2025-2026

EMPLOYEE BENEFITS GUIDE

FOR BENEFITS EFFECTIVE:
JULY 1, 2025 THROUGH JUNE 30, 2026

Collingswood 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.

WELCOME TO COLLINGSWOOD BOARD OF EDUCATION!

Questions?

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

Inside This Guide

WELCOME!

The Collingswood Board of Education is 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 2025-2026 benefit offerings and ensure that you are making the best benefits decisions for you and your eligible family members.

What Do You Need to Do Now?

In order to enroll in medical, prescription, and/or dental coverage, you must submit an enrollment form to the Business Office.

Please refer to your BenePortal site to obtain a copy of a Board of Education enrollment form.

For questions regarding your monthly employee contributions, please reach out to the Business Office.

ELIGIBILITY INFORMATION

Who is Eligible to Elect Benefits?

Full-time employees.

Who are Eligible Dependents?

- Spouse, Civil Union Partner, and Child(ren).
- A covered child not capable of self support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability. Coverage for children with disabilities may continue only while the child is unmarried or does not enter into a civil union or domestic partnership, and the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.
- 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.
- If you are enrolling a dependent(s) for the first time, you will need to provide proof of your dependent's eligibility (i.e., birth certificate, marriage certificate, proof of full-time status, etc.).

When Does Coverage for Dependent Children End?

- **Medical Coverage:** Young adults will be covered through the end of the calendar year in which they turn age 26.
- **Prescription Coverage:** Young adults will be covered through the end of the calendar year in which they turn age 26.
- **Dental Coverage:** Dependent children will be covered through the end of the calendar year in which they turn age 23.

Benefit Waiting Period

Benefits start the first day the employee starts.

NJ Dependent Under 31 Coverage

Certain young adults over age 26 may be eligible for continued coverage until age 31 under the NJ Dependent Under 31 for medical and prescription benefits only. In order to be eligible for the coverage, the young adult must meet certain criteria such as:

- Under the age of 31
- Had previously maintained creditable coverage from any state
- Unmarried
- Has no children or dependents of their own
- Lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education
- Not eligible for Medicare and is not actually covered under another group or individual health plan

For full eligibility details, please visit **www.state.nj.us/dobi/division_consumers/du31.html** or call the NJ Department's Consumer Protection Services at **609.292.7272**.

Please note, the young adult would be the one billed directly for coverage. Please contact the Business Office for monthly premium rates and enrollment forms.

ENROLLMENT & MAKING PLAN CHANGES

How to Enroll

You must complete an enrollment form if:

- You wish to add/terminate dependents from your medical, prescription drug or dental benefits coverage.
- You are enrolling in benefits for the first time.

Please refer to the Business Office for a copy of the enrollment form. **Completed forms must be returned to the business office.**

How Often Can I Change Plan Elections?

IRS Section 125 prohibits you from changing your enrollment during the plan year. Unless you have a qualified life event, you cannot make changes to the benefits you elect until the next Open Enrollment period.

Qualified life events include: marriage, divorce, death of a spouse, civil union partner or a dependent, birth or adoption of a child, termination or commencement of employment for your spouse/civil union partner, a change in employment status (full-time to part-time or part-time to full-time) for you or your spouse/civil union partner that affects benefits.

If an eligible dependent had other coverage and such coverage is lost, the eligible dependent may be eligible for enrollment during a "special enrollment period," which is usually the 60-day period following the date that other coverage was lost, due to a qualified change in status.

You must notify the business office within 60 days of experiencing a qualified status change. For birth of a child or adoption, please notify the business office within 60 days.

MEDICAL PLAN OPTIONS

AETNA

Through the Schools Health Insurance Fund (SHIF), Collingswood BOE offers the following medical plan options to their staff, administered by Aetna.

- **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 Benecard.**
- All other employees may elect any options offered by the District.

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

	NJEHP	GSP*	HMO $15/$25	HMO $15/$25 (100/200)
IN-NETWORK BENEFITS				
Calendar Year Deductible Individual Family	None	None	None	$100 $200
Calendar Year Out-of-Pocket Maximum Individual Family	$500 $1,000	$500 $1,000	$500 $1,000	$500 $1,000
Preventive Services	100% covered	100% covered	100% Covered	100% Covered
PCP Office Visits	$10 copay	$10 copay	$15 Copay	$15 Copay
Specialist Office Visit	$15 copay	$15 copay	$25 Copay	$25 Copay
Diagnostic Lab & X-Ray	100% covered	100% covered	100% covered	100% covered
Imaging (CT/PET Scans, MRIs)	100% covered	100% covered	100% covered	100% covered
Inpatient Hospital	100% covered	100% covered	$500 copay	$500 copay
Outpatient Surgery	100% covered	100% covered	$250 copay	$250 copay
Ambulance	90% covered	90% covered	100% covered	100% covered
Emergency Room	$125 copay	$125 copay	$50 copay	$50 copay
Urgent Care	$15 copay	$15 copay	$25 copay	$25 copay
Durable Medical Equipment	90% covered	90% covered	100% covered	100% covered
Vision Exam	$15 copay (1 exam/12 months)	$15 copay (1 exam/12 months)	$25 copay	$25 copay
Vision Hardware Reimbursement	N/A	N/A	$100 max/24 months	$100 max/24 months
OUT-OF-NETWORK BENEFITS				
Calendar Year Deductible Individual Family	$350 $700	$350 $700	Coverage for Emergency Services Only	Coverage for Emergency Services Only
Calendar YearOut-of-Pocket Maximum Individual Family	$2,000 $5,000	$2,000 $5,000		
Coinsurance (% Plan Pays)	70% after deductible	70% after deductible		

* GSP is a network of NJ providers only. Out of state services will not be covered unless it is a true medical emergency.

** Preauthorization may be required for certain services.

*** For the NJEHP & CSP, the employee's contribution is based on the new salary based contribution schedule. For all other plans, your employee contribution will remain the same per your collective bargaining agreement.

**** This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical plans. 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.

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	OA $5/$15 (GOLD)	OA $5/$15 (100/200 GOLD)	QPOS PATRIOT V (BLUE)	QPOS PATRIOT V (100/200 BLUE)
IN-NETWORK BENEFITS				
Calendar Year Deductible Individual Family	None	$100 $200	None	$100 $200
Calendar Year Out-of-Pocket Maximum Individual Family	$500 $1,000	$500 $1,000	$500 $1,000	$500 $1,000
Preventive Services	100% covered	100% covered	100% Covered	100% Covered
PCP Office Visits	$5 copay	$5 copay	$5 copay	$5 copay
Specialist Office Visit	$15 copay	$15 copay	$15 copay	$15 copay
Diagnostic Lab & X-Ray	100% covered	100% covered	100% covered	100% covered
Imaging (CT/PET Scans, MRIs)	100% covered	100% covered	100% covered	100% covered
Inpatient Hospital	100% covered	100% covered	100% covered	100% covered
Outpatient Surgery	100% covered	100% covered	100% covered	100% covered
Ambulance	100% covered	100% covered	100% covered	100% covered
Emergency Room	$50 copay	$50 copay	$50 copay	$50 copay
Durable Medical Equipment	100% covered	100% covered	100% covered	100% covered
Urgent Care	$15 copay	$15 copay	$15 copay	$15 copay
Vision Exam	$15 copay (1 exam/12 months)	$15 copay (1 exam/12 months)	$15 copay (1 exam/12 months)	$15 copay (1 exam/12 months)
Vision Hardware Reimbursement	$100 max/24 months	$100 max/24 months	$100 max/24 months	$100 max/24 months
OUT-OF-NETWORK BENEFITS				
Calendar Year Deductible Individual Family	$100 $200	$100 $200	$100 $200	$100 $200
Calendar Year Out-of-Pocket Maximum Individual Family	$2,000 $4,000	$2,000 $4,000	$2,000 $4,000	$2,000 $4,000
Coinsurance (% Plan Pays)	80% after deductible	80% after deductible	70% after deductible	70% after deductible

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	QPOS BUY-UP (BRONZE)	PPO CORE	PPO BUY-UP	PPO MEC
IN-NETWORK BENEFITS				
Calendar Year Deductible Individual Family	 $200 $400	 $1,000 $2,000	 $500 $1,000	 $4,000 $8,000
Calendar Year Out-of-Pocket Maximum Individual Family	 $1,000 $2,000	 $2,000 $4,000	 $1,000 $2,000	 $6,000 $12,000
Preventive Services	100% covered	100% covered	100% Covered	100% Covered
PCP Office Visits	$20 copay	$25 copay	$20 copay	$40 copay
Specialist Office Visit	$30 copay	$40 copay	$30 copay	$80 copay
Diagnostic Lab & X-Ray	$30 copay	$40 copay	$30 copay	$80 copay
Imaging (CT/PET Scans, MRIs)	$30 copay	$40 copay	$30 copay	$80 copay
Inpatient Hospital	$100 copay/day, up to 3 days	$200 copay/day, up to 5 days	$100 copay/day, up to 5 days	$100 copay/day, up to 5 days
Outpatient Surgery	90% covered	80% covered	90% covered	80% covered
Ambulance	90% covered	80% covered	90% covered	80% covered
Emergency Room	$150 copay	20% coinsurance after $100 copay	$100 copay	$150 copay
Urgent Care	$30 copay	$40 copay	$30 copay	$80 copay
Durable Medical Equipment	90% covered	80% covered	90% covered	80% covered
Vision Exam	No charge (1 exam/24 months)	No charge (1 exam/24 months)	No charge (1 exam/24 months)	No charge (1 exam/24 months)
OUT-OF-NETWORK BENEFITS				
Calendar Year Deductible Individual Family	 $1,250 $2,500	 $2,500 $5,000	 $1,250 $2,500	 $8,000 $16,000
Calendar Year Out-of-Pocket Maximum Individual Family	 $2,000 $5,000	 $5,000 $10,000	 $2,500 $5,000	 $10,050 $21,000
Coinsurance (% Plan Pays)	70%	60%	70%	60%

* Preauthorization may be required for certain services.

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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, coinsurance, 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:

Aetna Participants: Visit **www.aetna.com** and select **"Find a Doctor."**

Make Sure You are Using In-Network Labs

Aetna Participants may use either **Quest Diagnostics** or **LabCorp** for lab work.

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 Plans (NJEHP, POS Buy-Up, MEC, POS II, PPO Core)	Category Heading = **Aetna Open Access Plans** Plan Name = Aetna Choice POS II (Open Access)
Aetna Garden State Plan	Category Heading = **Aetna Whole Health Plan** Plan Name = (NJ) Aetna Whole Health New Jersey Choice POS II
HMO $15/$25, HMO $15/$25 (100/200)	Category Heading = **Aetna Standard Plan** Plan Name = HMO
QPOS Pat V Blue, QPOS Pat V Blue (100/200), QPOS Buy-Up (Bronze)	Category Heading = **Aetna Standard Plan** Plan Name = QPOS

TELEMEDICINE

CVS HEALTH VIRTUAL CARE

YOUR CARE. YOUR WAY

Convenient and affordable virtual care wherever you need it.

From your therapy appointments to quick care, CVS Health Virtual Care has got you covered. You can use CVS Health Virtual Care in addition to your traditional network of providers. Access is included as part of your medical plan from Aetna, a CVS Health company because healthier happens together.

- **On-Demand Care:** Access 24/7 quick care for minor illnesses and injuries.
- **Mental Health Services:** Get counseling for things like anxiety and stress, plus psychiatry services for medication management.
- Extend to in-person care when needed at nearby MinuteClinic locations or in-network provider clinics.

Get Started Today With CVS Health Virtual Care

- Activate your virtual care benefit by visiting **www.cvs.com/virtual-care**
- Create an account and confirm your details
- Schedule a mental health appointment, or request on-demand care 24/7/365

Scan the QR Code to activate your virtual care benefit!

KNOW WHERE TO GET 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 • 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 Schools Health Insurance Fund (SHIF) Health Plans have a $0 copay for the Telemedicine Services (CVS Virtual Care) listed below.

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 visits, please consult your insurance carrier at the customer service number on the back of your ID card.

CVS Virtual Care

- **Via phone: 877.933.4321**
- **Via the web: www.cvs.com/virtual-care**

URGENT CARE CENTERS

Urgent Care Centers are on **average 80% less costly than** Emergency Rooms. Plus, the Urgent Care copay matches your Specialist copay!

Urgent care centers are a **convenient, cost-effective** medical care alternative when your primary care physician is unavailable. Typically no appointments are necessary at most urgent care centers, and hours extend beyond regular doctor's office hours making them available earlier and later than your primary care physician. Most are open **7 days a week! To find an In-Network Urgent care center near you visit your medical carrier's website**

Treatment at urgent care centers are useful and appropriate for medical services that are not an emergency and require additional treatment such as:

- Allergies
- Asthma
- Sore Throat
- Stiches
- Ear Infection

Below is the emergency room cost compared against the urgent care cost for certain medical plans offered to employees of Collingswood BOE:

Plans	Emergency Room Copay	Urgent Care Copay	Estimated Savings
NJEHP	$125	$15	$110
GSP*	$125	$15	$110
QPOS Patriot V (Blue)	$50	$15	$35
OA $5/$15 (Gold)	$50	$15	$35

* GSP is a network of NJ providers only. Out of state services will not be covered unless it is a true medical emergency.

If your medical need is more urgent or life-threatening, please go right to the Emergency Room

CVS MINUTE CLINICS AND HEALTH HUBS*

minute clinic®

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

HealthHUB

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.*

PRESCRIPTION DRUG OPTIONS

BENECARD

Collingswood BOE offers the following prescription plan options to their staff, administered by Benecard.

- **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 Benecard.**
- All other employees may elect any options offered by the District.

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

	NJEHP/GSP	RX $15/$25	RX $15/$25/$50
RETAIL PHARMACY			
Generic	$5 Copay	$15 copay	$15 copay
Brand Without Generic Alternative	$10 Copay	$25 copay	$25 copay (Preferred)
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic & Brand Drug	$25 copay	$50 copay (Non-Preferred)
Retail Dispensing Limitation	30 day supply	34 day supply or 100 units	34 day supply or 100 units
MAIL ORDER (UP TO A 90-DAY SUPPLY)			
Generic	$10 Copay	$10 copay	$15 copay
Brand Without Generic Alternative	$20 Copay	$10 copay	$25 copay (Preferred)
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic & Brand Drug	$10 copay	$50 copay (Non-Preferred)
Mail Order Dispensing Limitation	90 day supply	90 day supply	90 day supply
ADDITIONAL FEATURES			
Step Therapy	Applies	Not Applicable	Not Applicable
Mandatory Generic	Applies	Not Applicable	Not Applicable
Mail Order for Specialty Medications	Applies	Applies	Applies
Performance Preferred Medication	Applies	Not Applicable	Applies

Save on Your Prescriptions

Using the mail order program for your maintenance medications will save you money. In addition to the savings, your prescriptions will be delivered right to your home. Refilling your order is easy and can be done over the phone.

For more information or to begin using mail order, simply contact Benecard at 877.723.6005.

ADDITIONAL PRESCRIPTION PLAN INFORMATION

BENECARD

The following additional features will apply to some of the prescription plan offerings. Please refer to the Benecard Member Brochures posted on your BenePortal for further details.

- **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. (Applies to NJEHP & GSP only).
- **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. (Applies to NJEHP & GSP only).
- **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 Benecard website using the following link: **https://benecardpbf.com**

SAVE MONEY USING MAIL ORDER

BENECARD

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 $15/$25		
RETAIL PHARMACY	**MAIL ORDER**	**ANNUAL SAVINGS**
Generic Copay **$15**	Generic Copay **$10**	**$140**
Annual Cost *($15 per month x 12 fills)* **$180**	Annual Cost *($10 per order x 4 fills per year)* **$40**	
Preferred Brand Copay **$25**	Preferred Brand Copay **$10**	**$260**
Annual Cost *($25 per month x 12 fills)* **$300**	Annual Cost *($10 per order x 4 fills per year)* **$40**	

CHAPTER 78 PERCENTAGE OF PREMIUM SCHEDULE

Pursuant to P.L. Chapter 78, all Collingswood Board of Education employees have a contribution arrangement for health benefits that is consistent with NJ State statute. Eligible employees and their eligible dependents share in the cost of healthcare premiums in accordance with the following schedule. The schedule is based upon employees' annual wages and coverage tier (Employee, Employee & Spouse/Child or Family coverage) and represents Year 4 of P.L. Chapter 78 contributions.

Please Note: Employees enrolled in the NJEHP & GSP for medical and prescription benefits will follow a new salary-based contribution schedule. Please refer to the following pages for information regarding these contribution schedules.

SALARY RANGE (ANNUAL)	EMPLOYEE ONLY
<$20,000	4.5%
20,000–24,999.99	5.5%
25,000–29,999.99	7.5%
30,000–34,999.99	10%
35,000–39,999.99	11%
40,000–44,999.99	12%
45,000–49,999.99	14%
50,000–54,999.99	20%
55,000–59,999.99	23%
60,000–64,999.99	27%
65,000–69,999.99	29%
70,000–74,999.99	32%
75,000–79,999.99	33%
80,000–94,999.99	34%
95,000 and over	35%

SALARY RANGE (ANNUAL)	EMPLOYEE & SPOUSE OR EMPLOYEE & CHILD(REN)
<$25,000	3.5%
25,000–29,999.99	4.5%
30,000–34,999.99	6%
35,000–39,999.99	7%
40,000–44,999.99	8%
45,000–49,999.99	10%
50,000–54,999.99	15%
55,000–59,999.99	17%
60,000–64,999.99	21%
65,000–69,999.99	23%
70,000–74,999.99	26%
75,000–79,999.99	27%
80,000–84,999.99	28%
85,000–99,999.99	30%
100,000 and over	35%

SALARY RANGE (ANNUAL)	EMPLOYEE & FAMILY
<$25,000	3%
25,000–29,999.99	4%
30,000–34,999.99	5%
35,000–39,999.99	6%
40,000–44,999.99	7%
45,000–49,999.99	9%
50,000–54,999.99	12%
55,000–59,999.99	14%
60,000–64,999.99	17%
65,000–69,999.99	19%
70,000–74,999.99	22%
75,000–79,999.99	23%
80,000–84,999.99	24%
85,000–89,999.99	26%
90,000–94,999.99	28%
95,000–99,999.99	29%
100,000–109,999.99	32%
110,000 and over	35%

NJ EDUCATOR'S HEALTH PLAN (NJEHP)

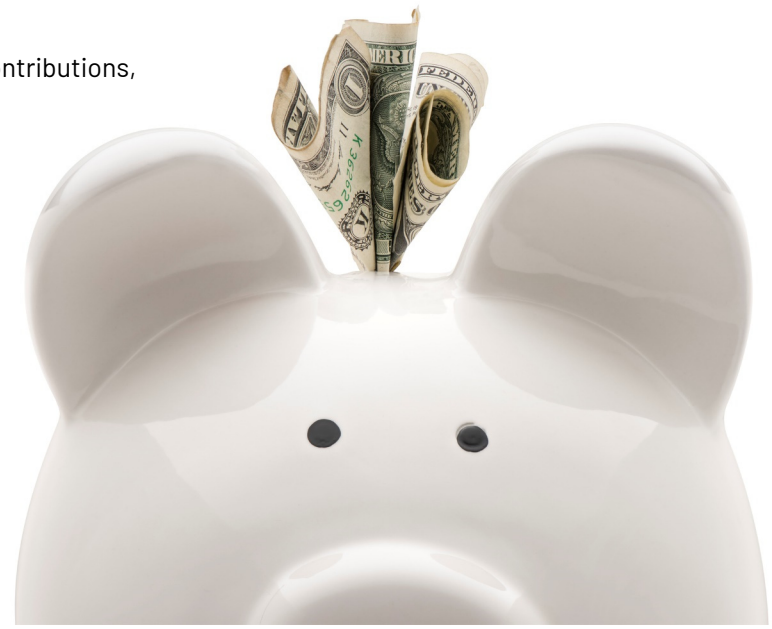
CHAPTER 44 SALARY BASED CONTRIBUTION SCHEDULE

The Chapter 44 NJ Educators' Health Plan is tied to a new salary based employee contribution schedule, that applies only to medical and prescription benefits. It does not apply to any other coverage that may be offered by the district, such as dental coverage. **For contributions for all other medical, plans, prescription plans, or separate lines of coverage, please speak with your Business Office.**.

NJEHP Salary Based Contribution	Single	Parent + Child	Employee + Spouse	Family
$0.00 - $40,000	1.7%	2.2%	2.8%	3.3%
$40,001 - $50,000	1.9%	2.5%	3.3%	3.9%
$50,001 - $60,000	2.2%	2.8%	3.9%	4.4%
$60,001 - $70,000	2.5%	3.0%	4.4%	5.0%
$70,001 - $80,000	2.8%	3.3%	5.0%	5.5%
$80,001 - $90,000	3.0%	3.6%	5.5%	6.0%
$90,001 - $100,000	3.3%	3.9%	6.0%	6.6%
$100,001 - $125,000*	3.6%	4.4%	6.6%	7.2%

Please Note:

- Employees with salaries above $125,000 shall pay at the $125,000 rate.
- This is for the medical and prescription benefits **ONLY** under the NJEHP, and **DOES NOT** apply to any other benefits you may be enrolled in with the district.
- For additional assistance regarding your employee contributions, please refer to your Business Office.



GARDEN STATE PLAN (GSP)

CHAPTER 44 SALARY BASED CONTRIBUTION SCHEDULE

The Chapter 44 Garden State Plan is tied to a new salary based employee contribution schedule, that applies only to medical and prescription benefits. It does not apply to any other coverage that may be offered by the district, such as dental coverage. **For contributions for all other medical, plans, prescription plans, or separate lines of coverage, please speak with your Business Office.**.

GSP Salary Based Contribution	Single	Parent + Child	Employee + Spouse	Family
$0.00 - $40,000	1.50%	1.50%	1.50%	1.65%
$40,001 - $50,000	1.50%	1.50%	1.65%	1.95%
$50,001 - $60,000	1.50%	1.50%	1.95%	2.20%
$60,001 - $70,000	1.50%	1.50%	2.20%	2.50%
$70,001 - $80,000	1.50%	1.65%	2.50%	2.75%
$80,001 - $90,000	1.50%	1.80%	2.75%	3.00%
$90,001 - $100,000	1.65%	1.95%	3.00%	3.30%
$100,001 - $125,000*	1.80%	2.20%	3.30%	3.60%

Please Note:

- Employees with salaries above $125,000 shall pay at the $125,000 rate.
- This is for the medical and prescription benefits **ONLY** under the GSP, and **DOES NOT** apply to any other benefits you may be enrolled in with the district.
- For additional assistance regarding your employee contributions, please refer to your Business Office.

DENTAL PLAN OPTIONS

DELTA DENTAL

Below is a summary of the dental plan options available to you and your family, administered by Delta Dental. For additional information regarding your dental contributions, please refer to your Business Office for assistance.

NOTE: Dependents are eligible for benefits until the end of the calendar year that he or she turns 23.

	DELTA DENTAL PPO PLUS PREMIER	
IN-NETWORK BENEFITS	**DELTA DENTAL PPO DENTISTS**	**DELTA DENTAL PREMIER & NON-PARTICIPATING DENTISTS**
Calendar Year Deductible Individual Family	 $50 $150	 $50 $150
Calendar Year Maximum (per patient)	$1,100	$1,000
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year)	 100% covered	 100% covered
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery Sealants	 85% covered 100% covered	 85% covered 100% covered
Major Services Crowns, Gold Restorations Bridgework Full and Partial Dentures	 50% covered 50% covered 50% covered	 50% covered 50% covered 50% covered
Orthodontia Benefits (Dependent Children Only)	Not Covered	Not Covered
Orthodontia Lifetime Maximum (per patient)	N/A	N/A

This is for illustrative purposes only. For complete listing of covered services, plan limitations, deductibles and maximums, please consult your benefit booklet or contact Delta Dental's service department at 800-452-9310.

Find a Dental Provider

- Visit **www.deltadental.com**
- One there, you may sign into your account or continue as a guest.
- Choose **a plan to start** (i.e. Delta Dental Premier Plan)
- Click **Search by Current Location** and enter **Zip Code** to limit options

DENTAL PLAN OPTIONS

DELTA DENTAL

Below is a summary of the dental plan options available to you and your family, administered by Delta Dental. For additional information regarding your dental contributions, please refer to your Business Office for assistance.

NOTE: Dependents are eligible for benefits until the end of the calendar year that he or she turns 23.

	DELTA DENTAL PPO PLUS ADVANTAGE	
IN-NETWORK BENEFITS	**DELTA DENTAL PPO DENTISTS**	**DELTA DENTAL ADVANTAGE & NON-PARTICIPATING DENTISTS**
Calendar Year Deductible Individual Family	 $50 $150	 $50 $150
Calendar Year Maximum (per patient)	$1,250	$1,000
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year)	 100% covered	 100% covered
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery Sealants	 90% covered 100% covered	 80% covered 100% covered
Major Services Crowns, Gold Restorations Bridgework Full and Partial Dentures	 90% covered 50% covered 50% covered	 80% covered 50% covered 50% covered
Orthodontia Benefits (Dependent Children Only)	Not Covered	Not Covered
Orthodontia Lifetime Maximum (per patient)	N/A	N/A

This is for illustrative purposes only. For complete listing of covered services, plan limitations, deductibles and maximums, please consult your benefit booklet or contact Delta Dental's service department at 800-452-9310.

Find a Dental Provider

- Visit **www.deltadental.com**
- One there, you may sign into your account or continue as a guest.
- Choose **a plan to start** (i.e. Delta Dental Premier Plan)
- Click **Search by Current Location** and enter **Zip Code** to limit options

DENTAL RESOURCES

DELTA DENTAL

Carryover Max

Carryover Max 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 as bridges, crowns, and root canales. Carryover Max is easy and automatic.

To qualify for Carryover Max:

- 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 benefit if less than half of the standard annual maximum is used in the prior benefit year.
- Carryover Max 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 $1,000, and you use $200, you can carry over $200 ($800 x 25% = $200).
- The accumulated amount can never exceed your standard annual maximum.
- Standard annual maximum dollars are used first. Carryover Max dollars are used after the standard annual maximum is met.

Oral Health Enhancement

Delta Dental's Oral Health Enhancement Option enables you to receive up to four (4) dental cleanings and/or periodontal maintenance procedures in any combination per benefit 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 must have had periodontal surgery or periodontal scaling and planing in the past. Details on how to qualify can be found in your benefit booklet.

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 extend that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member. Maximum benefit may be derived by utilizing the services of a participating dentist.

GUARDIAN NURSES

STRUGGLING WITH A HEALTHCARE ISSUE?

For Your Benefit...

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

- Visit you at home or in the hospital to assess your care needs.
- Be your guide, coach and advocate for any healthcare issue.
- Make appointments so you can be seen as quickly as possible.
- Go with you to see doctors, to ask questions and to get answers.
- Identify providers for all care needs and second opinions.
- Get things you need such as healthcare equipment.
- Provide decision support when you are thinking about treatments or surgery.
- Explain a new diagnosis to help you make informed decisions.

Who is Eligible?

The services of our Mobile Care Coordinator Nurses are available to members of the Schools Health Insurance Fund (SHIF) and their covered dependents. All services are free and confidential.

Contact Information

To request help from our Mobile Care Coordinators or the team at Guardian Nurses, call **215.836.0260** or toll-free **888.836.0260**.

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 you 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.

How to Contact Member Advocacy?

You may contact the Member Advocacy Team 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**

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**

HOSPITAL SAFETY GRADE
LEAPFROG

Know Where to Get Care!

Before you decide which hospital to use for elective care; whether in your network or not, it is advisable to check the hospital's quality rating. You can do so by checking their Leapfrog Group ("Leapfrog") score.

Leapfrog is an independent, national not-for-profit organization founded more than a decade ago by the nation's leading employers and private health care experts. They strive to make giant "leaps" forward in the safety, quality, and affordability of health care in the U.S. by promoting transparency through our data collection and public reporting initiatives.

With their goal of saving lives by reducing errors, injuries, accidents, and infections, the Leapfrog Group focuses on measuring and publicly reporting hospital performance through the annual Leapfrog Hospital Survey.

The survey is a trusted, transparent, and evidence-based national tool in which over 2,300 hospitals voluntarily participate free of charge. The Leapfrog Group advocates for public access to quality and safety data from all U.S. hospitals. Their letter-based rating system (i.e., A, B, C, etc.) makes it easy for consumers and patients to make informed decisions about their quality and ability to deliver care effectively.

Getting Started

Patients can check with their physician with questions about hospital quality. The service is free. To look up all Hospital Quality scores nationally, visit **www.hospitalsafetygrade.org**.

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
Medical Benefits - Aetna Benefit questions, claims, locating	**Aetna**	855-281-8858	www.aetna.com
Prescription Benefits - Express Scripts Benefit questions, claims, locating a provider, printing new ID cards	**Benecard**	877-723-6005	www.benecardpbf.com
Dental Benefits - Delta Dental Benefit questions, claims, locating a provider, printing new ID cards	**Delta Dental**	800-452-9310	www.deltadental.com
Plan Options, Benefit Questions and Claims Issues	**Member Advocacy**	800-563-9929	www.connerstrong.com/memberadvocacy
Nurse Advocacy	**Guardian Nurses**	888-836-0260	www.guardiannurses.com
Telemedicine	**CVS Virtual Care**	877-933-4321	www.cvs.com/virtual-care

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.

Collingswood BOE 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 Collingswood BOE 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 March 17, 2025. 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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

LEGAL NOTICES

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: KIHIPP.PROGRAM@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/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

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: 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: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@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://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: 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:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
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 RIte 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 and
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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 March 17, 2025, 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

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 Julie Stewart, Payroll & Benefits Coordinator at 609-859-2256, ext. 134. 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.

[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.

INSURANCE MARKETPLACE NOTICE CONT.

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 Collingswood Board of Education		4. Employer Identification Number (EIN)
5. Employer Address 100 Lees Avenue		6. Employer phone number 856-962-5700
7. City Collingswood	8. State New Jersey	9. Zip Code 08108
10. Who can we contact about employee health coverage at this job? Adrienne Stanbach		
11. Phone number (if different from above)	12. Email address astanbach@collsk12.org	

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

- As your employer, we offer a health plan to:
  - All employees. Eligible employees are: Full-Time Employees.
- With respect to dependents:
  - We do offer coverage. Eligible dependents are: Medical and Rx—Young adults will be covered through the end of the calendar year in which they turn age 26.

** 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, of if you have other income losses, you may still qualify for the premium discount.

If you decide to shop for coverage in the Marketplace, HeathCare.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.

DISCLAIMER: This guide provides a brief summary of the benefits available to you. Collingswood Board of Education reserves the right to modify, amend, suspend, or terminate any plan, at any time, and for any reason without prior notification. The plans described in this guide are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this guide as accurate as possible. However, should there be a discrepancy between this guide and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern.