SCHOOLS HEALTH INSURANCE FUND

c/o PERMA, P.O. Box 99106
Camden, NJ 08101

Benefits Enrollment Form

Employer Name:_______________________________

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: _____ Plan Name: _____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

Prescription Coverage

Carrier Name: _____ Plan Name: _____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

Dental Coverage

Carrier Name: _____ Plan Name: _____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/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: _____

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. Prescription Drugs separate out-of-pocket limit is $1,600 Individual/ $3,200 Family	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: 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
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 More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$5 retail; $10 mail	Not covered	Up to 30-day supply at retail; 90-day mail order. Step Therapy with NO Grandfathering applies. For Brand drugs with a Generic Equivalent available, member pays the difference in cost between generic & brand, plus brand copay.
	Preferred brand drugs	$10 retail; $20 mail	Not covered	
	Non-preferred brand drugs	$10 retail; $20 mail	Not covered	
	Specialty drugs	Same as retail	Not covered	Up to 30-day supply – must be filled through Accredo Specialty Pharmacy.
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

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 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.
	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.

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)	
	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.
	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.

Enrollment/ Change Form

DELTA DENTAL®

Delta Dental of New Jersey, Inc
1639 Route 10
Parsippany, NJ 07054
800-624-2633

Please check the applicable box or boxes.

- ☐ New enrollment
- ☐ Change of dependents
- ☐ Termination
- ☐ Decline Coverage
- ☐ Address change
- ☐ Coverage change
- ☐ Name change
- ☐ Continuation of Coverage

Please check the applicable box or boxes.

- Delta Dental PPO℠
- Delta Dental PPO℠ plus Premier
- EHB

Delta Dental of New Jersey, Inc.

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender ☐ Male ☐ Female

Alternate Identification Number (if applicable)	Address (Is this a change of address?) ☐ Yes ☐ No	Street	City	State	Zip Code
		Email Address:			

Group Number	Sublocation	Group Name

Change of Coverage

New Coverage:		Former Coverage:	

Name Change

From:		To:	

Dependent Change Please check one of the boxes:

☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below

Continuation of Coverage

Coverage For ☐ Employee ☐ Dependents

Length of Continuation ☐ 18 Months ☐ 36 Months

Date of Loss of Coverage		Date of Qualifying Event	

Do you or your dependents have other dental coverage? ☐ Yes ☐ No *If yes, please complete the following:*

Carrier Name and Address:	
Group Number:	

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse / Domestic Partner (if coverage applies)			☐ M ☐ F		
Children			☐ M ☐ F		
			☐ M ☐ F		
			☐ M ☐ F		
			☐ M ☐ F		
			☐ M ☐ F		

Date of Hire:	Effective Date:	Primary Enrollee Signature:	Date

Employer Verification - *To Be Completed by Employer* The requested activity is believed eligible and is approved	Employer Signature	Title	Date

RESET

Any person who includes any false or misleading information on an application for dental benefits is subject to criminal and civil penalties.
The dental benefits contract does not include coverage of pediatric dental services that meet requirements of the federal Patient Protection and Affordable Care Act.

DELTA DENTAL

Gloucester City Board of Education
Group #07759
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	100%	100%	100%
Basic Fillings Simple Extractions Root Canals (Endodontics) Periodontics Oral Surgery Space Maintainers Repair of Dentures	70%	70%	70%
Major Crowns & Gold Restorations Bridgework Full & Partial Dentures	50%	50%	50%
Annual Maximum (per person)	$ 2,000	$ 2,000	$ 2,000
Deductible Per Person Family Maximum Waived for	 None None	 None None	 None None
Orthodontics Children Only to age 23 Lifetime Maximum	 50% $ 500	 50% $ 500	 50% $ 500

Carryover Max[SM] from Delta Dental allows you to increase your benefits. This valuable benefit feature allows you to carry over a portion of your unused standard annual maximum benefit limit into the next year, and beyond. You can accumulate part of your unused benefit dollars from a healthy year and use it for services such a bridges, crowns, and root canals.

Carryover Max[SM] is easy and automatic.

- To qualify for Carryover Max[SM], you must receive at least one cleaning or one oral exam during the plan year. If you don't receive a cleaning or exam, you won't be eligible to carry over any of your benefit dollars to the following year. If you fail to do so, any accumulated carryover will be lost.
- A covered person is eligible for the Carryover Max [SM] benefit if less than half of the standard annual maximum is used in the prior benefit year.
- Carryover Max[SM] allows you to carry over up to 25% of the unused portion of your standard annual maximum up to a maximum of $500. For example, if your standard annual maximum is $2,0000, and you use $200, you can carry over $450 ($1800 x 25% = $450)
- The accumulated amount can never exceed your standard annual maximum.
- Standard annual maximum dollars are used first. Carryover Max[SM] dollars are used after the standard annual maximum is met.

Delta Dental's *Oral Health Enhancement Option* enables you to receive up to four dental cleanings and/or periodontal maintenance procedures in any combination per benef period if you have been treated for periodontal (gum) disease in the past. For the additional dental cleaning and/or periodontal maintenance procedures to be covered, you mu have had periodontal surgery or periodontal scaling and planing in the past. Details on how to qualify can be found in your benefit booklet.

In addition, members with defined medical conditions such as Diabetes, Cardiovascular Disease, Pregnancy or are undergoing certain Cancer treatments may qualify for up tc two additional cleanings when certified by a physician or dentist

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 Denta 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[SM] 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 charge 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

DELTA DENTAL

Carryover Max℠
A Delta Dental benefit feature that lets members carry over part of their unused standard annual maximum in one year to increase benefits for the following year and beyond.

Qualifying for Carryover Max Benefits
Members must meet the following criteria to qualify for Carryover Max benefits:

- Enroll on or before the effective date of the Carryover Max benefit year. The benefit year to accumulate Carryover Max benefits are the same as the group's standard annual maximum (calendar year or contract year). Members enrolling after the effective date of the Carryover Max benefit period are not eligible to accrue carryover benefits until the start of the next benefit year.
- Use no more than 50% of the standard annual maximum during the benefit year.
- See a dentist during the benefit year for an exam or cleaning and submit a claim for these services. If a claim for an exam or cleaning is not received, any accumulated Carryover Max benefit will be lost.

Members meeting these criteria can accumulate 25% of the unused standard annual maximum. Members continuing to accumulate benefits can eventually have twice the standard annual maximum available. The accumulated amount can never exceed the standard annual maximum amount. Claims will always use the plan's annual maximum first. The accumulated benefit is applied when the standard annual maximum is exhausted.

An Example of Carryover Max Benefits

Benefit Year	Standard Annual Maximum	Usage Limit: 50% of Standard Annual Maximum	Accumulation Limit: 25% of the Standard Annual Maximum	Maximum That Can Be Carried Over
Calendar Year Beginning 1/1/20XX	$2,000	$1,000	$500	$500

Year 1:
The member is eligible on 1/1/20XX. During the year, the member has a dental cleaning for $80 and no other dental services. At the end of the year, the member has $1,920 of the standard annual maximum remaining and used less than the $2,000 usage limit. This qualifies the member to accumulate a Carryover Max benefit for the following year. In this case, the member can accumulate 25% of the remaining maximum, or $480 since $480 does not exceed the carryover limit of $500.

Year 2:
The available annual maximum is now $2,480 ($2,000 standard annual maximum plus $480 accumulated Carryover Max benefit). This year, the member has a dental cleaning for $80 plus $300 in other dental services, totaling $380. At the end of the year, the member has $1,620 of the maximum remaining. The member used less than the usage limit of $1,000 and had a dental cleaning and qualifies for a Carryover Max benefit again. In this case, the member can accumulate 25% of the remaining maximum, or $405 since it does not exceed the carry over limit of $500.

Year 3:
The available annual maximum is now $2,885. Accumulations will continue in a similar manner unless:

- The member does not receive an exam or cleaning during the benefit period, in which case the entire accumulated benefit is lost.
- The accumulated benefit equals the standard annual maximum ($2,000 in this example), in which case the member will have a $4,000 annual maximum available.
- The member is no longer eligible with Delta Dental of New Jersey. Benefits are not transferable.

Questions? Please contact our Customer Service Agents at 1-800-452-9310.