2025 EMPLOYEE BENEFITS NEW HIRE GUIDE

INTRODUCTION

Gloucester Township strives to offer you and your dependents a comprehensive benefits package. This year is no exception. We encourage you to take the time to educate yourself about the benefit options available to you.

IN THIS GUIDE

Eligibility & Making Plan Changes	3
Medical Plans	4
How to Find an Aetna Provider	5
Prescription Drug Plan	6
Dental Plans	7
Vision Plan	8
Flexible Spending Accounts	10
BenePortal	11
Member Advocacy	12
Carrier Contacts	13
Legal Notices	14

ELIGIBILITY & MAKING PLAN CHANGES

WHO IS ELIGIBLE?

If you are a Gloucester Township full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this Guide. Please remember that only eligible dependents can be enrolled. Eligible dependents include all of the following:

- Your spouse (with proof of marriage), Civil Union, or Domestic Partner
- Your child(ren), step-child(ren), grandchild(ren) (proof of guardianship required), adoptive child(ren), child(ren) placed with you in anticipation of adoption, (child(ren) for whom you are the legal guardian, child(ren) who is an alternate recipient under a qualified medical support order. Your eligible child dependent(s) are covered until the end of the year (12/31) in which they attain age 26..
- A child(ren) who is totally disabled and relies on you for care and is covered under the Plan as an eligible dependent at the time he or she reaches age 26, may be covered beyond age 26.
- Individuals who are losing other coverage. An employee or dependent who is eligible, but not enrolled in this Plan, may enroll if they experience a qualified change in status.

MAKING PLAN CHANGES

Unless you experience a qualified change in status, you cannot make changes to the benefits you elect until the next Open Enrollment period. Qualified status changes include: marriage, divorce, legal separation, birth or adoption of a child, change in a child's dependent status, death of spouse, child, or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in your spouse's benefits or employment status.

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 31-day period following the date that other coverage was lost, due to a qualified change in status.

You must notify Human Resources within 31 days of experiencing a qualified status change.

MEDICAL PLANS: AETNA

Eligible employees and their eligible family members have the option of the below Aetna medical plans. Our plans allow you the freedom to use providers in and out-of-network. You are not required to designate a Primary Care Physician (PCP) or obtain referrals.

	AETNA CHOICE POS II PLAN F (BASE PLAN)		AETNA CHOICE POS II PLAN C (BUY-UP PLAN)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual/Family	\$100 / \$200	\$200 / \$500	\$100 / \$200	\$100 / \$200
Out-of-Pocket Maximum Individual/Family	\$800 / \$1,600	\$3,000 / \$10,000	\$400 / \$800	\$400 / \$800
Preventive Care Services	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 80%*
Primary Care Physician (PCP) Required?	No	N/A	No	N/A
PCP Office Visit	\$20 copay	Plan pays 70%*	\$10 copay	Plan pays 80%*
Specialist Office Visit	\$30 copay	Plan pays 70%*	\$10 copay	Plan pays 80%*
Diagnostic Laboratory LabCorp Outpatient Facility	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 80%*
Diagnostic X-Ray Outpatient Facility	Plan pays 100% \$30 copay	Plan pays 70%*	Plan pays 100%	Plan pays 80%*
Emergency Room	\$100 copay		100%	
Urgent Care Center	\$30 copay	Plan pays 70%*	\$10 copay	Plan pays 80%*
Inpatient Hospital	Plan pays 100%	\$500 copay per admission and Plan pays 70%*	Plan pays 100%	Plan pays 80%*
Outpatient Surgery	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 80%*

* After deductible

Note: Employee contributions will vary based on plan option and tier elections. See Human Resources for contribution schedules.

Don't Forget! Preventive Care Services are covered 100% in-network—no copays or coinsurance!

FINDING AN IN-NETWORK PROVIDER: AETNA

STEP 1: Visit Aetna's website at **www.aetna.com**

STEP 2: At the top of the webpage, click **"Member Support"**, then **"Account Management"**. Click on **"Find a Doctor"**.

STEP 3: On the right side of the page under the section labeled **"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, and a mile radius you would prefer your provider to be in. Select **"Search"**

STEP 5: You will be asked to **"Select a Plan"**. Under the category **"Aetna Open Access Plans"** select the plan, **"Aetna Choice POS II (Open Access)"**

STEP 6: Click **"Continue"** to yield search results

PRESCRIPTION DRUG PLAN: EXPRESS SCRIPTS

If you are enrolled in one of the medical plans, you are automatically enrolled in the prescription drug plan through Express Scripts.

	AETNA CHOICE POS II PLAN F (BASE PLAN)	AETNA CHOICE POS II PLAN C (BUY-UP PLAN)
RETAIL PRESCRIPTION (UP TO A 30-DAY SUPPLY)		
Generic Preferred Brand Non-Preferred Brand	\$5 copay \$15 copay \$35 copay	\$5 copay \$15 copay \$35 copay
MAIL ORDER PRESCRIPTION (UP TO A 90-DAY SUPPLY)		
Generic Preferred Brand Non-Preferred Brand	\$5 copay \$15 copay \$35 copay	\$5 copay \$15 copay \$35 copay

CONSIDER MAIL ORDER

Using the mail order program for your maintenance medications will save you money! In addition to the savings, your prescriptions will be delivered right ot your home.

To access the most current preferred Prescriptions Formulary Guide and to begin using the Mail Order Delivery Service, simply contact Express Scripts at **800.711.0917** or visit **www.express-scripts.com**.

SAVE MONEY ON PRESCRIPTIONS

Your plan may prefer some medications over others. These are called preferred drugs. You many pay:

- Lowest copayment/coinsurance for generic drugs
- Higher copayment/coinsurance for preferred brand name drugs
- Highest copayment/coinsurance for non-preferred brand name drugs

Your doctor may be able to help you save money by prescribing generic and preferred brand name drugs, if appropriate.

DENTAL PLAN: DELTA DENTAL OF NEW JERSEY

There are some changes to your dental benefits for the plan year, they are outlined at the bottom of this page. The Township plan allows you to pick from two different networks. Employees selecting Advantage will be subject to an additional upcharge.

PLEASE NOTE: The below dental benefits are available to certain Township employees with the exception of the Department of Public Works.

	OPTION 1: DELTA DENTAL PPO	OPTION 2: DELTA DENTAL ADVANTAGE PROGRAM
SERVICES		
Calendar Year Deductible	No Deductible	No Deductible
Calendar Year Maximum (per patient)	$1,000	$1,000
Preventive and Diagnostic Exams, cleanings, bitewing x-rays (each twice per calendar year) Fluoride Treatment (once in a calendar year, children to age 19)	100%	100%
Remaining Basic Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	80%	80%
Crowns & Prosthodontics Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	50%	50%
Orthodontia Benefits (child only 19 and below)	50%	50%
Orthodontia Lifetime Maximum (per patient)	$2,500	$2,500

FIND A PARTICIPATING DENTIST

To find a participating dentist contact Delta Dental at **800.335.8265** or visit **www.deltadentalnj.com.**

DENTAL PLAN: DELTA DENTAL OF NEW JERSEY

What's the difference between the Delta PPO Plan and the Delta Advantage plan? The Delta Dental PPO is offered in most states, the Advantage Program is only available in New Jersey. The plan coverage is identical under both plans, however, the network of participating providers is different.

DELTA DENTAL PPO

Participating dentists have agreed to accept the Delta Dental PPO schedule of fees as payment in full, offering guaranteed copayments to eligible patients using network dentists. These fees generally mean lower copayment costs to you. You may also select a Delta Dental Premier dentist who is not a Delta Dental PPO dentist. Delta Dental Premier participating dentists agree to pre-file their usual fee for each procedure commonly performed, and accept the least of their actual charge, their filed fee, or Delta Dental's Premier Plan approved amount as payment in full; however, Delta Dental's payments will be based on the applicable Delta Dental PPO schedule. Claims for services provided by participating specialists are paid based on the lesser of their usual fee, their actual fees, or Delta Dental's Premier Plan approved amount for the procedure. Claims for non-network providers' services are generally paid based on the lesser of the dentist's actual charge or the applicable Preferred schedule of fees.

You are responsible for payment of the difference between Delta Dental's payment and the fee approved by Delta Dental.

ADVANTAGE PROGRAM

Offers coverage where the eligible patient is treated by an Advantage Program dentist, the fee for the covered service(s) will not exceed the Advantage plan schedule of fees. Where the eligible patient is treated by a Delta Dental Premier dentist who does not participate in Advantage Program or by a participating specialist, you receive payment based on the Delta Dental Premier Plan approved charge and the dentist has agreed not to charge you more than the dentist's filed fee or Delta Dental's Premier Plan approved charge for the procedure(s). Claims for service(s) provided by dentists who are neither Delta Dental Premier, Advantage Program dentists, or participating specialists are generally paid based on the lesser of the dentist's actual charge or the fee level as determined by Delta Dental for non-participating dentists (subject to group contract limitations).

You are responsible for payment of the difference between Delta Dental's payment and the fee approved by Delta Dental.

VISION PLAN: NATIONAL VISION ADMINSITRATORS

Medical and prescription dug plan members receive vision coverage through National Vision Administrators (NVA) at no additional cost. For more information or to locate a participating providers, please visit **www.e-nva.com**.

PLEASE NOTE: This vision benefit is available to all Township employees with the exception of the Department of Public Works.

NVA ESSENTIAL PLUS PLAN

SERVICES	IN-NETWORK (MEMBER PAYS)
Eye Exam	
In-Network	$5 copay
Out-of-Network	Covered up to $35
Frames	35% off retail price
Lenses	
Single Vision Lenses	$35
Bifocal Lenses	$55
Trifocal Lenses	$70
Lenticular Lenses	$70
Lens Options	
UV Coating	$12
Tint (Solid & Gradient)	$12
Scratch Resistance Coating	$15
Polycarbonate	$35
Anti-Reflective	$45
Polarized	$75
Transitions	$65-$70
Progressive	$50
Other Add-On Services	20% off retail price
Contact Lenses	
Conventional	15% off retail price
Disposable	10% off retail price
Fitting & Follow-Up	10% off retail price
Frequency	
Vision Exam	Once every 12 months
Lenses	Unlimited
Frames	Unlimited

GET DISCOUNTS ON MAIL ORDER CONTACT LENS!

NVA has partnered with Contact Fill, L.L.C. Mail Order Contact Lens Replacement Program to offer additional discounts on contact lenses. Visit **www.contactfill.com** or call **866.234.1393** to take advantage of these discounts as a NVA member. Use the code **SHIP18** for free shipping on your first order.

BONUS! Use your FSA to purchase contacts with pre-tax dollars.

FLEXIBLE SPENDING ACCOUNTS: WEX

Gloucester Township provides you with the opportunity to pay for out-of-pocket medical, dental, and dependent care expenses with pre-tax dollars through Flexible Spending Accounts (FSAs).

HEALTHCARE FSA

The Healthcare FSA allows you to set aside pre-tax dollars via payroll deductions to pay for qualified healthcare expenses for you and your dependents. The annual maximum amount you may contribute is **$3,200**. The Healthcare FSA can be used for:

- Doctor office copays
- Non-cosmetic dental procedures (crowns, dentures, orthodontics)
- Prescription contact lenses, glasses and sunglasses
- LASIK eye surgery

CARES ACT AND QUALIFYING MEDICAL EXPENSES

Under the CARES Act, the definition of a qualifying medical expense now includes certain over-the-counter medications and products. Specifically, the act treats additional over-the-counter medications, along with menstrual care products, as qualified medical expenses that may be paid for using FSAs or other tax-advantaged accounts.

DEPENDENT CARE FSA

The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care expenses. The annual maximum amount you may contribute is $5,000 (or $2,500 if married and filing separately) per calendar year. The Dependent Care FSA can be used for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)
- Au Pair
- After school programs

HOW MUCH SHOULD I CONTRIBUTE?

Contributions to your FSA come out of your paycheck before any taxes are taken out. You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses in a plan period. If you do not use the money you contribute it will not be refunded to you are carried forward to a future plan year. This is the use-it-or-lose-it rule.

USE IT OR LOSE IT!

Flexible Spending Accounts operate under a use-it-or-lose-it rule, meaning that money not used by the end of the plan year does not rollover and must be forfeited, per IRS regulations. You can avoid forfeitures by carefully reviewing your prior year's expenses and planning only for predictable costs.

BENEPORTAL: ADDITIONAL RESOURCES

BENEPORTAL

At Gloucester Township, you have access to a full-range of valuable employee benefits 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.

Visit **www.gloucestertwpbenefits.com** to access your benefits information today!

BenePortal features include:

- Secure online access - NO login required
- Mobile optimized site
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms and flyers
- GoodRx
- Benefit Perks Discount Program
- And more!

BENEFITS MAC: ADDITIONAL RESOURCES

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!

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

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm ET
- Via the web: **www.connerstrong.com/memberadvocacy**
- Via email: **cssteam@connerstrong.com**
- Via fax: **856.685.2253**

Member Advocates are available **Monday through Friday, 8:30 am to 5:00 pm (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.

CARRIER CONTACTS

PLAN	CARRIER/VENDOR NAME	PHONE NUMBER	WEBSITE
Medical	Aetna	800-370-4526	www.aetna.com
Prescription	Express Scripts	800-711-0917	www.express-scripts.com
Dental	Delta Dental of NJ	800-452-9310	www.deltadentalnj.com
Vision	National Vision Administrators (NVA)	800-672-7723	www-enva.com
FSA Accounts	WEX (Benefit Express)	877-837-5017	www.myfsaexpress.com
Voluntary Benefits	Aflac	800-992-3522	www.aflac.com
Member Advocacy	Conner Strong & Buckelew	800-563-9929	www.connerstrong.com/memberadvocacy

LEGAL NOTICES

Patient Protection and Affordable Care Act
Please note: the Gloucester Township medical plans are considered compliant with the Patient Protection and Affordable Care Act.

Gloucester Townships 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.

Notice Regarding Special Enrollment
Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [30 days or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage. Coverage will be effective the first of the month following your request for enrollment.

Loss of coverage for Medicaid or a State Children's Health Insurance Program.
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within [30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources at 856-228-4007.

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

LEGAL NOTICES

enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

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

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

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

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

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

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

FLORIDA – Medicaid
Website: https://www.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/fss/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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

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

LEGAL NOTICES

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

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

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct 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: 1-800-562-3022

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

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

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

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

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

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

INSURANCE MARKETPLACE NOTICE

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

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

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

PART B: Information about Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Township of Gloucester		4. Employer Identification Number (EIN) 52-1270921
5. Employer Address 1261 Chews Landing Road		6. Employer phone number 856-228-4007
7. City Laurel Springs	8. State NJ	9. Zip Code 08021
10. Who can we contact about employee health coverage at this job? Carla Geppi		
11. Phone number (if different from above) 856-302-7071	12. Email address cgeppi@glotwp.com	

[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.

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