



2026-2027

EMPLOYEE BENEFITS GUIDE

FOR BENEFITS EFFECTIVE:
JULY 1, 2026 THROUGH JUNE 30, 2027

Deptford Township Board of Education 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.



INSIDE THIS GUIDE

Eligibility & Making Plan Changes	3
Medical Plan Options	4
Find an Amerihealth Administratos Provider	5
Prescription Drug Plan	6
Express scripts Digital ID Card	7
Understanding Your Prescription Drug Program	8
Save Money Using Mail Order	9
Dental Plan Options	10
Telemedicine	11
CVS Minute Clinics and Health Hubs*	12
Get to Know Guardian Nurses	13
Get to Know Guardian Nurses	13
Maximize Your Benefits	14
National Network Access	15
Benefits Member Advocacy Center	16
Value-Added Services	17
Benefits Contacts & Resources	18
Legal Notices	19

DON'T FORGET!

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status.



ELIGIBILITY & MAKING PLAN CHANGES

WHEN CAN I ENROLL?

New hires are eligible to enroll the first of the month following the date of hire. If the date of hire is the first of the month, then coverage begins on the first.

MAKING PLAN CHANGES

You cannot make changes to your elections or covered dependents during the plan year unless you experience a qualified life event. To make a change, you must contact your personnel department **within 60 days of the event**.

Qualified life events include:

- Marriage
- Loss or reduction of coverage for you or your spouse
- Birth or adoption of a child (must be reported **within 60 days of the event**)
- Death of a covered dependent
- Divorce

WHO IS ELIGIBLE?

Full-time employees who work a regular schedule of 30 hours or more per week are eligible to enroll in the benefits described in this Guide.

Please remember that only eligible dependents can be enrolled. Eligible dependents include:

- An employee's spouse (to whom you are legally married)
- Person of the same sex with whom you have entered into a Civil Union, requires documentation.
- Employee's child(ren) term the end of the year of their 26th birthday for medical and prescription. For dental coverage, dependents term at the end of the month in which they attain age 19 if not a full-time student. If a full-time student, then the end of the month in which they attain age 23. Proof of student status must be provided to the business office every semester.
- Legally adopted or any child in a guardianship relationship
- A covered child who is not capable of self support when he or she reaches the end of the year they turn age 26 due to a mental illness or incapacity or a physical disability. To continue coverage for a handicapped child evidence of the child's incapacity and dependency must be provided to the Business Office at least 31 days prior to the termination of coverage

For additional details on what constitutes an eligible dependent, please refer to the plan documents.

If you are enrolling a dependent(s) for the first time, you will need to provide proof of your dependent's eligibility (e.g. birth certificate, marriage certificate etc.).



MEDICAL PLAN OPTIONS

AMERIHEALTH ADMINISTRATORS

Through the SHIF, Deptford Board of Education offers the following medical plan options to their staff, administered by AmeriHealth Administrators. Please note, when you enroll in the medical plan you will automatically be enrolled in the corresponding prescription plan.

- **Employees hired on/after 7/1/2020 may only elect either the NJEHP or GSP for medical coverage and must be enrolled in the corresponding NJEHP or GSP prescription plan, administered by Express Scripts.**
- All other employees may elect any district offered plan design.

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

	AMERIHEALTH PPO \$10	AMERIHEALTH PPO \$20/\$40	NJ EDUCATORS PLANS (NJEHP)	GARDEN STATE PLAN (GSP)
IN-NETWORK BENEFITS				
Calendar Year Deductible				
Individual	\$0	\$0	\$0	\$0
Family	\$0	\$0	\$0	\$0
Calendar Year Out-of-Pocket Maximum				
Individual	\$1,000	\$2,000	\$500	\$500
Family	\$2,000	\$4,000	\$1,000	\$1,000
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Physician Visit	\$10 copay	\$20 copay	\$10 copay	\$10 copay
Specialist Office Visit	\$10 copay	\$40 copay	\$15 copay	\$15 copay
Diagnostic Laboratory (Bloodwork/X-rays)	100%	Bloodwork: 100% X-rays: \$40 copay	100%	100%
Diagnostic Imaging (MRI, CT-Scan)	100%	\$80 copay	100%	100%
Emergency Room	\$35 copay	\$100 copay	\$125 copay	\$125 copay
Urgent Care Center	\$10 copay	\$40 copay	\$15 copay	\$15 copay
Inpatient Hospital	100%	Facility Fee: \$200 copay (max 5 copays per stay)	100%	100%
Durable Medical Equipment	No Charge	Member pays 50% coinsurance	Member pays 10% coinsurance	Member pays 10% coinsurance
Eye Exam	\$10 copay Limited to Once/Plan year	\$20 copay Limited to Once/Plan year	\$15 copay Limited to Once/Calendar year	\$15 copay Limited to Once/Calendar year
Vision Hardware	\$50 Reimbursement Two Plan Years Combined In/Out-of-Network	\$50 Reimbursement Two Plan Years Combined In/Out-of-Network	Not Applicable	Not Applicable
OUT-OF-NETWORK BENEFITS				
Calendar Year Deductible				
Individual	\$250	\$1,000	\$350	\$350
Family	\$500	\$3,000	\$700	\$700
Calendar Year Out-of-Pocket Maximum				
Individual	\$1,000	\$6,000	\$2,000	\$2,000
Family	\$2,000	\$12,000	\$5,000	\$5,000
Coinsurance (% Plan Pays)	80%	70%	70%	70%

GSP is made up of a network of NJ Providers only. Only true medical emergencies will be covered outside of NJ.

For the **NJ Educators Health Plan and Garden State Plan**, an employee's contribution is based on the new salary-based contribution schedule under Chapter 44. All other medical plans follow the Chapter 78 contribution schedule.

Certain services may require prior authorization. Please refer to the carrier plan documents for full details.

FIND AN AMERIHEALTH ADMINISTRATORS PROVIDER

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 provider's name and then view information such as:

- Credentials
- Gender
- Hospital affiliations
- Specialty
- Reviews from other members
- Language spoken
- Office hours
- 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.

Please note: If searching for a Garden State Plan Provider, for accurate results, fill in your location and search for the Local Value Network at the top of the page.



PRESCRIPTION DRUG PLAN

EXPRESS SCRIPTS

Members can realize the greatest savings by using generic medications and filling their maintenance medications through the Express Scripts Mail Order Program. Members can receive a 90-day supply for one (1) copay through mail order.

RX \$10/\$20/\$30

NJEHP/GSP

RETAIL PHARMACY (30-DAY SUPPLY)		
Generic	\$10 copay	\$5 copay
Brand Without a Generic Alternative	\$20 copay	\$10 copay
Brand With a Generic Alternative	\$30 copay (non-preferred brand)	Member pays Brand copay plus difference in cost between Generic & Brand Drug*
MAIL ORDER (90-DAY SUPPLY)		
Generic	\$10 copay	\$10 copay
Brand Without a Generic Alternative	\$20 copay	\$20 copay
Brand With a Generic Alternative	\$30 copay (non-preferred brand)	Member pays Brand copay plus difference in cost between Generic & Brand Drug*

MANDATORY GENERICS PROGRAM*

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

STEP THERAPY PROGRAM

(NJEHP & GSP PLANS)

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

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 and generic drugs may move to non-formulary status if a generic version becomes available.

For the most up to date version of the formulary, please visit the Express Scripts website at:

www.express-scripts.com.



EXPRESS SCRIPTS DIGITAL ID CARD

YOUR PRESCRIPTION ID CARD IS NOW DIGITAL.

Connect to your digital prescription ID card. Anytime. Anywhere.

No more digging through cards at the pharmacy counter. Easily create your digital profile at www.express-scripts.com or on the Express Scripts mobile app to gain instance access to your prescription ID card. You can view your card online or even on the app, download it to your digital wallet, or even print a card from the Express Scripts website.

A digital profile also helps you connect to:

- Lower-cost medical options
- Nearby, in-network pharmacies
- More ways to manage your medications

DON'T WAIT UNTIL YOU ARE AT THE PHARMACY. CONNECT TO YOUR ID CARD TODAY.

Visit www.express-scripts.com or download the Express Scripts mobile app to create your profile in a few easy steps. You can also text **JOIN** to **69717** for a link to the Express Scripts registration page.

Scan the QR code to download the mobile app from the App Store or Google Play.



UNDERSTANDING YOUR PRESCRIPTION DRUG PROGRAM

HOW TO GET STARTED WITH EXPRESS SCRIPTS HOME DELIVERY

Contact Express Scripts

- For transfers from a retail pharmacy, sign in at [Express-Scripts.com](https://www.express-scripts.com), or
- Speak with a prescription benefit specialist by calling **800.698.3757** (7:30 a.m. – 5 p.m., Central, Monday–Friday)

DIY—Do It Yourself

- Complete a home delivery order form
- Get a 90-day prescription from your doctor plus refills for up to one year (if applicable)
- Include your home delivery copayment (acceptable forms include credit/debit card, check or money order)
- Mail your form and prescription to Express Scripts at the address on the form. You can also have your doctor ePrescribe or fax your prescription.

Your medication will arrive by mail within 8 days of receipt of your initial prescription.

RECOMMENDED DRUG DOSING

Your Prescription Drug plan includes a program that reviews prescribed drug quantities to ensure your medications are being safely prescribed in accordance with FDA guidelines. The drug quantity review program provides the medications you need for good health, while making sure the dose you are receiving is considered safe. For instance, if FDA guidelines allow one pill/dose per day the program will allow a maximum of 30 pills for a month's supply. This quantity will give you the right amount to take for a daily dose considered safe and effective.



SAVE MONEY USING MAIL ORDER EXPRESS SCRIPTS

HOW MUCH CAN YOU SAVE WHEN USING MAIL ORDER? COMPARE FOR YOURSELF...

NJEHP/GSP		
RETAIL PHARMACY	MAIL ORDER	ANNUAL SAVINGS
Generic Copay \$5	Generic Copay \$10	\$20
Annual Cost (\$5 per month x 12 fills) \$60	Annual Cost (\$10 per order x 4 fills per year) \$40	
Preferred Brand Copay \$10	Preferred Brand Copay \$20	\$40
Annual Cost (\$10 per month x 12 fills) \$120	Annual Cost (\$20 per order x 4 fills per year) \$80	

HOW MUCH CAN YOU SAVE WHEN USING MAIL ORDER? COMPARE FOR YOURSELF...

RX \$3/\$10/\$10		
RETAIL PHARMACY	MAIL ORDER	ANNUAL SAVINGS
Generic Copay \$3	Generic Copay \$5	\$16
Annual Cost (\$3 per month x 12 fills) \$36	Annual Cost (\$5 per order x 4 fills per year) \$20	
Preferred Brand Copay \$10	Preferred Brand Copay \$15	\$60
Annual Cost (\$10 per month x 12 fills) \$120	Annual Cost (\$15 per order x 4 fills per year) \$60	

DENTAL PLAN OPTIONS

DELTA DENTAL

The Board will pay for Single coverage only up to the annual maximum per the collective bargaining agreement. Contributions will be based upon the Chapter 78 percentage. Employees are also responsible for the difference between the Single coverage and the cost to add your dependents. To locate participating dentists, call **800.335.8265** or visit **www.deltadentalnj.com**.



PLEASE NOTE: Members electing the Premier Buy-Up Plan must pay the full cost of the monthly premium.

	PREMIER ADVANTAGE	PREMIER BUY-UP	*DeltaCare USA NJTIA
BENEFITS			
Provider Network	Members may select participating providers or go out-of-network. Members realize the greatest savings by visiting a participating provider.	Members may select participating providers or go out-of-network. Members realize the greatest savings by visiting a participating provider.	Members must visit a Delta Care provider for services. Members may not seek services out-of-network.
Calendar Year Maximum (per patient)	\$1,500	\$2,000	None
Deductible	None	None	None
Preventive & Diagnostic Exams, Cleanings, Bitewing X-rays (each twice in a calendar year) Fluoride Treatment (once in a calendar year, children to age 19)	100%	100%	Copays Vary
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	100%	100%	Copays Vary
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	60%	70% Includes Implants	Copays Vary
Orthodontia Benefits (children age 19 and below)	Not Covered	Not Covered	Adults and children are covered. Various copays apply.

*Various copays apply for services. Members should refer to the Delta Care USA NJTIA benefit summary for further details or contact Delta Care.

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



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 Schools Health Insurance Fund (SHIF) Health Plans have a **\$0 copay for the Telemedicine Services.**

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.

TELADOC

- **Call: 855.835.2362**
- **Visit: www.TeladocHealth.com**
- Go to **www.Teladoc.com/Mobile** to learn more or download the mobile app from the App Store or Google Play



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: <https://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.*

GET TO KNOW GUARDIAN NURSES

STRUGGLING WITH A HEALTHCARE ISSUE?

TAKE ADVANTAGE OF THIS UNION BENEFIT

Our Mobile Care Coordinator RNs, backed by a team of registered nurses, are ready to respond whenever you are struggling with a healthcare issue.



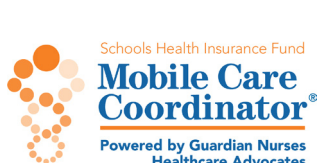
GUARDIAN NURSES CAN:

- **VISIT YOU AT HOME** or in the hospital to assess your care needs.
- **GO WITH YOU** to see doctors, to ask questions and to get answers.
- **BE YOUR GUIDE**, coach and advocate for any healthcare issue.
- **MAKE APPOINTMENTS** so you can be seen as quickly as possible.
- **IDENTIFY PROVIDERS** for all care needs and second opinions.
- **RESOLVE PROBLEMS** with billing, claims and health insurance.
- **GET THINGS YOU NEED** such as healthcare equipment.
- **PROVIDE DECISION SUPPORT** when considering treatments or surgery.
- **EXPLAIN A NEW DIAGNOSIS** to help you make informed decisions.

To request help from our Mobile Care Coordinator or the team at Guardian Nurses, call **609.703.0623** or **609.414.6093**.

WHO IS ELIGIBLE?

The services of our Mobile Care Coordinator Nurses are available to members of the Schools Health Insurance Fund and their covered dependents. All services are offered at no charge to you and are confidential.



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.

The amount you are required to pay out-of-pocket for out-of-network services may be significant.

TO LOCATE PARTICIPATING IN-NETWORK PROVIDERS:

Visit www.myahabenefits.com, select “Members” and then “Find a Doctor.”

MAKE SURE YOU ARE USING IN-NETWORK LABS

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.

NATIONAL NETWORK ACCESS THROUGH CIGNA HEALTHCARE PPO AMERIHEALTH ADMINISTRATORS

PLAN MEMBERS HAVE ACCESS TO QUALITY AND AFFORDABLE HEALTH CARE NATIONWIDE

If you are enrolled in an **AmeriHealth Administrators plan**, you have nationwide access to the Cigna Healthcare Preferred Provider Organization (PPO) Network.

The Cigna Healthcare PPO Network includes more than 1.5 million health care providers and 6,400 hospitals nationwide. AmeriHealth Administrators plan members can easily find providers in their region using the Cigna Healthcare provider search tool.

Look for the logo

You will find the Cigna logo on your AmeriHealth Administrators ID card if you have access to the Cigna Healthcare PPO Network.

Search for a provider

Visit www.myahabenefits.com or scan the QR code to access the provider finder. Select **Find a Doctor**, then the Find a provider button in the **"Through my job"** box.

Scan the QR Code to search for providers



Questions? Call the number on the back of your AmeriHealth Administrators ID card.



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!

HOW TO CONTACT MEMBER ADVOCACY?

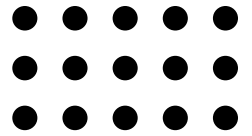
You may contact the Member Advocacy Team in any of the following ways:

- Phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Web: **www.connerstrong.com/memberadvocacy**
- Email: **cssteam@connerstrong.com**



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 Marketplace

Achieving optimal health and wellness doesn't have to be complicated or expensive. Access exclusive best-in-class pricing with some of the biggest brands in fitness, nutrition, and wellness with HUSK Marketplace (formerly GlobalFit).

Learn more at:

<https://marketplace.huskwellness.com/connerstrong>

GoodRX

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

Learn more at: www.goodrx.com

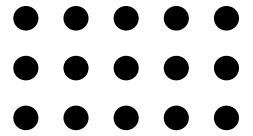
HealthyLearn

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>



BENEFITS CONTACTS & RESOURCES



QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE/EMAIL
Eligibility, enrollment, plan options, contributions, Qualifying Life Events, etc.	Please contact your entity's Human Resources/Benefits Office		
Medical Benefits - AmeriHealth Benefit questions, claims, locating a provider, printing new ID Cards	AmeriHealth Administrators	844.352.1706	www.myahabenefits.com
Prescription Drug Benefits	Express Scripts	800.467.2006	www.express-scripts.com
Dental Benefits	Please see the reverse side of your ID card		
Nurse Advocacy	Guardian Nurses	888.836.0260	www.guardiannurses.com

All plans above may not be offered by your employer. If you are not sure in which plan you are enrolled and/or eligible to elect, please refer to your ID card or contact your employer.



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.

The Fund offers a series of health coverage options. You should receive a Summary of Benefits and Coverage (SBC) during Open Enrollment. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions or did not receive your SBC.

Patient Protection and Affordable Care Act

Please note: the 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 fund 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 January 31, 2026. 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 Website:
<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/fssa/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:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: <https://hhs.iowa.gov/medicaid/plans-programs/hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program>
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

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: KIHIPPROGRAM@ky.gov
KCHIP Website: <https://kynect.ky.gov>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LEGAL NOTICES

LOUISIANA – Medicaid

Louisiana Medicaid Website:
<https://www.ldh.la.gov/healthy-louisiana>
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website:
<https://www.ldh.la.gov/lahipp>
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment Website: https://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: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840
TTY: 711
Email: masspreassistance@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: 573-751-2005

MONTANA – Medicaid

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

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfnv.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: 1-800-356-1561
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: Children's Health Insurance Program (CHIP) (pa.gov)
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: 1-800-250-8427

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>
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

West Virginia – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/http://mywvhipp.com/>
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: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, 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

INSURANCE MARKETPLACE NOTICE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverages Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution –as well as your employee contribution to employment-based coverage– is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2025. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as

March 31, 2023. **The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either– submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2025, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2025, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.** To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan’s summary plan description or contact Stephanie Marich. 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.

INSURANCE MARKETPLACE NOTICE

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. Employee Name Deptford Board of Education	4. Employer Identification Number (EIN) 21-6000342	
5. Employer Address 890 Bankbridge Road., Ste 100	6. Employer phone number 856-232-2700	
7. City Sewell	8. State NJ	9. Zip Code 08080
10. Who can we contact about employee health coverage at this job? Kelly Green	11. Phone number 856-232-2700 x 3004	12. Email address Green.k@deptfordschools.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - Some employees. Eligible employees are:
 - Full Time Staff:** Any employee that works a minimum of 30 hours per week
 - Food Services:** Working less than 30 hours a week and providing certification of no other available coverage are eligible for Single Coverage only after a 90 day waiting period (see CBA for more information)
 - Transportation:** Effective July 1, 2025, Transportation Staff shall be eligible for Single only coverage after 30 days of employment
- With respect to dependents:
 - We do offer coverage.
 - Full Time Staff:** Spouse and children
 - Food Services:** Can elect to cover a spouse/children but will be responsible for 100% difference in premium from Single Coverage.
 - Transportation:** Can elect to cover a spouse/children but will be responsible for 100% difference in premium from Single Coverage.
- This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary week to week (perhaps you are an hourly employee or you work on a commission bases), if you are newly employed mid-year, or if you have other income losses, you may still qualify for the premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.



This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical, prescription, dental, and vision programs. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.