



2025

EMPLOYEE BENEFITS GUIDE

FOR THE COVERAGE PERIOD ENDING ON
DECEMBER 31, 2025

Delran Township offers you and your eligible family members a comprehensive and valuable benefits program. This guide has been developed to assist you in learning about your benefit options and how to enroll.

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.



WELCOME TO DELRAN TOWNSHIP!



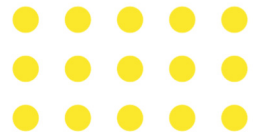
Questions?

If you have questions about your benefits, please contact the Conner Strong & Buckelew Benefits Member Advocacy Center at [800.563.9929](tel:800.563.9929) (Monday through Friday, 8:30 am to 5 pm ET) or go to www.connerstrong.com/memberadvocacy and complete the fields.

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WELCOME!



At Delran Township we are committed to providing our employees with a comprehensive, valuable benefits package and the resources you need to understand all the options available to you.

As an employer, we recognize that our team members are our most valuable asset. The health and well-being of our team members and that of your families is important to us as is the overall health and well-being of the organization. This is why we are committed to sustaining the high value benefit plans we make available.

We encourage you to carefully review this guide to familiarize yourself with our 2025 benefit offerings and ensure that you are making the best benefits decisions for you and your eligible family members.

Who is Eligible to Elect Benefits?

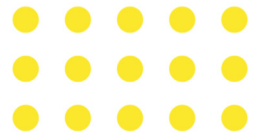
Full-time employees who work 35 or more hours per week.

General Enrollment

- An eligible individual and any eligible dependents (child(ren)/spouse) may enroll regardless of health status, age, or requirements for health services within 60 days of the eligibility date (birth/marriage/adoption, etc.)
- Newly eligible individuals and eligible dependents may enroll within 60 days of the eligibility date (birth/marriage/adoption, etc.)
- Eligible individuals or dependents who are eligible for enrollment but do not enroll within the first 60 days following eligibility, may be enrolled during any subsequent Open Enrollment period.



DEPENDENTS & MAKING PLAN CHANGES



Who is a Dependent?

- Spouse or Civil Union Partner
- A newborn child is covered for 60 days from the date of birth. To continue coverage beyond this initial period, the newborn child must be enrolled within the initial 60 day period.
- To continue coverage for a handicapped child evidence of the child's incapacity and dependency must be provided to the carrier at least 31 days prior to the termination of coverage.
- Under the Patient Protection and Affordable Care Act: A child is defined as an enrollee's child until age 26, regardless of the child's marital, student, or financial dependency status even if the young adult no longer lives with his or her parents (for medical and prescription coverage).

Child Dependent Coverage Timeframes

- **Medical Coverage:** Young adults will be covered through the end of the year in which they turn age 26.
- **Prescription Coverage:** Young adults will be covered through the end of the year in which they turn 26.
- **Dental Coverage:** Dependent children are covered until the end of the year that they turn 26.

Dependents Coverage to Age 31

Your dependent(s) under 31 can be covered by electing to continue coverage for young adults after age 26. DU31 is a New Jersey law that allows children older than the child-dependent age in a parents' coverage to elect to remain covered until age 31, if certain other eligibility standards are met.

For more information regarding dependent coverage to age 31 visit:

www.state.nj.us/dobi/division_consumers/du31.html

Family Status Change

A family status change is a personal event that can have an impact on many aspects of your employee benefits (pension, life insurance, health insurance, etc.). Use this as a guide to updating information pertaining to your pension and benefits for the following family status changes:

- Marriage, civil union, or domestic partnership;
- Addition of a newborn child, adopted child, stepchild, foster child, or legal ward to your family;
- Divorce or dissolution of a civil union or domestic partnership; or
- Death of a family member

In the event of a family status change, you should immediately update your personnel records with your Human Resources representative or Benefits Administrator.



MEDICAL PLAN OPTIONS

AETNA & AMERIHEALTH ADMINISTRATORS



Delran Township offers the following medical plan options to their staff, administered by Aetna or AmeriHealth Administrators.

NOTE: Dependents are eligible for benefits until the end of the year he/she turns age 26.

	AETNA CHOICE POS II (OPEN ACCESS) \$10 COPAY OR AMERIHEALTH ADMINISTRATORS PPO \$10 COPAY	AETNA CHOICE POS II (OPEN ACCESS) \$15 COPAY OR AMERIHEALTH ADMINISTRATORS PPO \$15 COPAY	AETNA HMO OR AMERIHEALTH ADMINISTRATORS EPO \$10 COPAY
IN-NETWORK BENEFITS			
Deductible Individual / Family	None	None	\$100 for DME Only
Out-of-Pocket Maximum Individual / Family	\$400/\$1,000	\$400/\$1,000	\$7,280/\$14,560
Preventive Care Services	No Charge	No Charge	No Charge
PCP Office Visits	\$10 copay	\$15 copay	\$10 copay
Specialist Office Visit	\$10 copay	\$15 copay	\$10 copay
Diagnostic Laboratory	No Charge	No Charge	No Charge
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	No Charge	No Charge	No Charge
Emergency Room	\$25 copay	\$50 copay	\$35 copay
Urgent Care Center	\$10 copay	\$15 copay	\$10 copay
Inpatient Hospital	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	No Charge
OUT-OF-NETWORK BENEFITS			
Deductible Individual / Family	\$100/\$250	\$100/\$250	N/A
Out-of-Pocket Maximum Individual / Family	\$2,000/\$5,000	\$2,000/\$5,000	N/A
Coinsurance	20%	30%	N/A

* The above overview is being provided as a reference and does not contain all the benefits or limitations of the plan. Please refer to the carrier plan documents for further details.



CVS MINUTE CLINICS AND HEALTH HUBS*



CVS Minute Clinics offer a broad range of services to keep you and your family healthy. In addition to diagnosing and treating illnesses, injuries and skin conditions, they provide wellness services including vaccinations, physicals, screenings and monitoring for chronic conditions.

- Located in select CVS pharmacies and Target stores nationwide
- No appointments necessary
- Visits usually last less than 30 minutes
- A record of your visit can be sent to your family doctor
- Open seven days a week with convenient evening hours

CVS Minute Clinic Practitioners Can:

- Treat common illnesses, like strep throat, ear ache, pink eye, and sinus infection
- Treat minor injuries and skin conditions
- Provide vaccinations such as flu, pneumonia, and hepatitis A/B
- Write prescriptions when appropriate
- Treat patients 18 months and older



CVS HealthHUB offers an expanded range of health services and wellness products for everyday care and chronic conditions. To learn more or to find a HealthHUB location, visit www.CVS.com/HealthHub.

Health Hubs Offer the Following Services:

- Nutritional Counseling
- Durable Medical Equipment
- A Health Concierge
- Enhanced Minute Clinic service offerings
- Enhanced Pharmacist counseling services
- Community programs and meeting spaces

** Prior to visiting a Minute Clinic or Health Hub, please check with your medical insurer to find out which facilities in your area may be participating with your plan.*

MAXIMIZE YOUR BENEFITS



Always Consider Your In-Network Options First

You will typically pay less for covered services when providers are in-network with your medical plan. In-network providers agree to discounted fees. You are responsible only for any copay or deductible that is included in your plan design. To verify that your providers are in-network, call the number on the back of your ID cards.

Limit Your Use of Out-of-Pocket Providers

The percentage of costs covered for out-of-pocket network care is based on the plan allowance. If the plan allowance is less than the provider's actual charge, the provider may bill you for the difference between these two amounts. **The amount you are required to pay out-of-pocket may be significant.**

Make Sure You are Using In-Network Labs

- **Aetna Participants** may use either **Quest Diagnostics** or **LabCorp** for lab work.
- **AmeriHealth Administrators Participants** must be sure that their providers send all blood work to a **LabCorp** location or other free standing lab. **Quest Diagnostics is not participating in the AmeriHealth Administrators network.**

In-Patient or Observation:

The difference between *inpatient* and *observation* status is important because benefits and provider payments are based on the status. Patients admitted under observation status are considered outpatients, even though they may stay in the hospital and receive treatment in a hospital bed.

Hospital admission status may affect coverage for services such as skilled nursing. Some health plans, including Medicare, require a three-day hospital inpatient stay minimum before covering the cost of rehabilitative care in a skilled nursing care center. However, observation stays regardless of length, do not count towards the requirement.

A new law requires hospitals to give Medicare patients notice of an observation status within 36 hours. This status determines how the hospital bills your health plan. Even if you are NOT under Medicare, when you or your family member arrives at the hospital, you can ask questions like:

- Is the patient's status *inpatient* or *observation*?
- How long will the hospital stay be?
- Will there be a need for specialized skilled or rehab care after discharged?

Asking these questions throughout the hospital stay is important because hospitals can change the status from one day to the next. You can ask to have the status changed, but it is important to do so while still in the hospital. If necessary, you can request the hospital's patient advocate for assistance.



HOW TO FIND IN-NETWORK PROVIDERS



To Find Participating Aetna Providers

- STEP 1:** Visit Aetna’s website at www.aetna.com
- STEP 2:** At the middle of the webpage on the right, click on **“Find a Doctor”**
- STEP 3:** On the right side of the page under Guest, select **“Plan from an employer”** (1st choice on the list)
- STEP 4:** Under Continue as a Guest, enter your 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’RE ENROLLING IN...	DOCFIND PLAN SELECTION IS...
Aetna Choice POS II Plan	Category Heading: Aetna Open Access Plans Plan Name: Aetna Choice POS II (Open Access)
Aetna HMO	Category Heading: Aetna Standard Plan Plan Name: HMO

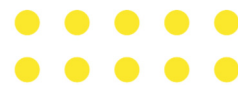
How to Find Participating AmeriHealth Administrators Providers

- STEP 1:** Visit the AHA website at www.myahabenefits.com
- STEP 2:** At the bottom of the webpage on the right, click on **“Find a Doctor”**
- STEP 3:** Search providers by category, specialty and much more!

Once you search for a list of doctors, you can click on the providers name and then view information such as:

- Credentials
- Hospital affiliations
- Review from other members
- Office hours
- Gender
- Specialty
- Language Spoken
- National Provider Number (NPI)

Easily compare up to five doctors and hospitals at once. You can compare specialties, education, board certifications, quality reviews, and more.



TELEMEDICINE

CVS VIRTUAL CARE (AETNA) & TELADOC (AMERIHEALTH ADMINISTRATORS)

ACCESS TO HIGH QUALITY CARE AT A LOWER COST - WITH A **\$0 COPAY!**

Telemedicine offers physician-based care around-the-clock at lower costs compared to visiting an urgent care center or emergency room. Plan members can use readily available technology and tools - toll-free number, secure website, or mobile app - to consult with a U.S. board certified physician.

With access to doctors 24 hours a day, 365 days a year, Teladoc and CVS Virtual Care provides low cost telemedicine that can help improve outcomes, speed recovery and eliminate wait time.

Plan members can consult with a licensed physician by: calling the toll-free number, logging into the secure website, or using the mobile app. Physicians can also prescribe medications, if needed.

When to Use Telamedicine

Teladoc and CVS Virtual Care doctors can treat a wide range of non-emergency conditions, including:

- Acne
- Allergies
- Cold and flu
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever
- Headache
- Insect bites
- Nausea
- Pink eye
- Rash
- Respiratory problems
- Sore throat
- Urinary tract infections
- Vaginitis
- Vomiting

Mental Healthcare Services

Telemedicine services include mental healthcare. This allows employees to have 24/7 video access to licensed psychiatrists, therapists, and psychologists to help treat a broad range of issues. Common conditions members may utilize the service for are:

- Anxiety/Stress
- Depression
- Work Pressures
- ADHD

The services are confidential and secure, and are also available at a \$0 copay* to all employees currently enrolled in benefits with the Township.

Get Started With TelamedicineToday

Aetna Members (CVS Virtual Care)

To take advantage of this great benefit, Aetna members can contact CVS Virtual Care in any of the following ways:

- **Via the web:** [CVS.com/virtual-care](https://www.cvs.com/virtual-care)



AmeriHealth Members (Teladoc)

To take advantage of this great benefit, AmeriHealth members can contact Teladoc in any of the following ways:

- **Via phone:** [855.835.2362](tel:855.835.2362)
- **Via the web:** www.teladoc.com/ahatpa
- **Via mobile app:** Go to www.Teladoc.com/Mobile to learn more or download the mobile app from the App Store or Google Play

GET QUALITY CARE FROM ANYWHERE



Save Time and Money!

Avoid long waits at the Emergency Room and reduce your out-of-pocket costs by utilizing Telemedicine and Urgent Care Centers for ailments that are not life-threatening. Both of these options provide fast, effective care - when you need care fast.

Know Where to Get Care

Visits to the ER can be very costly, so before you go to the ER, consider whether your condition is truly an emergency or if you can receive care from Telemedicine or at an Urgent Care Center instead.

Telemedicine	Urgent Care Center	Emergency Room
• Cold/Flu • Allergies • Animal/insect bite • Bronchitis • Skin problems • Respiratory infection • Sinus problems • Strep throat • Pink eye/ Eye irritation • Urinary issues	• Allergic reactions • Bone x-rays, sprains or strains • Nausea, vomiting, diarrhea • Fractures • Whiplash • Sports injuries • Cuts and minor lacerations • Infections • Tetanus vaccinations • Minor burns and rashes	• Heart attack • Stroke symptoms • Chest pain, numbness in limbs or face, difficulty speaking, shortness of breath • Coughing up blood • High fever with stiff neck, confusion or difficulty breathing • Sudden loss of consciousness • Excessive blood loss

How to Access Telemedicine 24/7

\$0 Cost Telemedicine VS. Virtual Office Visits

Please note that Telemedicine services are different from virtual/telephonic office visits with your participating provider. Most Health Plans have a \$0 copay for the Telemedicine services (Teladoc and CVS Virtual Care).

Virtual/Telephonic Office Visits with your participating provider may require a copay or coinsurance in accordance with your specific health plan. For more information on your cost-share for virtual office visits, please consult your insurance carrier at the customer service number on the back of your ID card.



PRESCRIPTION DRUG PLAN

EXPRESS SCRIPTS



Delran Township offers the following prescription plan options to their staff, administered by Express Scripts.

NOTE: Dependents are eligible for benefits until the end of the year that he/she turns age 26.

RX \$3/\$10 PLAN

RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)

Generic	\$3 Copay
Brand Without Generic Alternative	\$10 Copay
Brand With Generic Alternative	Member pays the applicable brand copay plus the cost difference between the brand drug & generic drug

MAIL ORDER (UP TO A 90-DAY SUPPLY)

Generic	\$0 Copay
Brand Without Generic Alternative	\$15 Copay
Brand With Generic Alternative	Member pays the applicable brand copay plus the cost difference between the brand drug & generic drug

* The above overview is being provided as a reference and does not contain all the benefits or limitations of the plan. Please refer to the carrier plan documents for further details.

Mandatory Mail Order Program

Employees must use the mail order program through Express Scripts for maintenance medications. Once the initial prescription and two refills are filled at the retail pharmacy, the mail order program is mandatory for coverage of the ongoing prescriptions. This means you are required to transition to mail order or pay the full cost of the medication.

Please Note:

- The prescription drug plan has dispensing limits when you receive your medication from a retail pharmacy. You may receive up to a 30 day supply at a retail pharmacy.
- Prior authorizations, clinical review and step therapy may apply to certain medications. Please refer to the Express Scripts formulary listing for more information or contact Express Scripts directly at **800.462.2006**.

ADDITIONAL PRESCRIPTION PLAN INFORMATION

EXPRESS SCRIPTS

The following additional features will apply to prescription drug coverage:

- **Mandatory Generics:** Pharmacists must dispense the generic equivalent medication when available. If a member fills the brand name drug instead, they will be responsible for the brand drug copay plus the difference in cost between the brand and generic medication.
- **Step Therapy:** Requires a trial with a lower cost medication before the member is given approval for a higher cost medication, when clinically appropriate. If a member purchases the higher cost medication without prior approval, then the medication will not be covered.
- **Formulary List:** A guide for selecting clinically and therapeutically appropriate medications. This list includes a majority of brand and generic medications, and also lists certain medications which will not be covered. The formulary updates throughout the year, and brand name drugs may move to non-formulary status if a generic version becomes available during the year. For the most up to date version, please visit the Express Scripts website using the following link:
www.express-scripts.com.



DENTAL BENEFITS

HORIZON



Below is a summary of the dental plan options available to you and your family, administered by Horizon. For additional information regarding your dental contributions, please contact Human Resources for assistance.

NOTE: Dependent children are eligible for benefits from age 2 until the end of the year in which they turn 26.

BENEFITS	DENTAL OPTION PLAN		HDC PLAN A	TOTAL CARE
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY	IN-NETWORK ONLY
Annual Deductible				
Individual	None	Costs may be higher	None	None
Family				
Calendar Year Maximum (per patient)	\$1,000	Costs may be higher	None	None
Preventive & Diagnostic Services				
Exams, Cleanings, Bitewing X-rays (each twice in a calendar year)	0%	Costs may be higher	0%	0%
Fluoride Treatment (once in a calendar year, children to age 19)				
Basic Services				
Fillings, Extractions			0%	
Endodontics (root canal),	20%	Costs may be higher	50%	0%
Periodontics Oral Surgery			50%	
Sealants			0%	
Major Services				
Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	50%	Costs may be higher	50%	0%

NOTE: This summary is for illustrative purposes only. For complete listing of covered services, plan limitations, deductibles and maximums, please consult your benefit booklet or contact Horizon's service department at 800.355.2583. Over 300,000 participating dental offices nationwide participate with the national Horizon system, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Horizon to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Horizon will make payment directly to the member. Maximum benefit may be derived by utilizing the services of a participating dentist.

An Out-of-Network Provider is any licensed Provider who does not have an agreement with Horizon. A Covered Person has the freedom to choose an Out-of-Network Provider, but since they have not agreed to any discount from their normal charges, the out-of-pocket costs may be higher.

* The above overview is being provided as a reference and does not contain all the benefits or limitations of the plan. Please refer to the carrier plan documents for further details.

Find a Dental Provider

- Visit www.dental.horizonblue.com
- Once there you may sign into your account or continue as a guest.
- Choose **Find a Dentist**
- **Choose your location** and enter your ZIP Code to limit options.



BENEFITS MEMBER ADVOCACY CENTER

CONNER STRONG & BUCKELEW

Don't get lost in a sea of benefits confusion!
With just one call or click, the Benefits MAC
can help guide the way!

The Benefits Member Advocacy Center (Benefits MAC), provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Rescue you from a benefits problem you've been working on
- Discover all that your benefit plans have to offer!

Member Advocates are available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

Contact the Benefits MAC

You may contact the Benefits Member Advocacy Center in any of the following ways:

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Via the web:
www.connerstrong.com/memberadvocacy
- Via email: **cssteam@connerstrong.com**



BENEPORTAL

ONLINE BENEFITS RESOURCE

At Delran Township , you have access to a full-range of valuable employee benefit programs. With BenePortal, you and your dependents can review your current employee benefit plan options online, 24 hours a day, 7 days a week!

Use BenePortal to access benefit plan documents, insurance carrier contacts, forms, guides, links and other applicable benefit materials.

Secure Online Access

Simply go to www.delrantownshipbenefits.com to access your benefits information today!

Mobile-Friendly Site

BenePortal is mobile-optimized, making it easy to view your benefits on-the-go. Simply bookmark the site in your phone's browser or save it to your home screen for quick access.

Other Features Include:

- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!



VALUE-ADDED SERVICES

CONNER STRONG & BUCKELEW

Benefit Perks

This feature provides a broad array of services, discounts and special deals on consumer services, travel services, recreational services and much more. Simply access the site and register and you can begin using it now.

Learn more at: <https://connerstrong.corestream.com>

HUSK Wellness

HUSK offers discounts at more than 10,000 gyms nationwide. Members also get exclusive savings on home health and fitness products from top brands nationwide!

Learn more about HUSK by visiting
www.huskwellness.com/connerstrong

GoodRX

Compare drug prices at local and mail-order pharmacies and discover free coupons and savings tips.

Learn more at: <https://connerstrong.goodrx.com>

HealthyLearn

This resource covers over a thousand health and wellness topics in a simple, straight-forward manner. The HealthyLearn On-Demand Library features all the health information you need to be well and stay well.

Learn more at: <https://healthylearn.com/connerstrong>



QUESTIONS? WHO TO CALL...

The resources identified below are available to assist you with any questions that you may have about your benefits.

QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE/EMAIL
Plan Options, Benefit Questions, and Claims Issues	Member Advocacy	800-563-9929	www.connerstrong.com/memberadvocacy
Medical Benefits Benefit questions, claims, locating a provider, printing new ID cards	Aetna AmeriHealth Administrators	800-370-4526 800-480-5031	www.aetna.com www.myahabenefits.com
Prescription Benefits	Express Scripts	800-467-2006	www.express-scripts.com
Dental Benefits	Horizon	Please see reverse side of your ID card	Please see reverse side of your ID card
Telemedicine	CVS Virtual Care (Aetna) Teladoc (AmeriHealth)	888-607-4287 855-835-2362	www.cvs.com/virtual-care (Aetna) www.teladoc.com/ahatpa (AmeriHealth)



LEGAL NOTICES

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

A Summary of Benefits and Coverage (SBC) will be available for your review at the Open Enrollment meetings or by request to Human Resources. These documents will summarize important information about health coverage in a standard format. If you would like a hard copy of the SBC, you may obtain one from Human Resources.

Patient Protection and Affordable Care Act

Please note: Delran Township's medical plans are considered compliant with the Patient Protection and Affordable Care Act. There are no annual limits, dependent children can be covered to age 26 and preventive care is covered at 100% with no member cost-sharing and the pre-existing exclusion limitations have been removed.

As new Health Care Reform requirements become effective, the Delran Township plans will be modified. We are fully committed to complying with all regulations and intend to notify you as soon as possible of any change(s).

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MYARHIPP (855-692-7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid Website: <https://www.in.gov/medicaid/>
<http://www.in.gov/fss/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

LEGAL NOTICES

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kynect.ky.gov>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 1-573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HHSHIPPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-495-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
Phone: 1-800-692-7462
CHIP Website: <https://www.pa.gov/en/agencies/dhs/resources/chip.html>
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
Website: <https://medicaid.utah.gov/upp/>
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: <https://medicaid.utah.gov/expansion/>
Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>
CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 1-800-562-3022

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <http://mywvhipp.com/> and <https://dhhr.wv.gov/bms/>
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

LEGAL NOTICES

Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to <https://www.healthcare.gov/marketplace/individual/>.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Delran Township		4. Employer Identification Number (EIN) 216000525	
5. Employer Address 900 Chester Avenue		6. Employer phone number (856)461-7734	
7. City Delran	8. State NJ	9. Zip Code 08075	
10. Who can we contact about employee health coverage at this job? Rachel Speer, Payroll Clerk			
11. Phone number (if different from above) (856)461-7734, ext. 126		12. Email address rspeer@delrantownship.org	

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.



ABOUT THIS BENEFITS SUMMARY

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. If you have any questions about your Guide, contact Human Resources.