2024-2025

EMPLOYEE BENEFITS GUIDE

Riverside 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 RIVERSIDE BOARD OF EDUCATION!

Questions?

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

Inside This Guide

ELIGIBILITY INFORMATION

Which Employees are Eligible for Benefits?

Full-time employees who work 20 hours a week or more for the regularly scheduled work period (12-months or 10-month school year). An employee's benefits terminate the first day after the first full month of no pay. Ambulatory Aides are not eligible for benefits.

Waiting Period

- **Medical, Dental, and Prescription Coverage:** 1st of the month following 60 days of employment.
- Coverage will be effective immediately for 10 month employees with a start date of September 1st.

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.

Eligible Dependents

- Spouse and Civil Unions
- A newborn child is covered for 60 days from the date of birth. To continue coverage beyond this initial period, the newborn child must be enrolled within the initial 60 day period.
- To continue coverage for a handicapped child evidence of the child's incapacity and dependency must be provided to the carrier at least 60 days prior to the termination of coverage.
- Medical and Prescription coverage for young adults will end when the employee's coverage ends or the end of the month in which age 26 is attained.
- Dental coverage for dependent children (subject to age limitations). Children include stepchildren, adopted children, and foster children, provided such children are dependent upon the employee for support and maintenance. Eligible children are covered from Age 2 until Age 23. The Dependent's coverage will end when the employee's coverage ends or on the last day of the benefit month in which the dependent fails to meet the definition of a dependent, or in the case of an unmarried child, on the last day of the calendar year during which the termination age of 23 is reached.
- A covered child not capable of self support when he or she reaches the limiting age 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. Documentation must be submitted to the business office at least 30 days before the child ages out. Please contact the Business Office for more details. You may be contacted periodically to verify that the child remains eligible for coverage.

ENROLLMENT & MAKING PLAN CHANGES

How to Enroll

You must complete an enrollment or waiver form if:

- You wish to add/terminate dependents from your medical, prescription drug or dental benefits coverage.
- You are enrolling in benefits for the first time.
- Waiving benefits - For members wishing to waive benefits, please complete the health benefits waiver form. If you waive benefits, you will not be eligible to enroll until the next open enrollment period unless you have a qualifying life event.

Please refer to the BenePortal site for a copy of the enrollment or waiver form. **Completed forms must be returned to the Business Office.**

How Often Can I Change Plan Elections?

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

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

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

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

MEDICAL PLAN OPTIONS

AETNA

Through the SHIF, Riverside Board of Education offers the following medical plan options to their staff, administered by Aetna.

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

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

	GSP*	NJEHP	PATRIOT V	PATRIOT X
IN-NETWORK BENEFITS				
Calendar Year Deductible Individual Family	None	None	None	None
Out-of-Pocket Maximum Individual Family	$500 $1,000	$500 $1,000	$400 $800	$4,000 $8,000
Preventive Services	100% Covered	100% Covered	100% Covered	100% Covered
PCP Office Visits	$10 Copay	$10 Copay	$5 Copay	$10 copay
Specialist Office Visit	$15 Copay	$15 Copay	$5 Copay	$15 copay
Diagnostic (X-ray/Bloodwork)	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	100% Covered	100% Covered
Emergency Room	$125 Copay	$125 Copay	$25 Copay	$35 Copay
Urgent Care	$15 Copay	$15 Copay	$5 Copay	$15 Copay
Durable Medical Equipment	90% Covered	90% Covered	100% Covered	100% Covered
Vision Exam	$15 Copay (1 exam/calendar year)	$15 Copay (1 exam/calendar year)	$5 copay (1 exam/12 months up to 19; 1 exam/24 months after 19)	$15 copay (1 exam/12 months up to 19; 1 exam/24 months after 19)
Vision Hardware Reimbursement	N/A	N/A	$70 max/24 months	$70 max/24 months
OUT-OF-NETWORK BENEFITS				
Deductible Individual Family	$350 $700	$350 $700	$100 $200	$100 $200
Out-of-Pocket Maximum Individual Family	$2,000 $5,000	$2,000 $5,000	$2,000 $4,000	$500 $1,400
Coinsurance (% Plan Pays)	70% after deductible	70% after deductible	70% after deductible	80% 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 & GSP, the employee's contribution is based on the new salary based contribution schedule. For all other plans, your employee contribution will remain the same per your collective bargaining agreement.

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

MEDICAL PLAN OPTIONS

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Through the SHIF, Riverside Board of Education offers the following medical plan options to their staff, administered by Aetna.

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

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

	PREMIER	PPO CORE	PPO BUY-UP
IN-NETWORK BENEFITS			
Calendar Year Deductible Individual Family	None	$1,000 $2,000	$500 $1,000
Out-of-Pocket Maximum Individual Family	$4,000 $8,000	$2,000 $4,000	$1,000 $2,000
Preventive Services	100% Covered	100% Covered	100% Covered
PCP Office Visits	$2 Copay	$25 Copay	$20 Copay (No Deductible)
Specialist Office Visit	100% Covered	$40 Copay	$30 Copay (No Deductible)
Diagnostic (X-ray/Bloodwork)	100% Covered	$40 Copay	$30 Copay (No Deductible)
Imaging (CT/PET scans, MRIs)	100% Covered	$40 Copay	$30 Copay (No Deductible)
Inpatient Hospital	100% Covered	$200 copay per day/up to 5 days No charge for Physician/Surgeon	$100 copay per day/up to 5 days (No Deductible) 90% Covered for Physician/Surgeon
Outpatient Surgery	100% Covered	80% Covered	90% Covered (No Deductible)
Ambulance	100% Covered	80% Covered	90% Covered
Emergency Room	$15 Copay	80% Covered after $100 copay	$100 Copay (No Deductible)
Urgent Care	100% Covered	$40 Copay	$30 Copay (No Deductible)
Durable Medical Equipment	90% Covered	80% Covered	90% Covered
Vision Exam	$2 copay (1 exam/12 months up to 19; 1 exam/24 months after 19)	No Charge (1 exam/24 months)	No Charge (1 exam/24 months)
Vision Hardware Reimbursement	$100 max/24 months	N/A	N/A
OUT-OF-NETWORK BENEFITS			
Deductible Individual Family	$1,000 $2,000	$2,500 $5,000	$1,250 $2,500
Out-of-Pocket Maximum Individual Family	$10,000 $20,000	$5,000 $10,000	$2,500 $5,000
Coinsurance (% Plan Pays)	70% after deductible	60% after deductible	70% after deductible

* 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

Consider Your In-Network Options First

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

Limit Your Use of Out-of-Network Providers

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

CVS MINUTE CLINICS AND HEALTH HUBS*

minute clinic®

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

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

CVS Minute Clinic Practitioners Can:

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

HealthHUB

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

HOW TO FIND IN-NETWORK 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 decision.

If you are enrolling in an...	DocFind Plan selection is....
Aetna QPOS Plan (PCP Required)	Category Heading: Aetna Standard Plan Plan Name: QPOS
Aetna Choice POS II Plan (NJEHP)	Category Heading: Aetna Open Access Plans Plan Name: Aetna Choice POS II (Open Access)
Aetna Garden State Plan	Category Heading: Aetna Whole Health Plan Plan Name: (NJ) Aetna Whole Health New Jersey Choice POS II
HMO	Category Heading: Aetna Standard Plans Plan Name: HMO

Access information on the go with the Aetna app! Access ID cards and claims information, search for providers, refill prescriptions and more - directly from your smartphone or mobile device!

TELEMEDICINE

TELADOC

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

Effective 9/1/2021, the SHIF expanded the telemedicine service to include mental healthcare. 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.Teladoc.com/Aetna**
- **Via mobile app:** Go to **www.Teladoc.com/Mobile** to learn more or download the mobile app from the App Store or Google Play

URGENT CARE CENTERS

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

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

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

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

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

Plans	Emergency Room Copay	Urgent Care Copay	Estimated Savings
NJEHP	$125	$15	$110
GSP*	$125	$15	$110
Patriot V	$25	$5	$20
Patriot X	$35	$15	$20

* 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

PRESCRIPTION DRUG OPTIONS

BENECARD

The following prescription drug plans are available to employees hired before 7/1/2020, through the SHIF. Benecard is the Pharmacy Benefit Manager. Please note, employees enrolled in the NJEHP/GSP prescription must also be enrolled in the NJEHP/GSP for medical coverage through the SHIF.

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

	NJEHP & GSP*	RX $5/$10	OPTION A $5/$25/$40	OPTION B $10/$30/$45
RETAIL PHARMACY				
Generic	$5 Copay	$5 copay	$5 copay	$10 copay
Brand Without Generic Alternative	$10 Copay	$10 copay	$25 copay	$30 copay
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic & Brand Drug	$10 copay	$40 copay	$45 copay
Dispensing Limitation	30 day supply	34 day supply or 100 units	34 day supply or 100 units	34 day supply or 100 units
MAIL ORDER				
Generic	$10 Copay	$5 copay	$5 copay	$20 copay
Brand Without Generic Alternative	$20 Copay	$5 copay	$25 copay	$60 copay
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic & Brand Drug	$5 copay	$40 copay	$90 copay
Dispensing Limitation	90 day supply	90 day supply	90 day supply	90 day supply
ADDITIONAL FEATURES				
Step Therapy	Applies	Not Applicable	Not Applicable	Not Applicable
Mandatory Generic	Applies	Not Applicable	Not Applicable	Not Applicable
Mail Order for Specialty Medications	Applies	Applies	Applies	Applies
Performance Preferred Medication	Applies	Not Applicable	Applies	Applies

Save on Your Prescriptions

Using the mail order program for your maintenance medications will save you money. You will receive up to a 90-day (3-month) supply for two retail copays. In addition to the savings, your prescriptions will be delivered right to your home. Refilling your order is easy and can be done over the phone.

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

ADDITIONAL PRESCRIPTION PLAN INFORMATION

BENECARD

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

- **Mandatory Generics:** Pharmacists must dispense the generic equivalent medication when available. If a member fills the brand name drug instead, they will be responsible for the brand drug copay plus the difference in cost between the brand and generic medication. (Applies to NJEHP and 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 and 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 Benecard website using the following link: **www.benecardpbf.com**

SAVE MONEY USING MAIL ORDER

BENECARD

HOW MUCH CAN YOU SAVE WHEN USING MAIL ORDER?

COMPARE FOR YOURSELF...

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

HOW MUCH CAN YOU SAVE WHEN USING MAIL ORDER?

COMPARE FOR YOURSELF...

RX $5/$10		
RETAIL PHARMACY	**MAIL ORDER**	**ANNUAL SAVINGS**
Generic Copay **$5**	Generic Copay **$5**	**$40**
Annual Cost *($5 per month x 12 fills)* **$60**	Annual Cost *($5 per order x 4 fills per year)* **$20**	
Preferred Brand Copay **$10**	Preferred Brand Copay **$5**	**$100**
Annual Cost *($10 per month x 12 fills)* **$120**	Annual Cost *($5 per order x 4 fills per year)* **$20**	

DENTAL PLAN OPTIONS

DELTA DENTAL OF NEW JERSEY

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

NOTE: Dependent children are covered until the end of the month in which they turn age 23.

	PPO PLUS PREMIER PLAN
IN-NETWORK BENEFITS	
Calendar Year Deductible Individual Family	 $50 N/A
Calendar Year Maximum (per patient)	$1,500
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year) Fluoride Treatment (Once in a calendar year, children to age 19)	 100% Covered 100% Covered
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	70% Covered
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	50% Covered
Orthodontia Benefits	Not Covered
Orthodontia Lifetime Maximum (per patient)	Not Applicable

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

Find a Dental Provider

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

BENEPORTAL

ONLINE BENEFITS RESOURCE

At Riverside 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.riversideboebenefits.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.

Contact the Benefits MAC

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

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

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 about HUSK by visiting:
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: **https://connerstrong.goodrx.com**

HealthyLearn

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

Learn more at: **https://healthylearn.com/connerstrong**

QUESTIONS? WHO TO CALL...

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

QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE/EMAIL
Medical Benefits Benefit questions, claims, locating a provider, printing new ID cards	**Aetna**	855-281-8858	www.aetna.com
Telemedicine	**Teladoc**	855-835-2362	www.teladoc.com/aetna
Nurse Advocacy	**Guardian Nurses**	888-836-0260	www.guardiannurses.com
Prescription Benefits Benefit questions, claims, locating a provider, printing new ID cards	**Benecard**	877-723-6005	www.benecardpbf.com
Dental Benefits Benefit questions, claims, locating	**Delta Dental**	800-452-9310	www.deltadentalnj.com
Vision Benefits Benefit questions, claims, locating a provider, printing new ID cards	**Aetna**	877-973-3238	www.aetna.com
Plan Options, Benefit Questions and Claims Issues	**Benefits Member Advocacy Center**	800-563-9929	www.connerstrong.com/memberadvocacy

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 Janis Conard at 856-461-1255. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

INSURANCE MARKETPLACE NOTICE CONT.

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer Name Riverside Township Board of Education		4. Employer Identification Number (EIN) 216000297
5. Employer Address 112 East Washington Street		6. Employer phone number 856-461-1255
7. City Riverside	8. State New Jersey	9. Zip Code 08075
10. Who can we contact about employee health coverage at this job? Janis Conard		
11. Phone number (if different from above) 856-461-1255 ext. 1112	12. Email address jconard@riverside.k12.nj.us	

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

- As your employer, we offer a health plan to:
  - Some employees. Full-time employees working at least 20 hours per week for the regularly scheduled work period (12 month or 10 month school year) except for Ambulatory Aides. Ambulatory Aides are not eligible for benefits.
- With respect to dependents:
  - We do offer coverage. Eligible dependents are: Spouse, Civil Unions and Children.
- 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, of if you have other income losses, you may still qualify for the premium discount.

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

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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 the Benefits Department.

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.

Riverside 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.

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

LEGAL NOTICES

in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 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
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
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: 1-800-766-9012

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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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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) 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 5218

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

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

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
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 January 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

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