to $52/visit
	Unlimited	
Other Therapies (Chelation, dialysis, Infusion)	100%	70% after deductible
	Unlimited	
Hearing Aids	100%	70% after deductible
	One hearing aid for each impaired ear once in a 24-month period, only for members are 15 or younger	
Durable Medical Equipment/Medical Supplies	90%	70% after deductible
Prosthetics and Orthotics	90%	70% after deductible
Inpatient Mental Illness/Substance Abuse/Alcohol Treatment [3]	Covered as any other illness	Covered as any other illness
Outpatient Mental Illness/Substance Abuse/Alcohol Treatment [3]	Covered as any other illness	Covered as any other illness
Routine Vision Exam	$15 copay (one annual exam/year)	Not Covered
Vision Hardware	Not Covered	
Child Dependent Termination age	Children covered to End of Year they turn age 26	

Comparison is for illustrative purposes only.
Written plan documents will supersede any errors on this illustration.

1 Out-of-Network providers may bill you for difference between the carrier's Reasonable and Customary (R&C) limit and the provider's actual charges. This amount may be significant. It is important to note that all percentages for out-of-network services are percentages of the carrier's R&C, not the provider's actual charge. You are responsible for any charges in excess of R&C. R&C is 90th percentile of FAIR Health for SHIF $10 & $15 plans, and 200% CMS SHIF/Aetna EHP & GSHP plans.

2 Copayments apply to in-network primary care and specialist office visits unless otherwise indicated

3 Mental health conditions and Alcohol/Substance Abuse treatment are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

SCHOOLS HEALTH INSURANCE FUND

c/o PERMA PO BOX 99106
Camden, NJ 08101

Benefits Enrollment Form

Employer Name: Clinton Township BOE

EMPLOYEE/PARTICIPANT INFORMATION (Employee or Dep. 31)

Please PRINT and fill this section out COMPLETELY

Social Security #:	Last Name:	First Name:	M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:	Address:	
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:	PCP # (if required):	Division (if any):	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Requested Effective Date:		

DEPENDENT INFORMATION (Spouse, Child or Children)

Please PRINT and fill this section out COMPLETELY

Please list all eligible dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

PLAN SELECTIONS

Medical Coverage

Carrier Name: SHIF/Aetna _____ Plan Name: _____

Type of Coverage: ☐ EE Only ☐ EE + Family ☐ EE + Spouse ☐ EE + Child(ren)

Prescription Coverage

Carrier Name: N/A _____ Plan Name: _____

Type of Coverage: ☐ EE Only ☐ EE + Family ☐ EE + Spouse ☐ EE + Child(ren)

Dental Coverage

Carrier Name: N/A _____ Plan Name: _____

Type of Coverage: ☐ EE Only ☐ EE + Family ☐ EE + Spouse ☐ EE + Child(ren)

TYPE OF ACTIVITY

☐ New Hire Date: _____ ☐ Open Enrollment Date: _____ ☐ Rehire Date: _____

☐ Termination of Employment
Date: _____

☐ COBRA (please check box indicating reason for COBRA eligibility):
- ☐ Employment Terminated ☐ Reduction in hours ☐ Divorce
- ☐ Spouse/dependent child of deceased employee ☐ Loss of dependent child status under plan rules
- ☐ Spouse/dependent's loss of coverage due to employee's Medicare entitlement

Addition of Dependent (legal documentation required)

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care Date of Event: _____

Add Coverage: ☐ Medical ☐ Rx ☐ Dental

Deletion of Dependent Date of Event: _____ Dependent Name: _____

☐ Divorce (legal documentation required) ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Rx ☐ Dental

Other

☐ Dependent Age 31 ☐ Newly Eligible (PT or FT)

☐ Death (Name of Deceased): _____ Date of Death: _____

☐ Other (Give Reason):

EMPLOYEE CERTIFICATION

I certify that all of the information supplied on this form is true to the best of my knowledge. I understand if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment. I understand that there is no guarantee of continuous participation by medical service providers, doctors or facilities in the Plans. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the medical plans or assignee may require. I also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the Plan. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the Plan that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties. I further agree that the SHIF may, at any time, request that I supply evidence that substantiates the eligibility status of any person I cover as a dependent under the Plan.

Print Name: _____ Employee Signature: _____

Date: _____

ID Cards

If your ID card is lost or you need a duplicate card, you can view or print your ID card online through the member portal at www.benecardpbf.com or through the Benecard PBF mobile app. You can also notify your Human Resources Coordinator to request a physical ID card. If there is an emergency, and you need a prescription filled, call Benecard PBF Member Service toll-free at 1-877-723-6005 (TDD: 1-888-907-0020) and they will provide your pharmacist with the required information to facilitate processing the claim.

Member Resources at www.benecardpbf.com

Maximize your benefit with our online member resource tools including the network pharmacy finder, mail service, your plan coverage details, comparison pricing tool, as well as view recent personal medication utilization history, including what you have paid and what the plan has paid on your behalf.

Coverage

Your prescription program covers most Medically Necessary, Federal Legend, State Restricted and Compounded Medications which by law may not be dispensed without a prescription. Your pharmacist has online access to see which medications are covered under the benefit guidelines of your program. Alternatively, you can contact Member Services with questions about coverage details. Prescription drug programs do not cover any over-the-counter medications, medical supplies or devices even if purchased at a pharmacy, and even if a prescription order is written. Clinical Review may be required before dispensing certain medications. Your program covers certain diabetic supplies, including insulin. Dispensing of male sexual dysfunction medications is limited to four tablets or six injections per month based on prior approval and appropriate medical diagnosis of non-psychological impotence.

Exclusions

A summary of the exclusions are as follows:

- Medications which do not require a prescription order, even if one is written.
- Medications which are not considered medically necessary for the care and treatment of an injury or sickness.
- Medications which are considered "off-label use" as they are not prescribed in accordance with FDA-approved utilization or are prescribed or dispensed in a manner contrary to normal medical practices.
- Medications administered by a physician or prescriber and those not dispensed at a pharmacy, including medications you receive at your doctor's office, in a hospital, clinic or other care facility.
- Medications for which the cost is recoverable under a government program, Workers' Compensation, occupational disease law, or medications for which no charge is made to you.
- Immunologicals, vaccines, allergy sera, biological sera, blood plasma and charges for the administration or injection of medications.
- Any medication labeled for "Investigational Use" or as experimental.

Therapeutic Categories of medications excluded from your program include:

- Medications prescribed for cosmetic purposes
- Hair loss medications
- OTC Medications
- Growth hormones, unless medically necessary
- Needles, syringes and injection devices, except with insulin
- Male sexual dysfunction medications are covered with restrictions

This brochure is only a general description of your prescription benefit program and it is not a contract. All benefits described herein are subject to the terms, conditions and limitations of the group master contract and applicable law. All personal health information is kept strictly confidential, as required by the privacy rules of the Health Insurance Portability and Accountability Act.

7/2022

Clinton Township Board of Education

Client ID#: 3820 Group #: 4000 - 4099

Your Co-Payment Schedule

Retail:

- $5 for a Generic Equivalent Medication
- $10 for a Brand Name Medication

Mail Order:

- $10 for a Generic Equivalent Medication
- $20 for a Brand Name Medication

Brown & Brown INSURANCE

Benecard Member Services
1-877-723-6005
TDD: 1-888-907-0020
24 hours a day, 7 days a week

BeneCard PBF
Prescription Benefit Facilitator®

www.benecardpbf.com

Retail Program

Your ID card provides all the information your pharmacist will need to process your prescription through Benecard PBF.

Your retail co-payment amount will be:

- $5 for a Generic Equivalent Medication
- $10 for a Brand Name Medication

You will only pay the actual cost of your prescription if it is less than your co-payment amount. Retail quantities will be dispensed according to the prescription order written by your physician up to a 90-day supply; however, 1 co-payment will apply per 30-day supply.

- 1 to 30-day supply – 1 co-pay
- 31 to 60-day supply – 2 co-pays
- 61 to 90-day supply – 3 co-pays

There is a $1,600 individual and $3,200 family maximum out of pocket limit for the period January 1st through December 31st.

Discounts For Non-Covered Medications

Be sure to present your Benecard PBF ID card at a participating network pharmacy to receive a discount off the retail price of medications that may not be covered under the guidelines of your prescription benefit program.

Pharmacy Network

Your Benecard PBF prescription benefit program provides you with access to an extensive national pharmacy network. To locate a participating pharmacy, visit www.benecardpbf.com or call Benecard Member Services toll-free at 1-877-723-6005 (TDD: 1-888-907-0020).

Direct Reimbursement

If you must pay out-of-pocket for the full price of your medication that should have been covered under the program, manually submit a Direct Member Reimbursement Form, available from your Human Resources Coordinator or online at www.benecardpbf.com. You will need to provide an itemized receipt showing: the amount charged, prescription number, name of medication dispensed, manufacturer, dosage form, strength, quantity, and date dispensed. Your pharmacist can assist you if you do not have a detailed receipt. Direct reimbursement is based upon the coverage outlined herein and is reimbursable at the same rate that would have been reimbursed to the pharmacy, less any applicable co-payment amount. This amount may be significantly lower than the retail price you paid; therefore, it is advised that you use a participating network pharmacy to reduce your out-of-pocket costs.

Mail Service Pharmacy

You may wish to consider the convenience and savings offered by Benecard PBF's mail service pharmacy, Benecard Central Fill, if you take maintenance type medications on a long-term basis. Information on how to take advantage of this service is included and available from your Human Resources Coordinator or online at www.benecardpbf.com. Up to a 90-day supply may be obtained on a non-emergency basis through mail order. The medication can be shipped directly to your home.

Your mail order co-payment amount required at the time you place your order, will be:

- $10 for a Generic Equivalent Medication
- $20 for a Brand Name Medication

Specialty Medications

Specialty pharmaceuticals are typically produced through biotechnology, administered by injection, and/or require special handling and patient monitoring. If your doctor has prescribed a specialty medication, the Clinton Township Board of Education will require that specialty pharmaceutical medications be obtained through Benecard Central Fill Specialty. As to not interrupt your current therapeutic regimen, you will be allowed to obtain 1 fill of your initial specialty medication at a participating retail pharmacy. Any refills obtained thereafter will need to be dispensed through Benecard Central Fill Specialty. This can be done in the same manner you submit mail order prescriptions through Benecard Central Fill. Specialty medications are subject to your program's mail order co-payment. Initial fills of a specialty medication MAY be limited to a maximum two-week supply in order to determine how the patient's mental and physical health will react to a particular medication.

Copay Assistance Program

Certain specialty medications are eligible for copay assistance, providing members with a $0 copay when submitted through our mail order pharmacy, Benecard Central Fill (BCF), or through a Benecard limited distribution pharmacy. Eligible members will be contacted by a Benecard representative who will help assist them in the enrollment process when applicable and prior to filling their specialty medication.

Generic Substitution

Your program requires your pharmacist to dispense the generic equivalent medication when one is available. If you or your physician prefers the brand name medication rather than an available generic equivalent, you will be charged the brand co-payment plus the network cost differential between the generic and the brand medications.

Performance Preferred Medication List Program

The Performance Preferred Medication Program is designed to provide a broad selection of therapeutically sound medications while encouraging the use of reasonably priced brand medications. A great majority of brand-name medications and all low-cost generic medications are included on the Performance Preferred Medication List. In addition, the Performance Preferred Medication Program excludes several medications, regardless if the Clinton Township Board of Education's plan design allows for such coverage. You would be responsible for paying 100% of the medication cost of these excluded medications identified in the Performance Preferred Medication Program. The Performance Preferred Medication List is available on-line at www.benecardpbf.com and is updated monthly. We suggest you share the Performance Preferred Medication List with your healthcare provider to facilitate prescribing from this list whenever appropriate to allow you to take advantage of cost savings that may be available to you. You may also consult with your pharmacist regarding generic medication options for your current brand medications.

Save With Generics

Generic equivalent medications must meet the same Food and Drug Administration (FDA) standards for purity, strength and safety as brand name medications. They also must have the same active ingredients and identical absorption rate within the body as the brand name version. If you wish to take advantage of this savings opportunity, you should ask your physician to prescribe your medication either generically or as a brand with substitutions permissible. You may also consult with your pharmacist regarding generic medication options that may be available to you.

Step Therapy

The Step Therapy program is designed to ensure quality and manage costs. Where more than one medication in certain drug classes has been shown to be clinically effective but at varying costs, the Step Therapy program requires a trial with lower cost medications before approval of the higher cost medication, where clinically appropriate. If you purchase the higher cost medication without a prior approval, there will be no coverage for the higher cost medication.

Eligibility

Your Human Resources Coordinator determines who is eligible for benefits under Clinton Township Board of Education prescription benefit program. Eligible dependents may include your spouse or domestic partner and unmarried children who are dependent upon you. Coverage for a dependent will end:

- when your coverage ends,
- on the last day of the benefit month in which the dependent fails to meet the definition of a dependent, or
- on the last day of the calendar year they turn 26, unless dependent qualifies as an overage dependent.

You should notify your Human Resources Coordinator at 908-236-7235 regarding any eligibility change such as adding or removing a dependent, address or name changes, or other family status change.

BeneCard PBF
Prescription Benefit Facilitator

Enrollment Form

TODAY'S DATE:

CLIENT INFORMATION

Clinton Township BOE | 3820 | 4040 - EHP

CLIENT NAME (PLAN SPONSOR / EMPLOYER) | CLIENT # | GROUP #

CARDMEMBER INFORMATION

FIRST NAME | MI | LAST NAME | ID # | SSN

MAILING ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | CELL PHONE | EMAIL

COVERAGE TYPE

PLEASE CHECK ONE:

☐ SINGLE ☐ CARDMEMBER/SPOUSE ☐ CARDMEMBER/CHILD ☐ CARDMEMBER/CHILDREN ☐ FAMILY

EFFECTIVE DATE:

REASON CODE

A	NEW ENROLLMENT
B	REINSTATE MEMBER
C	REINSTATE DEPENDENT / SPOUSE
D	ADD DEPENDENT / SPOUSE
E	TERMINATE COVERAGE
F	TERMINATE DEPENDENT COVERAGE
G	NAME CHANGE
H	ADDRESS CHANGE
I	GROUP CHANGE: FROM_____ TO _____

J	RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: _____
K	ISSUE CARD
L	DO NOT ISSUE ID CARD
M	COBRA ENROLLMENT
N	COBRA TERMINATION
O	STUDENT STATUS UPDATE
P	DISABLED DEPENDENT
Q	OVERAGE DEPENDENT**
R	DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK)

ELIGIBILITY

	LAST NAME	FIRST NAME	MI	GENDER	BIRTHDATE	SSN	HICN	REASON CODES
CARDMEMBER								
02 SPOUSE								
EMAIL/PHONE*								
03 DEPENDENT								
EMAIL/PHONE*								
04 DEPENDENT								
EMAIL/PHONE*								
05 DEPENDENT								
EMAIL/PHONE*								
06 DEPENDENT								
EMAIL/PHONE*								
07 DEPENDENT								
EMAIL/PHONE*								
08 DEPENDENT								
EMAIL/PHONE*								

*OPTIONAL, ONLY IF DIFFERENT FROM CARMEMBER

COORDINATION OF BENEFITS

SECONDARY COVERAGE ID NUMBER | INSURANCE COMPANY | POLICY / GROUP#

EMPLOYER/PLAN SPONSOR | EFFECTIVE DATE

SIGNATURES

MEMBER SIGNATURE | CLIENT SIGNATURE

FOR INTERNAL USE ONLY:

DATE ENTERED:_____ ENTERED BY:_____ LOGGED BY:_____

5040 Ritter Road, Mechanicsburg, PA 17055 Fax: 888-907-0040 eligibility@benecardpbf.com www.benecardpbf.com

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

Clinton TWP BOE
Horizon Dental Option Plan with ortho
96819

Benefit	
Benefit Period	Calendar Year
DEDUCTIBLE	
Individual	$25
Family	$75
BENEFIT PERIOD MAXIMUM	$1,000 (per person)
Benefit Period Maximum Applies To	**Preventive & Diagnostic, Treatment & Therapy, Endodontics, Periodontics, Oral Surgery, Prosthodontics, Crowns and Onlays**
COINSURANCE	
Preventive Diagnostic	
Exam and Preventive Services Exams	100%
Fluoride Treatment	100%
Sealants Application	100%
Adult Prophylaxis	100%
X-rays (Bitewing & Full Mouth)	100%
Treatment and Therapy	
Space Maintainers	90%
Amalgam Restorations	90%
Composite Restorations - Anterior & Bicuspid	90%
Denture Adjustments	90%
Denture Repairs	90%
Simple Extractions	90%
Endodontics	
Root Canal Therapy - Anterior & Bicuspid	90%
Root Canal Therapy - Molar	90%
Periodontics	
Scaling & Root Planing	90%
Gingivectomy	90%
Periodontal Maintenance	90%
Osseous Surgery	90%
Oral Surgery	
Surgical Extractions	90%
Partial Bony Extractions	90%
Complete Bony Extractions	90%
Prosthodontics	
Bridgework	50%
Partial Dentures	50%
Crowns and Onlays	
Crown – porcelain fused to high noble metal	90%
Orthodontics	NOT COVERED
Eligibility	Dependent Children of enrolled employees are covered to the end of the year age 23.

Services are for illustrative purposes only. For complete listing of covered services, plan limitations, deductibles and maximums, consult your benefit booklet.

Reset Form

Horizon Blue Cross Blue Shield of New Jersey

ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Dental Programs

P.O. Box 1710
Newark, NJ 07101-1938
www.HorizonBlue.com/dental
1-800-4DENTAL

Group Information - To Be Completed by Employer

Group Name	Group Number	Subgroup Number
Clinton Township Board of Education	096819	001

A. Type of Activity - To Be Completed by Employer *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment
☐ New Subscriber

Effective Date
____/____/____

Date of Hire
____/____/____

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse		
☐ Domestic Partner		
☐ Civil Union Partner	__/__/__	
☐ Add Dependent Child	__/__/__	
☐ Name Change	__/__/__	
☐ Change Plan	__/__/__	
☐ Other	__/__/__	
☐ Add/Change Dentist Office ID		

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse/Domestic Partner/ Civil Union Partner*	__/__/__	
☐ Remove Dependent Child*	__/__/__	
☐ Employee Withdrawal/Termination	__/__/__	

Note: Employee must be enrolled for spouse/domestic partner/civil union partner/ dependent(s) to have coverage.
*Please complete Add/Change/Remove and Name columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State, Total Disability
Not all options are available. Contact Employer for available options.
Coverage For: ☐ Employee ☐ Dependents
Length of Continuation: ☐ 18 mos ☐ 29 mos* ☐ 36 mos ☐ Total Disability
Date of Loss of Coverage: __/__/__
Date of Qualifying Event: __/__/__
*Attach proof of disability

B. Employee Information - Complete Sections B - G

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code
Date of Employment	Hours Worked		

C. Plan Option - Your selection must be offered by your employer.

Horizon BCBSNJ	Horizon Healthcare Dental	Contract Type
☐ Horizon Dental Traditional	☐ *Horizon Dental Choice	☐ S - Single ☐ F - Family
☐ Horizon Dental Option	☐ *Horizon TotalCare Dental	☐ 2 Adults
☐ Horizon Dental PPO		☐ P/C - Parent & Child
☐ Horizon Dental PPO Access		

*Please select Dentist Office ID Number-Section D

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Dental Coverage Check If Yes	Dentist Office ID Number (if applicable)	NPI Number	Current Patient Check If Yes	Previous Coverage Check If Yes
Employee			☐ ☐	/ /		☐			☐	☐
Spouse			☐ ☐	/ /		☐			☐	☐
Domestic Partner			☐ ☐	/ /		☐			☐	☐
Civil Union Partner			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐
Child			☐ ☐	/ /		☐			☐	☐

E. Other/Previous Insurance

Is your Spouse/Domestic Partner/Civil Union Partner Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse's/ Domestic Partner's/Civil Union Partner's employer.

If "Yes" to Other Dental Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to previous coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Credible Coverage issued by the previous carrier, if available.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes," who and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

G. Employee Signature

If you have any questions concerning the benefits and services provided by or excluded under this contract, contact a benefits representative at your company before signing this form.

I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/ change request. I authorize deductions from my earnings for any required contribution.

Employee Signature - *Required*
X

Date __/__/__

E-Mail Address

H. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*
X

Title

Date __/__/__

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Horizon BCBSNJ Dental Programs prior to visiting a specialist or admission to a hospital.

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

EHP Medical & Rx Contribution Schedule

BASE SALARY	LEVEL OF COVERAGE/PERCENTAGE OF SALARY			
	Single	Parent/Child(ren)	Two Adult	Family
Up to - $40,000	1.7%	2.2%	2.8%	3.3%
$40,001 - $50,000	1.9%	2.5%	3.3%	3.9%
$50,001 - $60,000	2.2%	2.8%	3.9%	4.4%
$60,001 - $70,000	2.5%	3.0%	4.4%	5.0%
$70,001 - $80,000	2.8%	3.3%	5.0%	5.5%
$80,001 - $90,000	3.0%	3.6%	5.5%	6.0%
$90,001 - $100,000	3.3%	3.9%	6.0%	6.6%
$100,001 and over	3.6%	4.4%	6.6%	7.2%

1. This contribution cannot exceed the previous Chapter 78 contributions. In every case, the lower contribution applies.

Brown & Brown INSURANCE

Knowledge You Can Trust ™