



2025-2026

EMPLOYEE BENEFITS GUIDE MEDICAL & PRESCRIPTION

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

Voorhees 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 VOORHEES BOARD OF EDUCATION!



The Voorhees 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.

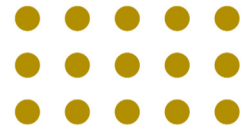
Questions?

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.

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ELIGIBILITY INFORMATION



Who Is Eligible For Benefits?

- A.** In accordance with Chapter 2, P.L. 2010, to be eligible for health benefits coverage a full-time employee must work a minimum of 25 hours per week.
- 1.** Employees hired and working in a new permanent position for the contractual year, shall be eligible for single, parent and child, member and spouse and family coverage for health, prescription, dental and vision benefits. This provision shall apply to current employees except as noted in B. below.
 - 2.** Employees hired on September 1st will be eligible for and receive benefits effective September 1st.
 - 3.** Employees hired after September 1st will be eligible for and receive benefits effective the first of the month following sixty (60) calendar days of employment
- B.** Effective July 1, 2011, full-time Instructional Associates hired after July 1, 2012 shall be eligible for full single benefits only, for the duration of their employment.

Employees hired and working in a replacement position (position being held for an employee on a leave of absence) shall be entitled to single Medical coverage only. They are not eligible for dental or vision coverage.

Eligible Dependents

- Spouse, Civil Union Partner, Child(ren).
- Subscribers' Children until the end of the year in which he or she achieves the age of 26 for medical and prescription coverage - regardless of marital, student, or financial dependency status. Even if they no longer live with the parents. Includes step children, foster child.
- 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.



ELIGIBILITY INFORMATION

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. 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 or prescription drug benefits coverage.
- You are enrolling in benefits for the first time.

Please refer to the BenePortal site 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/domestic partner, a change in employment status (full-time to part-time or part-time to full-time) for you or your spouse/domestic 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 & AMERIHEALTH ADMINISTRATORS



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

- **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 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*	POS/PP0 \$10	POS/PP0 \$15
IN-NETWORK BENEFITS				
Calendar Year Deductible Individual / Family	None	None	None	None
Calendar Year Out-of-Pocket Maximum Individual / Family	\$500 / \$1,000	\$500 / \$1,000	\$400 / \$1,000	Coinsurance: \$400 / \$1,000 Copays: \$5,320 / \$10,440
Preventive Services	100% Covered	100% Covered	100% Covered	100% Covered
PCP Office Visits	\$10 Copay	\$10 Copay	\$10 Copay	\$15 Copay
Specialist Office Visit	\$15 Copay	\$15 Copay	\$10 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	90% Covered	90% Covered	90% covered	90% covered
Emergency Room	\$125 Copay	\$125 Copay	\$25 Copay	\$50 Copay
Urgent Care	\$15 Copay	\$15 Copay	\$10 Copay	\$15 Copay
Durable Medical Equipment	90% covered	90% covered	90% covered	90% covered
Vision Exam	\$15 Copay 1 exam / calendar year	\$15 Copay 1 exam / calendar year	\$10 Copay 1 exam / calendar year	\$15 Copay 1 exam / calendar year
OUT-OF-NETWORK BENEFITS				
Calendar Year Deductible Individual / Family	\$350 / \$700	\$350 / \$700	\$100 / \$250	\$100 / \$250
Calendar Year Out-of-Pocket Maximum Individual / Family	\$2,000 / \$5,000	\$2,000 / \$5,000	\$2,000 / \$5,000	\$2,000 / \$5,000
Coinsurance (% Plan Pays)	70% after deductible	70% after deductible	80% 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 and GSP, the employee's contribution is based on the new salary contribute 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.

MEDICAL PLAN OPTIONS

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- 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.

	POS/PP0 \$15/\$25	POS/PP0 \$20/\$20	POS/PP0 \$20/\$35	HNO/EPO \$20/\$35
IN-NETWORK BENEFITS				
Calendar Year Deductible Individual / Family	None	None	\$200 / \$500	\$200 / \$500
Calendar Year Out-of-Pocket Maximum Individual / Family	Coinsurance: \$400 / \$1,000 Copays: \$5,320/\$10,440	Coinsurance: \$800 / \$2,000 Copays: \$4,920 / \$9,440	Coinsurance: \$2,000 / \$5,000 Copays: \$3,720 / \$6,440	Copays: \$5,720/\$11,400
Preventive Services	100% Covered	100% Covered	100% Covered	100% Covered
PCP Office Visits	\$15 Copay	\$20 Copay	\$20 Copay	\$20 Copay
Specialist Office Visit	\$25 Copay	\$20 Copay	\$35 Copay	\$35 Copay
Diagnostic Lab & X-Ray	100% Covered	100% Covered	80% after deductible	80% after deductible
Imaging (CT/PET Scans, MRIs)	100% Covered	100% Covered	80% after deductible	80% after deductible
Inpatient Hospital	100% Covered	100% Covered	80% after deductible	80% after deductible
Outpatient Surgery	100% Covered	100% Covered	80% after deductible	80% after deductible
Ambulance	90% Covered	90% Covered	80% after deductible	80% after deductible
Emergency Room	\$75 Copay	\$125 Copay	\$300 Copay	\$300 Copay
Urgent Care	\$25 Copay	\$20 Copay	\$35 Copay	\$35 Copay
Durable Medical Equipment	90% covered	90% covered	80% after deductible	80% after deductible
Vision Exam	\$25 Copay	\$20 Copay	\$35 Copay 1 exam /calendar year	\$35 Copay 1 exam /calendar year
OUT-OF-NETWORK BENEFITS				
Calendar Year Deductible Individual / Family	\$100 / \$250	\$200 / \$500	\$800 / \$2,000	Covered for Emergency Services Only
Calendar Year Out-of-Pocket Maximum Individual / Family	\$2,000 / \$5,000	\$5,000 / \$12,500	\$6,500 / \$13,000	
Coinsurance (% Plan Pays)	70% after deductible; \$200 Facility Fee	70% after deductible; \$500 Facility Fee	60% after deductible; \$600 Facility Fee	

* Preauthorization may be required for certain services.

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.

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.”
- **AmeriHealth Administrators Participants:** Visit www.myahabenefits.com, select “Members” and then “Find a Doctor.”

Make Sure You are Using In-Network Labs

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

In-Patient or Observation:

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

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

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

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

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



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 to search for providers



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

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...
NJ Educators Health Plan POS \$10, POS \$15, POS \$15/\$25, POS \$20/\$20, POS \$20/\$35	Category Heading = <u>Aetna Open Access Plans</u> Plan Name = Aetna Choice POS II (Open Access)
Aetna Garden State Plan	Category Heading = <u>Aetna Whole Health Plan</u> Plan Name = (NJ) Aetna Whole Health New Jersey Choice POS II
HNO \$20/\$35	Category Heading = <u>Aetna Open Access Plans</u> Plan Name = Elect Choice EPO (Open Access)

How to Find Participating AmeriHealth Administrators Providers

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

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

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

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

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.



TELADOC

AMERIHEALTH ADMINISTRATORS COVERED MEMBERS

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

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

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

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

When to Use Teladoc

Teladoc doctors can treat a wide range of non-emergency conditions, including:

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

Mental Healthcare Services Enhancement

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

- Anxiety/Stress
- Depression
- Work Pressures
- ADHD

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

** Members participating in a High Deductible Health Plan (HDHP) may have a copay if their INN deductible has not been met.*

Get Started With Teladoc Today

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

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



CVS HEALTH VIRTUAL CARE

AETNA COVERED MEMBERS



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 SHIF Health Plans have a \$0 copay for the Telemedicine Services (Teladoc & 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.

Teladoc (For AmeriHealth Administrators Members)

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

CVS Virtual Care (For Aetna members)

- **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
- Sore Throat
- Ear Infection
- Asthma
- Stiches

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

Plans	Emergency Room Copay	Urgent Care Copay	Estimated Savings
NJEHP	\$125	\$15	\$110
GSP*	\$125	\$15	\$110
POS/PP0 \$10	\$25	\$10	\$15
POS/PP0 \$15	\$50	\$15	\$35
POS/PP0 \$15/\$25	\$75	\$25	\$50
POS/PP0 \$20/\$20	\$125	\$20	\$105
POS/PP0 \$20/\$35	\$300	\$35	\$265
HNO/EPO \$20/\$35	\$300	\$35	\$265

* 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*



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 [CVS.com/HealthHub](https://www.cvs.com/HealthHub).

Health Hubs Offer the Following Services:

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

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

PRESCRIPTION DRUG OPTIONS

EXPRESS SCRIPTS

Through the SHIF, Voorhees offers the following prescription plan options to their staff, administered by Express Scripts.

- **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 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 RETAIL \$3/\$10	RX RETAIL \$7/\$16/\$35
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)			
Generic	\$5 Copay	\$3 Copay	\$7 Copay
Brand Without Generic Alternative	\$10 Copay	\$10 Copay	\$16 Copay
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic & Brand Drug	\$10 Copay	\$35 Copay
MAIL ORDER (UP TO A 90-DAY SUPPLY)			
Generic	\$10 Copay	\$5 Copay	\$18 Copay
Brand Without Generic Alternative	\$20 Copay	\$15 Copay	\$40 Copay
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic & Brand Drug	\$15 Copay	\$88 Copay
ADDITIONAL FEATURES			
Step Therapy	Applies	N/A	N/A
Mandatory Generic	Applies	N/A	N/A
Mail Order for Specialty Drugs	Applies	Applies	Applies
Closed Formulary	Applies	N/A	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 Express Scripts at 800.467.2006.



PRESCRIPTION DRUG OPTIONS

EXPRESS SCRIPTS

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- 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.

	RX RETAIL \$3/\$18/\$46	RX RETAIL \$7/\$21/DIFF
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)		
Generic	\$3 Copay	\$7 Copay
Brand Without Generic Alternative	\$18 Copay	\$21 Copay
Brand With Generic Alternative	\$46 Copay	Member pays the difference between \$21 and cost of drug
MAIL ORDER (UP TO A 90-DAY SUPPLY)		
Generic	\$5 Copay	\$18 Copay
Brand Without Generic Alternative	\$36 Copay	\$52 Copay
Brand With Generic Alternative	\$92 Copay	Member pays the difference between \$52 and cost of drug
ADDITIONAL FEATURES		
Step Therapy	N/A	N/A
Mandatory Generic	N/A	Member pays the difference
Mail Order for Specialty Drugs	Applies	Applies
Closed Formulary	Applies	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.

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DIGITAL ID CARD

EXPRESS SCRIPTS

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.



ADDITIONAL PRESCRIPTION PLAN INFORMATION

EXPRESS SCRIPTS

The following additional features may apply to your prescription drug coverage.

- **Mandatory Generics:** Pharmacists must dispense the generic equivalent medication when available. If a member fills the brand name drug instead, they will be responsible for the brand drug copay plus the difference in cost between the brand and generic medication. (Applies to NJEHP & GSP).
- **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).
- **Formulary List:** A guide for selecting clinically and therapeutically appropriate medications. This list includes a majority of brand and generic medications, and also lists certain medications which will not be covered. The formulary updates throughout the year, and brand name drugs may move to non-formulary status if a generic version becomes available during the year. For the most up to date version, please visit the Express Scripts website using the following link: www.express-scripts.com
- **Non-participating pharmacies:** A majority of New Jersey pharmacies as well as other pharmacies located throughout the United States participate with ESI. However, some pharmacies in New Jersey and in other states do not have agreements with ESI and do not accept ID cards from this Prescription Drug Plan. When using a non-participating pharmacy, you will be asked to pay the full cost of the prescription drug to the pharmacist. You then must file a claim for reimbursement with ESI. After you log into ESI, go to Find a Pharmacy under Prescriptions in the main menu. You can search for nearby network pharmacies by ZIP code or city and state.



HOME DELIVERY AND RECOMMENDED DRUG DOSING

EXPRESS SCRIPTS

Getting started with Home Delivery

Contact Express Scripts

- For transfers from a retail pharmacy, sign in at 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.



BENEPORTAL

ONLINE BENEFITS RESOURCE

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

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

Secure Online Access

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

Mobile-Friendly Site

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

Other Features Include:

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



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:

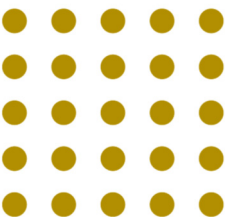
- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company such as a bill, claim, or explanation of benefits (EOB)
- Rescue you from a benefits problem you've been working on
- Discover all that your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

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

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 a provider, printing new ID cards	Aetna	800-370-4526	www.aetna.com
Medical Benefits - AmeriHealth Administrators Benefit questions, claims, locating a provider, printing new ID cards	AmeriHealth Administrators	844-352-1706	www.myahabenefits.com
Prescription Benefits - Express Scripts Benefit questions, claims, locating a provider, printing new ID cards	Express Scripts	800-467-2006	www.express-scripts.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	Teladoc (AmeriHealth Administrators) CVS Virtual Care (Aetna)	855-835-2362 877-933-4321	www.teladoc.com 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.

Voorhees 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 Voorhees 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.flmedicaidtprecovery.com/flmedicaidtprecovery.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

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

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

LEGAL NOTICES

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: 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://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 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> 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

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 Employer Health Coverage 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.¹²

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.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

INSURANCE MARKETPLACE NOTICE

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 by your employer, please check your summary plan description or contact: Tricia Malady malady@voorhees.k12.nj.us, 856-751-8446. 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 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.

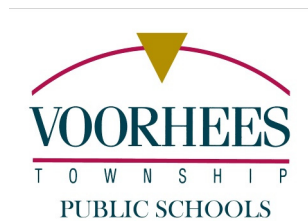
3. Employer Name Voorhees Township Board of Education		4. Employer Identification Number (EIN) 21-600014	
5. Employer Address 329 Route 73		6. Employer phone number 856-751-8446	
7. City Voorhees	8. State NJ	9. Zip Code 08043	
10. Who can we contact about employee health coverage at this job? Tricia Malady			
11. Phone number (if different from above) N/A		12. Email address malady@voorhees.k12.nj.us	

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

- As your employer, we offer a health plan to:
 - Permanent contracted employees (excluding food services, custodial and CER employees) working 25 hours per week or more. Food services, custodial and CER employees working 30 hours per week or more.
- With respect to dependents:
 - Spouses, civil union partners, and children of permanent contracted employees as stated above excluding: part time instructional associates hired after June 30, 2011, all CER staff, food services staff working less than 30 hours per week.
- 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.



DISCLAIMER: This guide provides a brief summary of the benefits available to you. Voorhees 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.