2020 EMPLOYEE BENEFITS GUIDE

in this guide

Lumberton Township Board of Education (Lumberton BOE) strives to offer you and your dependents a competitive and comprehensive benefits package. This year is no exception. We encourage you to take the time to educate yourself about the available benefit options.

The benefits you elect will be effective from January 1, 2020 through December 31, 2020. **Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status (see page 2 of this guide for more information).**

Important Enrollment Information

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 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 the Payroll and Benefits Administrator within 31 days of experiencing a qualified status change.

Who is Eligible?

- Opposite or same sex to whom you are legally married
- Person of the same sex with whom you have entered into a civil union. Requires documentation.
- Person of the same sex with whom you have entered into a domestic partnership under Chapter 246.
- Subscribers Children until age 26- regardless of marital, student, or financial dependency status. Even if they no longer live with the parents. Includes step children, foster child.
- Legally adopted or any child in a guardianship relationship.
- A covered child is 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.
- Certain children over age 26 may be eligible for continued coverage until age 31 under chapter 375. This includes a child by blood or law under age 31, unmarried, or not a partner in a civil union or domestic partner, has no dependents of his or her own, is a resident of NJ or is a full-time student at an accredited public or private institution of higher education, is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health plan, church plan or entitled benefits under Medicare.

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

Enrollment/change forms and waiver forms are available in the Business Office. **Completed forms must be returned to Betsy Zeng (in the Payroll and Benefits Office).**

Medical Plan Options: SHIF - Aetna

Eligible employees and their eligible family members have the option of seven SHIF-Aetna medical plans that provide equal to or better benefits than your current plans. Please review the plans carefully. If you select a QPOS plan you are required to designate a Primary Care Physician (PCP) and obtain referrals.

	AETNA CHOICE POS II $15		AETNA CHOICE POS II $15/$25	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Individual/Family	None	$100/$250	None	$100/$250
Out-of-Pocket Maximum Individual/Family	$400/$800	$2,000/$5,000	$400/$800	$2,000/$5,000
Preventive Care Services	Plan pays 100%	Plan pays 70% (no deductible)	Plan pays 100%	Plan pays 70% (no deductible)
Referrals Required	Not Required		Not Required	
Primary Care Physician (PCP) Required?	Not Required		Not Required	
PCP Office Visit	$15 copay	Plan pays 70%*	$15 copay	Plan pays 70%*
Specialist Office Visit	$15 copay	Plan pays 70%*	$25 copay	Plan pays 70%*
Diagnostic Laboratory	Plan pays 100% in office or Labcorp Plan pays 100% in Outpatient Facility	Plan pays 70%*	100% in office or Labcorp 100% in Outpatient Facility	Plan pays 70%*
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	Plan pays 100% in office or Plan pays 100% in Outpatient Facility	Plan pays 70%*	100% in office or 100% in Outpatient Facility	Plan pays 70%*
Emergency Room	Plan pays 100% after $50 copay		$75 copay	
Inpatient Hospital	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 70%* and $200 copay
Outpatient Surgery	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 70%*
Vision Exam (At Aeta Vision Provider)	$15 copay	Not Covered	$15 copay	Not Covered
PRESCRIPTION BENEFITS	**RETAIL** (Up to a 30-day supply)	**MAIL ORDER** (Up to a 90-day supply)	**RETAIL** (Up to a 30-day supply)	**MAIL ORDER** (Up to a 90-day supply)
Generic	$3	$5	$7	$18
Preferred Brand	$10	$15	$16	$40
Non-Preferred Brand	$10	$15	$35	$88

* After deductible

Medical Plan Options: SHIF - Aetna

Eligible employees and their eligible family members have the option of seven SHIF-Aetna medical plans that provide equal to or better benefits than your current plans. Please review the plans carefully. If you select a QPOS plan you are required to designate a Primary Care Physician (PCP) and obtain referrals.

	AETNA QPOS $10		AETNA QPOS $20	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Individual/Family	None	$500/$1,000	None	$500/$1,000
Out-of-Pocket Maximum Individual/Family	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000
Preventive Care Services	Plan pays 100%	Plan pays 60% (no deductible)	Plan pays 100%	Plan pays 60% (no deductible)
Referrals Required	Required		Required	
Primary Care Physician (PCP) Required?	Required		Required	
PCP Office Visit	$10 copay	Plan pays 60%*	$20 copay	Plan pays 60%*
Specialist Office Visit	$10 copay *Referral required*	Plan pays 60%*	$20 copay *Referral required*	Plan pays 60%*
Diagnostic Laboratory	Plan pays 100% in office or Lab Corp Plan pays 100% in Outpatient facility	Plan pays 60%*	Plan pays 100% in office or Labcorp Plan pays 100% in Outpatient Facility	Plan pays 60%*
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	Plan pays 100% in office or Plan pays 100% in Outpatient facility	Plan pays 60%*	Plan pays 100% in office or Plan pays 100% in Outpatient Facility	Plan pays 60%*
Emergency Room	Plan pays 100% after $35 copay		$100 copay	
Inpatient Hospital	Plan pays 100%	Plan pays 60%*	100%	Plan pays 60%*
Outpatient Surgery	Plan pays 100%	Plan pays 60%*	100%	Plan pays 60%*
Vision Exam (At Aetna Vision Provider)	$10 copay	Plan pays 60%*	$15 copay	Plan pays 60%*
PRESCRIPTION BENEFITS	**RETAIL** (Up to a 30-day supply)	**MAIL ORDER** (Up to a 90-day supply)	**RETAIL** (Up to a 30-day supply)	**MAIL ORDER** (Up to a 90-day supply)
Generic	$3	$5	$3	$5
Preferred Brand	$10	$15	$18	$36
Non-Preferred Brand	$10	$15	$46	$92

* After deductible

Medical Plan Options: SHIF - Aetna

Eligible employees and their eligible family members have the option of seven SHIF-Aetna medical plans that provide equal to or better benefits than your current plans. Please review the plans carefully. If you select a QPOS plan you are required to designate a Primary Care Physician (PCP) and obtain referrals.

	AETNA CHOICE POS II $20/$30		AETNA CHOICE POS II $20/$35		AETNA QPOS $20/$35	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Individual/Family	None	$200/$500	$200/$400	$800/$2,000	$200/$400	$500/$1,000
Out-of-Pocket Maximum Individual/Family	$800/$1,600	$5,000/$12,500	$2,000/$4,000	$5,000/$12,500	$2,000/$4,000	$4,000/$8,000
Preventive Care Services	Plan pays 100%	Plan pays 70% (no deductible)	Plan pays 100%	Plan pays 60% (no deductible)	Plan pays 100%	Plan pays 60% (no deductible)
Referrals Required	Not Required		Not Required		Required	
Primary Care Physician (PCP) Required?	Not Required		Not Required		Required	
PCP Office Visit	$20 copay	Plan pays 70%*	$20 copay	Plan pays 60%*	$20 copay	Plan pays 60%*
Specialist Office Visit	$30 copay	Plan pays 70%*	$35 copay	Plan pays 60%*	$35 copay *Referral Required*	Plan pays 60%*
Diagnostic Laboratory	100% in office or Labcorp 100% in Outpatient Facility	Plan pays 70%*	Plan pays 100% in office or Labcorp Plan pays 100% in Outpatient Facility	Plan pays 60%*	Plan pays 100% in office or Labcorp Plan pays 80% in Outpatient facility	Plan pays 60%*
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	100% in office or 100% in Outpatient Facility	Plan pays 70%*	Plan pays 100% in office or Plan pays 100% in Outpatient Facility	Plan pays 60%*	Plan pays 100% in office or Plan pays 100% in Outpatient facility	Plan pays 60%*
Emergency Room	Plan pays 100% after $100 copay		Plan pays 100% after $100 copay		Plan pays 80% after $100 copay	
Inpatient Hospital	Plan pays 100%	Plan pays 70%* and $500 copay	Plan pays 80%*	Plan pays 60%* and $500 copay	Plan pays 80%*	Plan pays 80%*
Outpatient Surgery	Plan pays 100%	Plan pays 70%*	Plan pays 80%	Plan pays 60%*	Plan pays 100%	Plan pays 60%*
Vision Exam (At Aetna Vision Provider)	$15 copay	Not Covered	$15 copay	Not Covered	$15 copay	Not Covered
PRESCRIPTION BENEFITS	**RETAIL** (Up to a 30-day supply)	**MAIL ORDER** (Up to a 90-day supply)	**RETAIL** (Up to a 30-day supply)	**MAIL ORDER** (Up to a 90-day supply)	**RETAIL** (Up to a 30-day supply)	**MAIL ORDER** (Up to a 90-day supply)
Generic	$3	$5	$7	$18	$7	$18
Preferred Brand	$18	$36	$21	$52	$21	$52
Non-Preferred Brand	$46	$92	Member Pays the Difference	Member Pays the Difference	Member Pays the Difference	Member Pays the Difference

* After deductible

Monthly Employee Rates

Medical Benefits - Schools Health Insurance Fund (Aetna)

Rates effective 1/1/2020 to 6/30/2021 (18 months)

TIER/PLAN	Aetna Choice POS II $15	Aetna Choice POS II $15/$25	Aetna Choice POS II $20/$30	Aetna Choice POS II $20/$35	Aetna QPOS $10	Aetna QPOS $20	Aetna QPOS $20/$35
Single	$792.00	$769.00	$723.00	$622.00	$763.00	$663.00	$570.00
Parent/Child(ren)	$1,475.00	$1,432.00	$1,346.00	$1,158.00	$1,406.00	$1,234.00	$1,062.00
2 Adults	$1,586.00	$1,539.00	$1,447.00	$1,245.00	$1,528.00	$1,327.00	$1,142.00
Family	$2,268.00	$2,201.00	$2,069.00	$1,780.00	$2,184.00	$1,897.00	$1,632.00

Prescription Drug Benefits - Benecard

Rates effective 1/1/2020 to 6/30/2021 (18 months)

TIER/PLAN	Rx $3/$10	Rx $7/$16/$35	Rx $3/$18/$46	Rx $7/$21	Rx $3/$10	Rx $3/$18/$46	Rx $7/$21
Single	$245.64	$222.79	$215.91	$204.05	$245.64	$215.91	$204.05
Parent/Child(ren)	$456.88	$367.60	$421.72	$379.54	$456.88	$421.72	$379.54
2 Adults	$491.26	$467.85	$453.42	$428.51	$491.26	$453.42	$428.51
Family	$702.52	$637.17	$648.44	$489.72	$702.52	$648.44	$489.72

Combined Medical & Prescription Drug Rates

Rates effective 1/1/2020 to 6/30/2021 (18 months)

TIER/PLAN	Aetna Choice POS II $15 ($3/$10)	Aetna Choice POS II $15/$25 ($7/$16/$35)	Aetna Choice POS II $20/$30 ($3/$18/$46)	Aetna Choice POS II $20/$35 ($7/$21)	Aetna QPOS $10 ($3/$10)	Aetna QPOS $20 ($3/$18/$46)	Aetna QPOS $20/$35 ($7/$21)
Single	$1,037.64	$991.79	$938.91	$826.05	$1,008.64	$878.91	$774.05
Parent/Child(ren)	$1,931.88	$1,799.60	$1,767.72	$1,537.54	$1,862.88	$1,655.72	$1,441.54
2 Adults	$2,077.26	$2,006.85	$1,900.42	$1,673.51	$2,019.26	$1,780.42	$1,570.51
Family	$2,970.52	$2,838.17	$2,717.44	$2,269.72	$2,886.52	$2,545.44	$2,121.72

Chapter 78 Percentage of Premium Schedule

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

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

Salary Range (Annual)	Employee & Spouse OR Employee & Child(ren)
<$25,000	3.5%
25,000—29,999.99	4.5%
30,000—34,999.99	6%
35,000—39,999.99	7%
40,000—44,999.99	8%
45,000—49,999.99	10%
50,000—54,999.99	15%
55,000—59,999.99	17%
60,000—64,999.99	21%
65,000—69,999.99	23%
70,000—74,999.99	26%
75,000—79,999.99	27%
80,000—84,999.99	28%
85,000—99,999.99	30%
100,000 and over	35%

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

How to Calculate Your Contributions

The worksheet shown below can help you determine your estimated monthly contributions.

The example column shown below is for Employee Only coverage in the Aetna Choice POS II $15 Plan (ACPOS II $15) with the $3/$10 prescription drug plan. In this example, the employee earnings are $50,000 annually. Please use the columns labeled "Your Info" to calculate up to three different contribution scenarios and determine what your monthly payroll contribution will be.

ACPOS II $15

Employee Contribution Worksheet		Example	Your Info	Your Info	Your Info
Calculate Monthly Rate Percentage:					
1.	Use **MONTHLY RATE CHART** on previous page and enter the premium amount for your Medical and Prescription plan.	$1,037.64	**$**	**$**	**$**
2.	Use the **CHAPTER 78 SCHEDULE CHARTS** on the previous page to find your salary range and applicable percentage.	20%	**%**	**%**	**%**
3.	**CALCULATE YOUR MONTHLY CONTRIBUTION:** Multiply the monthly rate by the Chapter 78 percentage.	$207.53	**$**	**$**	**$**
Calculate Minimum Required Contribution: Employees must pay a minimum of 1.5% of Annual Salary					
4.	Enter your annual salary.	$50,000	$	$	$
5.	**MULTIPLY** your annual salary by 1.5% (Salary x 0.015).	X 0.015	**X 0.015**	**X 0.015**	**X 0.015**
6.	This is your 1.5% minimum annual percentage of salary.	$750	**$**	**$**	**$**
7.	**DIVIDE** the annual percentage on line #6 by 12 months	÷ 12	**÷**	**÷**	**÷**
8.	This is the minimum monthly amount you are required to contribute.	$62.50	**$**	**$**	**$**
Calculate Your Per Pay Contribution:					
9.	If the amount on line #3 is larger than the amount on line #8, enter it here. Otherwise, enter the amount on line #8. ***This is your estimated monthly contribution for Medical and Prescription Drug benefits.***	$207.53	**$**	**$**	**$**

DocFind Instructions: Aetna

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

Step 2: At the top of the webpage, click on **"Find a Doctor"**

Step 3: On the right side of the page under the section labeled **"Not a member yet"** 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 **" Select a Plan"**. Use the key below to help you make the correct selection.

Step 6: Click **"Continue"** to search for the type of provider.

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	Category Heading: Aetna Open Access Plans Plan Name: Aetna Choice POS II (Open Access)

Prescription Drug Information

Effective January 1, 2020, Benecard is the Pharmacy Benefit Manager for the school district. If you are enrolled in one of the medical plans, you are automatically enrolled in the corresponding prescription drug plan through Benecard.

How Do I Locate a Participating Pharmacy?

Your Benecard PBF prescription benefit program provides you with access to an extensive national pharmacy network including all major retail chains. To locate a participating pharmacy once your benefit begins, visit **www.benecardpbf.com** or call the Member Services number on the back of your ID card.

To Transfer a Current Prescription

Call member services at **888.907.0070**. Ask to transfer the prescription from your current pharmacy to Benecard.

Mail Order Program - Benecard Central Fill

To get started with the mail order program, have your doctor write you a new prescription and send it to Benecard. Forms can be located on the Benecard website at **www.benecardpbf.com**. Members can also have their physician fax their prescription to Benecard at **888.907.0040**. The physician must include the cardholder name, ID number, shipping address and date of birth. Only prescriptions faxed from a doctor's office will be accepted via fax.

There are 3 ways to request a refill after your first fill through Benecard mail order pharmacy:

- **Internet:** Visit **www.benecardpbf.com** - if you have not yet registered click on **"Register"**. If you are a registered user, login and select **"Mail Order"**.
- **Phone:** Call Member Services on the back of your ID card 24 hours a day, 7 days a week and the use the prompts to order your refills. Have your ID number and credit card information ready.
- **Mail:** Send the Refill Request Order Form provided with your last shipment back to Benecard Central Fill mail service in the pre-addressed envelope.

How Do I Order Specialty Medications?

Specialty medications can be ordered through the Benecard Central Fill mail order pharmacy. This can be done in the same manner you submit mail order prescriptions.

Dental Plan: Delta Dental

Below is an overview of the Delta Dental PPO Plus Premier Plan. The PPO network provides access to greater discounts and lower out-of-pocket expenses for members.

	PPO Plus Premier Plan
Calendar Year Maximum (per patient)	$2,000
Preventive & Diagnostic Exams, Cleanings, Bitewing X-rays (twice a calendar year) Fluoride Treatments (once a calendar year, children to age 19)	Plan pays 100%
Remaining Basic Fillings, Extractions, Oral Surgery Endodontics Periodontics Sealants	Plan pays 100%
Crowns Crowns & Crown-Related Procedures	Plan pays 100%
Prosthodontics Bridgework Dentures (Full and Partial)	Plan pays 50%
Orthodontia Benefits (child only)	Plan pays 50%
Orthodontia Lifetime Maximum (per patient)	$1,000

Oral Health Enhancement Program

- If you had periodontal surgery or scaling and root planing in the past while covered by Delta Dental of New Jersey, you should be automatically covered! You may have to submit additional information if the procedure was more than 2 years ago.
- Eligible members who have been previously treated for periodontal (gum) disease will receive up to four dental cleanings and/or periodontal maintenance procedures per benefit period.
- If you have not had Delta Dental of New Jersey benefits in the past or are newly eligible: You need to submit evidence to us of previous periodontal treatment to ensure your claims are processed under Oral Health Enhancement Option provisions. Information about how to submit previous treatment evidence is available at **www.deltadentalnj.com**. Click **"Members"** then **"Oral Health Enhancement"** under **"Additional Resources".**

Carryover Max Benefit

The Carryover Max Benefit allows you to carry over part of your unused standard annual maximum in one year to increase your benefits for the following year and beyond.

Member Advocacy

Do You Need Help Resolving a Benefits Issue?

Member Advocacy, provided by Conner Strong & Buckelew, allows you to speak to a specially trained and experienced Member Advocate who can help you get the most out of your benefits.

You can contact Member Advocacy for assistance if you:

- Believe your claim was not paid properly
- Need clarification on information from the insurance company
- Have a question regarding a bill from a doctor, lab or hospital
- Are unclear on how your benefits work
- Need information about adding or deleting dependents
- Need help resolving a benefits problem you've been working on

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

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm, EST
- 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 EST. After hours, you will be able to leave a message with a live representative and receive a respond by phone or email during business hours within 24 to 48 hours of your inquiry.

BenePortal: Online Benefits Resource

Your Benefits Information In One Place

BenePortal, powered by Wix, is the Lumberton Township Board of Education virtual employee benefits portal, providing access to company benefits programs, health and wellness information, recommended links, pertinent forms and guides, and a wealth of additional tools and resources.

BenePortal is available 24/7 to Lumberton Township Board of Education employees and their eligible dependents.

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

BenePortal features include:

- Secure online access - with **NO** login required
- Mobile optimized site
- Direct links to specific insurance carrier websites
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!

Guardian Nurses: Effective January 1, 2020

Struggling With a Healthcare Issue?

Guardian Nurses Healthcare Advocates Can Help

If you or a dependent is ill with a serious and/or catastrophic condition, changes are you could use some help.

Your Nurse Advocate can:

- **BE YOUR GUIDE**, coach and advocate for any healthcare issue.
- **MAKE APPOINTMENTS** to get you seen as quickly as possible.
- **GO WITH YOU TO SEE DOCTORS**, ask questions and get answers.
- **IDENTIFY PROVIDERS** for all care need and second opinions.
- **RESEARCH AND EXPLAIN EVERYTHING** so that you and your loved one understand the options and can make the best decisions.
- **HELP FAMILY MEMBERS** understand complex healthcare issues and explain treatment plans.
- **GET THINGS YOU NEED** such as covered healthcare services (i.e. medical equipment or items necessary for complex care).

With Guardian Nurses, your peace of mind is just a phone call away. Call **215.836.0260** or toll free **888.836.0260**. When calling, please reference Conner Strong & Buckelew and provide your school's name.

GUARDIAN™ NURSES
Healthcare Advocates

Telemedicine: Effective January 1, 2020

With telemedicine, you have access to high-quality care - at no cost!*

Telemedicine offers physician-based care around-the-clock at lowers 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 low cost telemedicine that can help improve outcomes, speed recovery and eliminate wait time.

Convenient Care From Board-Certified Physicians

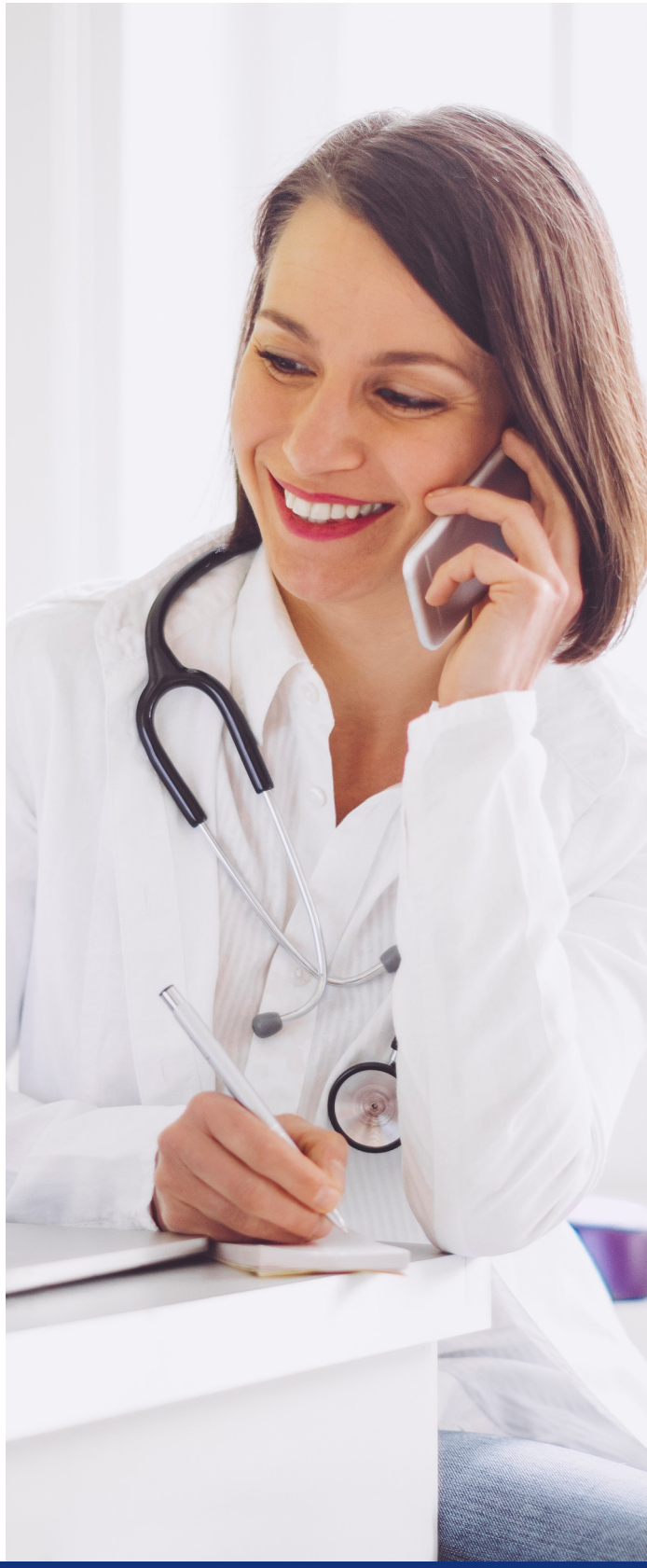
Plan Members can consult with a license physician by; calling a toll-free number; logging into a secure website; or using the mobile app. Physicians can prescribe medication when needed. A wide range of non-emergency conditions may be treated, including:

- Acne
- Allergies or respiratory problems
- Cold and flu
- Constipation, diarrhea, vomiting and stomach issues
- Urinary tract infections
- Ear problems
- Fever or headache
- Insect bites, rashes and skin irritations
- Pink eye

To Take Advantage of This Great Benefit, Contact:

Teladoc (for Aetna members)

- Call **1.855.Teladoc (835.2362)**
- Visit **www.Teladoc.com/Aetna**
- Go to **Teladoc.com/Mobile** to learn more or download the mobile app from the App Store or Google Play.



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/ADDRESS
Eligibility, enrollment, plan options, contributions, Qualifying Life Events, etc.	Please contact your School District's Business Office		
Medical Benefits—Aetna Benefit questions, claims, locating a provider, printing new ID Cards	**Aetna**—QPOS **Aetna**—ACPOSII	800.370.4526 855.281.8858	www.aetna.com
Telemedicine Effective January 1, 2020	**Teladoc**—Aetna Members	855.835.2362	www.teladoc.com/aenta
Nurse Advocacy Effective January 1, 2020	**Guardian Nurses**	888.836.0260	www.guardiannurses.com
Prescription Drug Benefits	**Benecard**	877.723.6005	www.benecard.com
Dental Benefits	**Delta Dental**	800.452.9310	www.deltadentalnj.com
New Hire Guide	**Office of SHIF Program Manager**	800.563.9929	www.connerstrong.com

Access Information On the Go!

The Aetna Apps allow members to access to ID cards and claims information, search for participating providers and pharmacies, refill prescriptions and much more—directly from your smartphone or mobile device. Download them today at the websites shown above.

Qualified Life Events

Your benefit elections and covered dependents will remain in place unless you experience one of the below **qualified life event**. If you **wish** to make an enrollment status or plan change due to one of these events, you must contact your personnel department within 30 days of the event.

- Marriage
- Birth or Adoption of a Child (must be reported within 60 days of the event)
- Loss or Reduction of Coverage for you or your spouse

Other Life Events:

If you experience one of these **life events**, you **must** notify your benefits administrator within 30 days of the event so your enrollment status can be updated accordingly.

- Death of a covered dependent
- Divorce

Legal Notices

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.

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.

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This Notice has information about your current prescription drug coverage with the Lumberton Township Board of Education Health Benefit Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Lumberton Township Board of Education has determined that the prescription drug coverage offered by the Lumberton Township Board of Education Health Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Lumberton Township Board of Education coverage will not be affected. If you elect Medicare Part D coverage, the Lumberton Township Board of Education coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Lumberton Township Board of Education coverage, be aware that you and your dependents will not be able to get this coverage back during the year without a qualifying event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Lumberton Township Board of Education and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at

least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact Human Resources. Please note that you will get this notice each year. You also may request a copy of this notice at any time.

More Information About Your Options Under Medicare the Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 TTY users should call 1-800-325-0778.

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 2019
Sender:	Lumberton Township Board of Education
Contact:	Business Office
Address:	33 Municipal Drive Lumberton, NJ 08048
Phone Number:	(609) 267-1406

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.

Lumberton Township Board of Education 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.

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 July 31, 2019. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

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+ Website: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/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: 573-751-2005

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

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/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 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://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
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
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311

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: http://gethipptexas.com/
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: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, 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