Benefits Enrollment Form

c/o PERMA, 401 Route 73 North,
Suite 300, Marlton, NJ 08053

Employer Name: Clayton 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:		Division (if any): Leave Blank	
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:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female		
Relationship:			

PLAN SELECTIONS

Medical Coverage

Please select one plan:

☐ Aetna Choice POS II - New Jersey Educators Health Plan

☐ Amerihealth PPO - New Jersey Educators Health Plan

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

☐ I wish to waive medical coverage ☐ I wish to cancel my medical coverage

TYPE OF ACTIVITY (Leave this section blank.)

☐ 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 - Date of Event: ______________ **Dependent Name:** ______________________

Legal Documentation is required

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care

Add Coverage: ☐ Medical

Deletion of Dependent Date of Event: ______________ **Dependent Name:** ______________________

☐ Divorce (Legal Documentation is required) ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical

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: ____________

DO NOT FORGET TO SIGN & DATE

Enrollment Form

TODAY'S DATE:

CLIENT INFORMATION

Clayton Board of Education

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

CARDMEMBER INFORMATION

FIRST NAME | MI | LAST NAME | ID # N/A | 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: 1/1/2018

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								A
02 SPOUSE								A
EMAIL/PHONE*								
03 DEPENDENT								A
EMAIL/PHONE*								
04 DEPENDENT								A
EMAIL/PHONE*								
05 DEPENDENT								A
EMAIL/PHONE*								
06 DEPENDENT								A
EMAIL/PHONE*								
07 DEPENDENT								A
EMAIL/PHONE*								
08 DEPENDENT								A
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:______

3131 Princeton Pike, Bldg. 2B, Suite 103, Lawrenceville, NJ 08648 Fax: 609-219-1660 eligibility@benecard.com www.benecardpbf.com

DELTA DENTAL

Enrollment/Change Request

Employer Group Information - To be completed by Employer

Group Name ____________ Group Number ____________ Sublocation/Store location ______/______

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

1. **Enrollment** ☐ New Enrollee / Subscriber **Effective Date** **Date of Hire**

2. **Change - Check all that apply** — Date of Event — Reason

- ☐ Add Spouse
- ☐ Add Domestic Partner
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Change Plan
- ☐ Other
- ☐ Add/Change Office ID Numbers

3. Remove or Terminate - Check all that apply — Effective Date — Reason

- ☐ Remove Spouse*
- ☐ Remove Domestic Partner*
- ☐ Remove Dependent Child*
- ☐ Employee Withdrawal/Termination

NOTE: Employee must be enrolled for spouse/dependents(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 or applicable. Contact Employer for available options.**

Coverage for: ☐ **Employee** ☐ **Dependents**

Length of Continuation: ☐ 12 months ☐ 18 months ☐ 29 months ☐ 36 months ☐ Total Disability* Attach proof of total disability

Date of Loss of Coverage: __/__/__ Date of Qualifying Event: __/__/__

Billing: ☐ Home ☐ Group

(B) **Employee Information - Complete Sections (B-G)**

Last name, First name, MI ____________ Social Security Number ____________ Home Telephone ____________

E-mail Address ____________ Home Address ____________ Apt # ____ City, State ________ Zip Code ______

Employer Name ____________ Work Telephone ____________ Work Address ____________

City, State ____________ Zip Code ____________ Date of Employment __/__/__ Hours Worked per week ________

(C) **Plan Option** - Your selection must be offered by your Employer Check one: ☐ Delta Dental Premier® ☐ Delta Dental PPO℠ ☐ Advantage Program ☐ Delta Dental PPO plus Premier ☐ DeltaCare®

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

	(A) Add (C) Change (R) Remove	Last Name First Name, MI	Sex M F	Birthdate MM/DD/YYYY	Social Security Number	Other Health Coverage	Previous Coverage Check if Yes
Employee	_R _						☐
Domestic Partner (If Coverage offered)	_R _						☐
Spouse	_R _						☐
Child	R						☐
Child	_R _						☐
Child	_R _						☐
Child	R						☐

(E) Other/Previous Insurance

Is your spouse employed? ☐ Yes ☐ No If "Yes", give name and address of your spouse's employer.

___

If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#.

___

If "Yes" to Previous Coverage, identify names(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

___

(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 questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Service Agent at 1-800-452-9310 before signing this form.*

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

Employee Signature - Required ____________ Date ☐ E-mail Address ____________

(H) Employer Verification - To be Completed by Employer

Employer Signature - Required ____________ Title ____________ Date ☐

Instuctions

Employer

*Complete the Employer Group Information in the upper left corner of the form.
*Section A - Type of Activity:Check boxes indicating reason(s) for submitting application.
*Complete Section (H) - Employer Verification (in the upper left corner of the second page)of the form.
*Employer must complete this section for all new enrollments, coverage changes and terminations.
*Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections (B-G)

Section (B) - **Employee Information**
- Complete all information in order for your application to be processed.

Section (C) **Plan Option:**
- Check one Plan option box ( ) Delta Dental Premier ( ) Delta Dental PPO ( ) Delta Dental POS ( ) Delta Dental PPO Advantage Program ( ) DeltaCare Select only an option offred by your employer.

Section (D) - **Individuals Covered:**
- Add/Change/Remove - Use "A","C",or"R" to indicate wqhether you are adding,changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex,Birthdate,and Social Security number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being contiuned beyond the limiting age, attach proof of disibility.
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section (F) - Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID number for the dentist (if applicable). Indicate office ID number selection(s) on the form.

Section (E) - **Pre-Existing Conditions Statement**
- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in the group coverage in a group of 2-5 employees and by late entrants.

Section (F) - **Other/Previous Insurance**
- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section (G) - **Dependent Information**
- Complete this section for all new enrollments or coverage changes.

Section (H) - **Employee Signature:**
- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section (I) - **Employer Verification**
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditons of Enrollment

Application Acknowledgment and Agreements

1. On behalf of myself and the dependents listed on the reverse side I agree to or with the following:
   a)I authorize the sources stated below to give Delta Dental of New Jersey, Inc. or any consumer reporting agency acting on its behalf, information about me and my minor childern, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or medical condition. Authorization sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier, any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not afect any action which Delta Dental of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Delta Dental of New Jersey, Inc. plan or group policy coverage is provided by Delta Dental of New Jersey, Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Delta Dental of New Jersey, Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request form for a health benefits plan is subject to criminal and civil penalties.

NJ Educators Health Program (NJEHP)

Simplified Medical/Prescription Plan Benefits Overview

	NJ Educators Health Plan	
	In-Network	Out-of-Network
Referral Required	No	
Individual Deductible	None	$350
Family Deductible	None	$700
Coinsurance	10% (Select Services)	30%
PCP Office Copay	$10	30% after deductible
Specialist Office Copay	$15	30% after deductible
Inpatient Hospital	100%	30% after deductible
Emergency Room Copay	$125	
Maximum Out of Pocket	$500	$2,000
Coinsurance Max Family	$1,000	$5,000
Retail Generic Copay*	$5	
Retail Brand w/ No Generic Available*	$10	
Retail Brand w/ Generic Available *	Member Pays the Difference	
Mail Order Generic Copay*	$10	
Mail Order Brand w/ No Generic Available *	$20	
Mail Order Brand w/ Generic Available*	Member Pays the Difference	

*What you need to know about the prescription coverage:

* Mandatory Generic: You pay the cost difference between the generic and brand name plus the brand copay when a generic is available

* Step Therapy is included. This can require a trial of a lower-cost prescription drug before the approval of the higher-cost prescription, where clinically appropriate. New NJEHP enrollees will be required to repeat step therapy even if completed previously.

* There is a formulary on this plan. Please review the NJEHP Prescription Formulary attached to this bulletin to check if your medications, both generic and brand name, are covered.

NJ EDUCATORS HEALTH PLAN (NJEHP) CONTRIBUTION SCHEDULE

BASE SALARY OR PENSION AMOUNT	LEVEL OF COVERAGE/PERCENTAGE OF SALARY			
	Single	Parent/child(ren)	Two Adults	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 - $125,000	3.6%	4.4%	6.6%	7.2%

[1] This contribution cannot exceed the previous Ch. 78 contribution. In every case, the lower contribution applies.

[2] Only applicable to retirees required to contribute under Ch. 78. Retirees currently receiving or eligible to receive premium-free health benefits will continue to do so.

[3] For any employee earning a base salary above $125,000, the maximum contribution will be based on a salary of $125,000.

Estimated NJ Educators Health Plan (NJEHP) Annual Employee Contribution

Based on Percentage of Current Salary

Estimated Salary	SINGLE Coverage		Parent/Child(ren) Coverage		Two Adults Coverage		Family Coverage	
	Contribution Percentage	Estimated Annual Contribution Amount	Contribution Percentage	Estimated Annual Contribution Amount	Contribution Percentage	Estimated Annual Contribution Amount	Contribution Percentage	Estimated Annual Contribution Amount
$25,000	1.7%	$425.00	2.2%	$550.00	2.8%	$700.00	3.3%	$825.00
$30,000	1.7%	$510.00	2.2%	$660.00	2.8%	$840.00	3.3%	$990.00
$35,000	1.7%	$595.00	2.2%	$770.00	2.8%	$980.00	3.3%	$1,155.00
$40,000	1.7%	$680.00	2.2%	$880.00	2.8%	$1,120.00	3.3%	$1,320.00
$45,000	1.9%	$855.00	2.5%	$1,125.00	3.3%	$1,485.00	3.9%	$1,755.00
$50,000	1.9%	$950.00	2.5%	$1,250.00	3.3%	$1,650.00	3.9%	$1,950.00
$55,000	2.2%	$1,210.00	2.8%	$1,540.00	3.9%	$2,145.00	4.4%	$2,420.00
$60,000	2.2%	$1,320.00	2.8%	$1,680.00	3.9%	$2,340.00	4.4%	$2,640.00
$65,000	2.5%	$1,625.00	3.0%	$1,950.00	4.4%	$2,860.00	5.0%	$3,250.00
$70,000	2.5%	$1,750.00	3.0%	$2,100.00	4.4%	$3,080.00	5.0%	$3,500.00
$75,000	2.8%	$2,100.00	3.3%	$2,475.00	5.0%	$3,750.00	5.5%	$4,125.00
$80,000	2.8%	$2,240.00	3.3%	$2,640.00	5.0%	$4,000.00	5.5%	$4,400.00
$85,000	3.0%	$2,550.00	3.6%	$3,060.00	5.5%	$4,675.00	6.0%	$5,100.00
$90,000	3.0%	$2,700.00	3.6%	$3,240.00	5.5%	$4,950.00	6.0%	$5,400.00
$95,000	3.3%	$3,135.00	3.9%	$3,705.00	6.0%	$5,700.00	6.6%	$6,270.00
$100,000	3.3%	$3,300.00	3.9%	$3,900.00	6.0%	$6,000.00	6.6%	$6,600.00
$105,000	3.6%	$3,780.00	4.4%	$4,620.00	6.6%	$6,930.00	7.2%	$7,560.00
$110,000	3.6%	$3,960.00	4.4%	$4,840.00	6.6%	$7,260.00	7.2%	$7,920.00
$115,000	3.6%	$4,140.00	4.4%	$5,060.00	6.6%	$7,590.00	7.2%	$8,280.00
$120,000	3.6%	$4,320.00	4.4%	$5,280.00	6.6%	$7,920.00	7.2%	$8,640.00
$125,000+	3.6%	$4,500.00	4.4%	$5,500.00	6.6%	$8,250.00	7.2%	$9,000.00

To calculate your approximate contribution amount per paycheck: divide the shown estimated contribution amount matching your estimated salary by the number of paychecks you receive annually.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2021-12/31/2021

aetna™ SCHOOLS HEALTH INSURANCE FUND : Aetna Choice® POS II - SHIF - NJ EDUCATORS HEALTH PLAN (NJEHP)

Coverage for: Individual + Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0. Out-of-Network: Individual $350 / Family $700.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $2,000 / Family $5,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit, deductible doesn't apply	30% coinsurance	None
	Specialist visit	$15 copay/visit, deductible doesn't apply	30% coinsurance	None
	Preventive care /screening /immunization	No charge	Not covered, except 30% coinsurance for immunizations up to 12 months, mammograms & gynecological exams	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	Not covered.
	Non-preferred brand drugs	Not covered	Not covered	Not covered.
	Specialty drugs	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$125 copay/visit, deductible doesn't apply	$125 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance, deductible doesn't apply	10% coinsurance, deductible doesn't apply	Non-emergency transport: not covered, except 30% coinsurance if pre-authorized.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Urgent care	$15 copay/visit, deductible doesn't apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $15 copay/visit, deductible doesn't apply	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge; except $15 copay for initial visit to confirm pregnancy, deductible doesn't apply	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization may be required for out-of-network care.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	$15 copay/visit, deductible doesn't apply	30% coinsurance	$52 maximum/visit for Physical Therapy for out-of-network.
	Habilitation services	$15 copay/visit, deductible doesn't apply	30% coinsurance	$52 maximum/visit for Physical Therapy for out-of-network.
	Skilled nursing care	No charge	30% coinsurance	120 days/calendar year for in-network, 60 days/calendar year for out-of-network. Pre-authorization required for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	10% coinsurance, deductible doesn't apply	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit, deductible doesn't apply	Not covered.	1 routine eye exam/calendar year.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - Up to $60 or 75% of in-network payments, whichever is lower for out-of-network.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year. $35 maximum/visit for out-of-network.
- Hearing aids - 1 hearing aid to $1,000 maximum per ear/24 months up to age 16.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar year for in-network only.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? No.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $0
- **Specialist copayment** $15
- **Hospital (facility) copayment** $0
- **Other copayment** $0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $0
- **Specialist copayment** $15
- **Hospital (facility) copayment** $0
- **Other copayment** $0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $0
- **Specialist copayment** $15
- **Hospital (facility) copayment** $0
- **Other copayment** $0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$90
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

The new Find a Provider tool on **myahabenefits.com** is a better way to help you to make confident decisions about your health care.

- **Easy-to-use search**
  A single search bar helps you find network doctors and facilities, as well as treatments and services, faster and more accurately.
- **Doctor and hospital profiles**
  Informative doctor and hospital profiles and nationally recognized quality measurements help you find the doctor that is right for you. The profiles offer more than just location and phone number. They also show credentials, network and hospital affiliations, and office hours, as well as gender, specialty, language, and if a doctor is accepting new patients.
- **Rate and review your experience**
  Feedback and ratings provide insights into other plan members' experiences with doctors and hospitals. Anyone can read ratings and reviews, but you must be registered at **myahabenefits.com** to share your own experiences.
- **Compare doctors and facilities**
  The Compare feature lets you easily compare up to five doctors or hospitals at once. You can compare specialties, education, board certifications, quality reviews, and more.

Questions?

Call the service number on your ID card (TTY: 711) for more information.

Nondiscrimination Notice and Language Access Services

This plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en su tarjeta de identificación (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电您ID卡上的电话号码。

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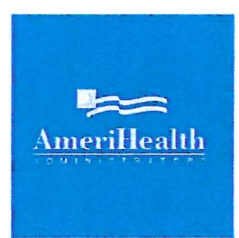


DocFind Instructions – Initial Enrollment

Step 1: Visit Aetna's website at www.aetna.com

Step 2: At the top of the webpage, click on "**Find A Doctor**"

Step 3: On right side of page under the section labeled **"Not a member yet"** select **"Plan from an employer"** (*1st choice on the list*)

Step 4: Under Continue as a Guest, enter you zip code, city, state or county

Step 5: You will be asked to **"Select a Plan".** Use the Key below to help you make the correct selection:

If you are enrolling in an...	DocFind Plan selection is...
NJ Educator's Health Plan (Aetna Choice POS II plan)	Category Heading = **Aetna Open Access Plans** Plan Name = Aetna Choice POS II (Open Access)

Step 6: Click **CONTINUE** to search for the type of provider.

No Plan ID Card? No Problem!

You don't need a plan ID card to receive service from your dentist.

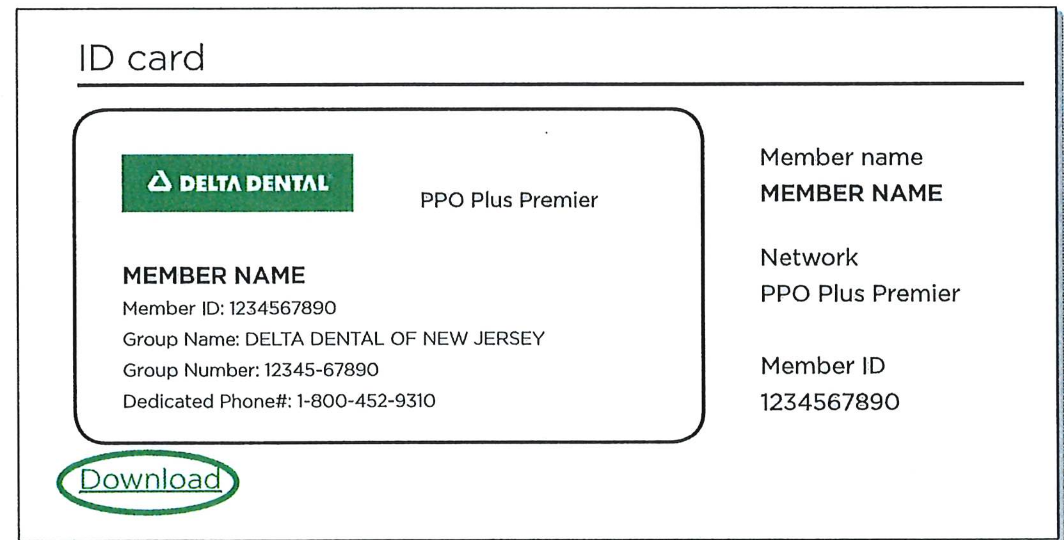
Just tell your dental office that you're covered by Delta Dental and provide your **name**, your **date of birth**, your **enrollee ID number**, and the **name of your employer**.

Do you have dependents on your plan? Tell them to provide your plan details.

Want an ID Card anyway?

Print one from your computer:
- Go to **DeltaDentalNJ.com**
- Log in to MySmile® and download your ID card from your dashboard

Download our app:
- Search 'Delta Dental' in the App Store or Google Play
- Our App is provided by Delta Dental Plans Association



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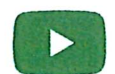
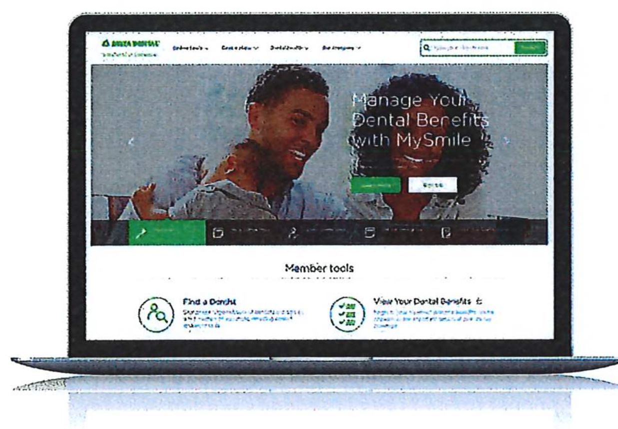


DELTA DENTAL®

Connect with Your Benefits on MySmile®

MySmile offers free, easy-to-use tools that make navigating your Delta Dental benefits a whole lot simpler.



Benefits Information with a Click (or Tap)

Access MySmile from your computer or mobile device to securely:

- View your coverage
- Check your dental claims
- View and print your ID card
- Review your treatment history
- Find a dentist
- Get a cost estimate
- And more

Visit our Website or Download our App

How to Register:

1. Visit DeltaDentalNJ.com; click "Sign In or Register" on the top right corner of the homepage.
2. Click "Register Now" and enter your contact information.
3. Create a username and password when prompted.
4. Read and check the box to "agree to Terms of Use" for our website.
5. Click "Register"; you will be emailed a code within 24 hours to the email address you used when registering.
6. Enter the code when prompted.
7. Once you enter the code, you will be able to access your account using your newly created username and password!

The subscriber and any adult dependents on the plan can create their account with or without an ID number.

(800) 452-9310 www.deltadentalnj.com

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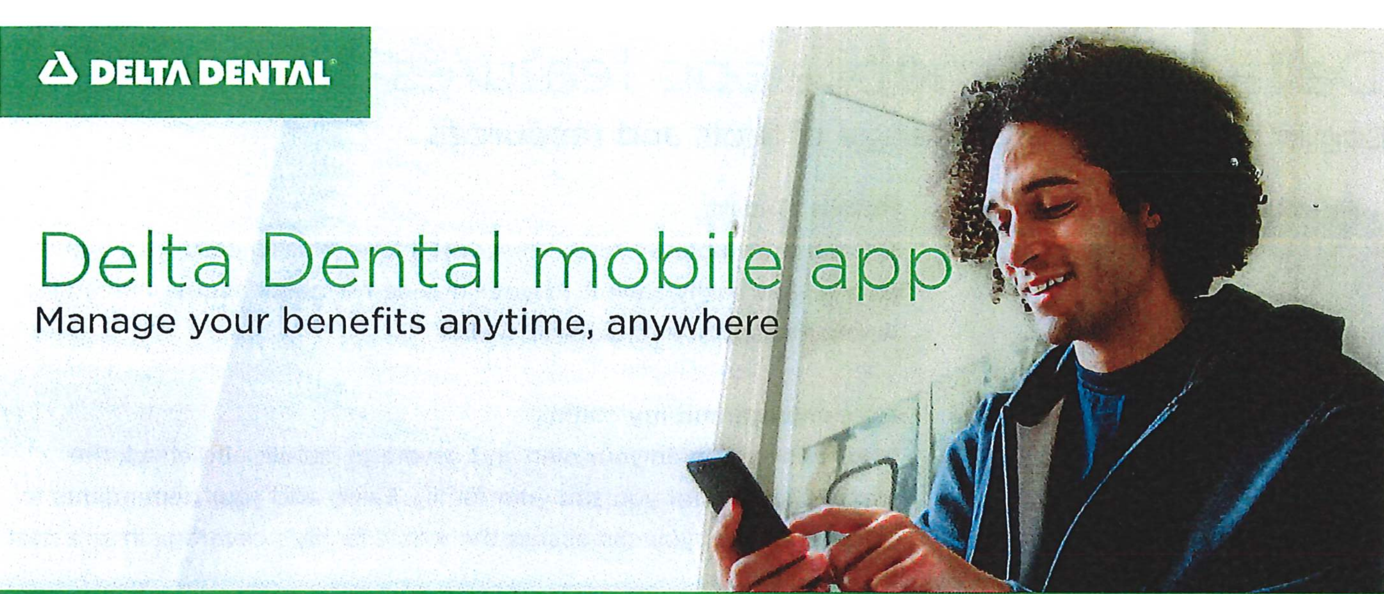
August 2020



Delta Dental mobile app

Manage your benefits anytime, anywhere

Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, check claims and coverage, view ID cards and more, right on your mobile device.

Getting started

Delta Dental's mobile app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, scan the QR code at right. You will need an internet connection in order to download and use most features of our free app.

SCAN TO DOWNLOAD DELTA DENTAL MOBILE

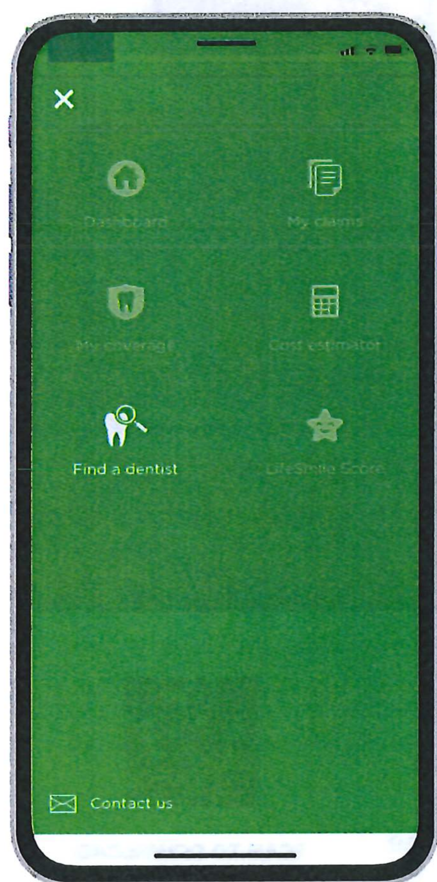
Logging in to view benefits

Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental mobile app.

Please note information displayed may vary based on your particular coverage. For more information on your coverage, contact your Delta Dental company.

Delta Dental mobile app features

Log in to access the full range of tools and resources



Mobile ID card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.

My coverage and my claims

View information on your plan and coverage details, and check the status of claims for you and your family. Easily add your dependents to your account so you can access the whole family's coverage in one spot.

Find a dentist

It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.

Dental Care Cost Estimator*

Find out what to expect with our Dental Care Cost Estimator. Our easy to use tool provides estimated cost ranges on common dental care needs for dentists in your area, now with the option to select your dentist for tailored cost estimates.

LifeSmile™ Score

Do you know how your smile scores? Learn more about your personal oral health risk profile by taking our simple risk assessment survey.

*Feature not available in all geographic areas and is subject to dentist participation.

Secure access to your benefits

You must log in each time you access the secure portion of the mobile app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed by clicking the lock icon on the main menu.

Clayton Public School District
Group #07755
Delta Dental PPO Plus Premier™

	In-Network		Out-of-Network
	If a Delta Dental PPO™ Dentist is Used	If a Delta Dental Premier® is Used	If a Non-Participating Dentist is Used
Preventive & Diagnostic Exams Cleanings Bitewing X-Rays Fluoride Treatments (Frequency limitations apply) Sealants Space Maintainers	100%	100%	100%
Basic Fillings Simple Extractions Root Canals (Endodontics) Periodontics Oral Surgery Repair of Dentures	80%	80%	80%
Major Crowns & Gold Restorations Bridgework Full & Partial Dentures Implant Crowns	50%	50%	50%
Annual Maximum (per person)	$ 1,000	$ 1,000	$ 1,000
Annual Deductible Per Person Family Maximum Waived for	 $40 $120 Preventive & Diagnostic	 $40 $120 Preventive & Diagnostic	 $40 $120 Preventive & Diagnostic
Orthodontics Adult & Child to age 19 Lifetime Maximum	 50% $ 1,000	 50% $ 1,000	 50% $ 1,000

There are not separate calendar year maximums and deductibles for each type of dentist. The calendar year maximums & deductibles cross-accumulate among Delta Dental PPO, Delta Dental Premier and non-participating dentists.

Over 300,000 participating dental offices nationwide participate with the national Delta Dental system, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member. **Maximum benefit may be derived by utilizing the services of a participating dentist.**

Where the eligible patient is treated by a Delta Dental PPO℠ dentist, the fee for the covered service(s) will not exceed the Delta Dental PPO maximum allowable charge(s). Where the eligible patient is treated by a Delta Dental Premier® dentist who does not participate in Delta Dental PPO or by a *Participating Specialist*, the dentist has agreed not to charge eligible patients more than the dentist's filed fee or Delta Dental's established maximum plan allowance, and Delta Dental will pay such dentists based on the least of the actual fee, the filed fee, or Delta Dental's established maximum plan allowance for the procedure(s). Claims for services provided by dentists who are neither Delta Dental Premier, Delta Dental PPO dentists, or *Participating Specialists* are paid based on the lesser of the dentist's actual charge or the prevailing fee. Members utilizing non-participating dentists may be billed for the difference between the dentist's change and Delta Dental's allowable charge.

Visit your own dentist. If you do not have a dentist, visit www.deltadentalnj.com for a directory of participating dentists.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Member ID number.

If you have any questions regarding your benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST, at 1-800-452-9310.

This overview contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of New Jersey, Inc. which governs the benefits and operation of your program. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this overview.

2021