2021-2022

EMPLOYEE BENEFITS GUIDE

NON-REPRESENTED STAFF HIRED BEFORE 7/1/2020

Lumberton 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 LUMBERTON BOARD OF EDUCATION!

Questions?

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

Inside This Guide

DEPENDENT ELIGIBILITY INFORMATION

Eligible Dependents

- 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 for medical and prescription coverage - regardless of marital, student, or financial dependency status. Even if they no longer live with the parents. Includes step children, foster child.
- For dental coverage, dependents are covered up to age 19, and up to age 23 if a full-time student at an accredited school, college, or university. Includes step children, foster child.
- Legally adopted or any child in a guardianship relationship.
- A covered child not capable of self support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability. Coverage for children with disabilities may continue only while the child is unmarried or does not enter into a civil union or domestic partnership, and the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.

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 Betsy Zeng (in the Payroll & Benefits Office) for monthly premium rates and enrollment forms.

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 Non-Represented Employees section of your BenePortal site for a copy of the enrollment or waiver form. **Completed forms must be returned to Betsy Zeng (in the Payroll and Benefits 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 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.

MEDICAL PLAN OPTIONS

SHIF-AETNA

The school district participates in the Schools Health Insurance Fund (SHIF) for medical benefits. The SHIF is comprised of many school districts that have joined together to purchase their health benefits. Through the SHIF, Lumberton offers to Non-Represented employees hired before 7/1/2020 the following medical plan options, administered by Aetna. Employees enrolled in the NJEHP for medical coverage must also be enrolled in the NJEHP prescription plan administered through Benecard. **NOTE:** Dependents are eligible for benefits until the end of the calendar year that he/she turns 26.

	NJEHP	CHOICE POS II $10	CHOICE POS II $15
IN-NETWORK BENEFITS			
Calendar Year Deductible Individual Family	None	None	None
Out-of-Pocket Maximum Individual Family	$500 $1,000	$400 $800	$400 $800
Member Coinsurance	10%	10%	10%
PCP Required/Referral Required for Specialist Visit	No	No	No
Preventive Services	100% Covered	100% Covered	100% Covered
PCP Office Visits	$10 Copay	$10 Copay	$15 copay
Specialist Office Visit	$15 Copay	$10 Copay	$15 copay
Diagnostic Lab & X-Ray	100% Covered	100% Covered in office, LabCorp, and Outpatient Facility	100% Covered in office, LabCorp, and Outpatient Facility
Inpatient Hospital	100% Covered	100% Covered	100% Covered
Outpatient Surgery	100% Covered	100% Covered	100% Covered
Ambulance	10% Coinsurance	10% coinsurance	10% coinsurance
Emergency Room	$125 Copay	$25 Copay	$50 Copay
Durable Medical Equipment	10% Coinsurance	10% coinsurance	10% coinsurance
Vision Exam Materials	$15 Copay* N/A	$10 Copay* Refer to Aetna Vision Gold Plan	$10 Copay* Refer to Aetna Vision Gold Plan
OUT-OF-NETWORK BENEFITS			
Deductible Individual Family	$350 $700	$100 $250	$100 $250
Out-of-Pocket Maximum Individual Family	$2,000 $5,000	$2,000 $5,000	$2,000 $5,000
Coinsurance (% Plan Pays)	70%**	80%**	70%**

* Once every calendar year.
** After deductible.

The above is an overview of your medical plan option and does not contain all of the benefits or limitations that may apply to the plan. Please see the plan document from the carrier for greater detail.

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	CHOICE POS II $15/$25	QPOS $10	QPOS $20
IN-NETWORK BENEFITS			
Calendar Year Deductible Individual Family	None	None	None
Out-of-Pocket Maximum Individual Family	$400 $800	$4,000 $8,000	$4,000 $8,000
Member Coinsurance	10%	None	None
PCP Required/Referral Required for Specialist Visit	No	Yes	Yes
Preventive Services	100% Covered	100% Covered	100% Covered
PCP Office Visits	$15 copay	$10 copay	$20 copay
Specialist Office Visit	$25 copay	$10 copay	$20 copay
Diagnostic Lab & X-Ray	100% Covered in office, LabCorp, and Outpatient Facility	100% Covered in office, LabCorp, and Outpatient Facility	100% Covered in office, LabCorp, and Outpatient Facility
Inpatient Hospital	100% Covered	100% Covered	100% Covered
Outpatient Surgery	100% Covered	100% Covered	100% Covered
Ambulance	10% coinsurance	100% Covered	100% Covered
Emergency Room	$75 Copay	$35 copay	$100 copay
Durable Medical Equipment	10% coinsurance	100% Covered	100% Covered
Vision Exam Materials	$10 copay* Refer to Aetna Vision Gold Plan	$10 copay* Refer to Aetna Vision Gold Plan	$10 copay* Refer to Aetna Vision Gold Plan
OUT-OF-NETWORK BENEFITS			
Deductible Individual Family	$100 $250	$500 $1,000	$500 $1,000
Out-of-Pocket Maximum Individual Family	$2,000 $5,000	$4,000 $8,000	$4,000 $8,000
Coinsurance (% Plan Pays)	70%**	60%**	60%**

* Once every calendar year.
** After deductible.

The above is an overview of your medical plan option and does not contain all of the benefits or limitations that may apply to the plan. Please see the plan document from the carrier for greater detail.

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	CHOICE POS II $20/$30	CHOICE POS II $20/$35	QPOS $20/$35
IN-NETWORK BENEFITS			
Calendar Year Deductible Individual Family	None	$200 $400	None
Out-of-Pocket Maximum Individual Family	$800 $1,600	$2,000 $4,000	$4,000 $8,000
Member Coinsurance	10%	20%	None
PCP Required/Referral Required for Specialist Visit	No	No	Yes
Preventive Services	100% Covered	100% Covered	100% covered
PCP Office Visits	$20 copay	$20 copay	$20 copay
Specialist Office Visit	$30 copay	$35 copay	$35 copay
Diagnostic Lab & X-Ray	100% Covered in office, LabCorp, and Outpatient Facility	100% Covered in Office 80% Covered in LabCorp and Outpatient Facility	100% Covered in Office, LabCorp, and Outpatient Facility
Inpatient Hospital	100% covered	80% Covered	100% covered
Outpatient Surgery	100% covered	80% covered	100% covered
Ambulance	10% Coinsurance	20% Coinsurance	100% Covered
Emergency Room	$100 copay	$100 copay	80% covered after $100 copay
Durable Medical Equipment	10% Coinsurance	20% Coinsurance	$100 copay
Vision Exam Materials	$10 copay* Refer to Aetna Vision Gold Plan	$10 copay* Refer to Aetna Vision Gold Plan	$10 copay* Refer to Aetna Vision Gold Plan
OUT-OF-NETWORK BENEFITS			
Deductible Individual Family	$200 $500	$800 $2,000	$500 $1,000
Out-of-Pocket Maximum Individual Family	$5,000 $12,500	$5,000 $12,500	$4,000 $8,000
Coinsurance (% Plan Pays)	70%**	60%**	60%**

* Once every calendar year.
** After deductible.

The above is an overview of your medical plan option and does not contain all of the benefits or limitations that may apply to the plan. Please see the plan document from the carrier for greater detail.

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 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.**

LOCATE PARTICIPATING PROVIDERS

Aetna DocFind Provider Search

STEP 1: Go to **www.aetna.com**

STEP 2: Click on **"Find a Doctor"** located at the top of the screen.

STEP 3A: If you are already a registered member on Aetna's website please click **"Find a Provider"** on the left hand side and follow the prompts to search for a provider

STEP 3B: If you are not a member, click **"Plan from an employer"** on the right hand side. When you reach the following page, scroll to the bottom to **"Continue as a Guest"** and enter a zip code, city, state or country and click **"Search"**

STEP 4: You will then be asked to **"Select a Plan"**. Use the key below to make the correct selection.

STEP 5: On the following page enter what type of provider you are searching for (i.e. PCP, Specialist) and click **"Enter"** and your results will pop up. You can also find a provider by category by scrolling down and choosing the appropriate provider category

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)

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.

Get Started With Teladoc Today

To take advantage of this great benefit, contact MDLIVE 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

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

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 Lumberton:

Plans	Emergency Room Copay	Urgent Care Copay	Estimated Savings
NJEHP	$125	$15	$110
POS/PPO $10	$25	$10	$15
POS/PPO $15	$50	$15	$35

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 prescription must also be enrolled in the NJEHP for medical coverage through the SHIF. **NOTE:** Dependents are eligible for benefits until the end of the calendar year that he/she turns 26.

	NJEHP	RX $3/$10/$10	RX $7/$16/$35	RX $3/$18/$46	RX $7/$21
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)					
Generic	$5 Copay	$3 copay	$7 copay	$3 copay	$7 copay
Brand Without Generic Alternative	$10 Copay	$10 copay	$16 copay	$18 copay	$21 copay
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic & Brand Drug	$10 copay	$35 copay	$46 copay	$21 copay
MAIL ORDER (UP TO A 90-DAY SUPPLY)					
Generic	$10 Copay	$5 copay	$18 copay	$5 copay	$18 copay
Brand Without Generic Alternative	$20 Copay	$15 copay	$40 copay	$36 copay	$52 copay
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic & Brand Drug	$15 copay	$88 copay	$92 copay	$52 copay

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 Only).
- **Step Therapy**: Requires a trial with a lower cost medication before the member is given approval for a higher cost medication, when clinically appropriate. If a member purchases the higher cost medication without prior approval, then the medication will not be covered. (Applies to NJEHP Only).
- **Formulary List:** A guide for selecting clinically and therapeutically appropriate medications. This list includes a majority of brand and generic medications, and also lists certain medications which will not be covered. The formulary updates throughout the year, and brand name drugs may move to non-formulary status if a generic version becomes available during the year. For the most up to date version, please visit the Benecard website using the following link: **www.benecardpbf.com/PBF**

SAVE MONEY USING MAIL ORDER

BENECARD

HOW MUCH CAN YOU SAVE WHEN USING MAIL ORDER?

COMPARE FOR YOURSELF...

NJEHP		
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 $3/$10/$10		
RETAIL PHARMACY	**MAIL ORDER**	**ANNUAL SAVINGS**
Generic Copay **$3**	Generic Copay **$5**	**$16**
Annual Cost *($3 per month x 12 fills)* **$36**	Annual Cost *($5 per order x 4 fills per year)* **$20**	
Preferred Brand Copay **$5**	Preferred Brand Copay **$15**	**$60**
Annual Cost *($5 per month x 12 fills)* **$120**	Annual Cost *($15 per order x 4 fills per year)* **$60**	

MONTHLY EMPLOYEE RATES

MEDICAL BENEFITS - SCHOOLS HEALTH INSURANCE FUND (AETNA)

COVERAGE LEVEL	*NJEHP POS $10/$15	Aetna Choice POS II $10	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	$820.00	$878.00	$836.00	$812.00	$763.00	$657.00	$805.00	$700.00	$602.00
Parent/Child	$1,527.00	$1,635.00	$1,557.00	$1,511.00	$1,421.00	$1,222.00	$1,484.00	$1,302.00	$1,121.00
2 Adults	$1,641.00	$1,758.00	$1,674.00	$1,624.00	$1,527.00	$1,314.00	$1,613.00	$1,401.00	$1,205.00
Family	$2,347.00	$2,514.00	$2,394.00	$2,323.00	$2,184.00	$1,879.00	$2,305.00	$2,002.00	$1,723.00

PRESCRIPTION BENEFITS - BENECARD/RX ALLIANCE

COVERAGE LEVEL	*NJEHP Rx $5/$10	Rx $3/$10	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	$225.79	$262.83	$262.83	$238.39	$231.02	$218.33	$262.83	$231.02	$218.33
Parent/Child	$380.33	$488.86	$488.86	$393.33	$451.24	$406.11	$488.86	$451.24	$406.11
2 Adults	$459.09	$525.65	$525.65	$500.60	$485.16	$458.51	$525.65	$485.16	$458.51
Family	$654.72	$751.70	$751.70	$681.77	$693.83	$524.00	$751.70	$693.83	$524.00

COMBINED - MEDICAL AND PRESCRIPTION RATES

COVERAGE LEVEL	*NJEHP POS $10/$15 $5/$10	Aetna Choice POS II $10 $3/$10	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	$1,045.79	$1,140.83	$1,098.83	$1,050.39	$994.02	$875.33	$1,067.83	$931.02	$820.33
Parent/Child	$1,907.33	$2,123.86	$2,045.86	$1,904.33	$1,872.24	$1,628.11	$1,972.86	$1,753.24	$1,527.11
2 Adults	$2,100.09	$2,283.65	$2,199.65	$2,124.60	$2,012.16	$1,772.51	$2,138.65	$1,886.16	$1,663.51
Family	$3,001.72	$3,265.70	$3,145.70	$3,004.77	$2,877.83	$2,403.00	$3,056.70	$2,695.83	$2,247.00

* Please note, the NJ Educator Plan for medical and prescriptions benefits must be selected together. Employee contributions for this plan are based on the new Chapter 44 Contribution Scale. All other options apply to the Chapter 78 and/or Collectively Bargained employee contributions.

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.

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

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

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

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

NJ EDUCATOR'S HEALTH PLAN (NJEHP)

CHAPTER 44 SALARY BASED CONTRIBUTION SCHEDULE

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

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

Please Note:

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

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 eligible for benefits from age 2 to age 19, or up to age 23 for full-time students enrolled in an accredited school, college, or university..

IN-NETWORK BENEFITS	PPO PLUS PREMIER PLAN
Calendar Year Deductible	
Individual	$0
Family	$0
Calendar Year Maximum (per patient)	$2,000
Preventive & Diagnostic Services	
Exams, Cleanings, Bitewing X-rays (each twice in a calendar year)	100%
Fluoride Treatment (Once in a calendar year, children to age 19)	100%
Basic Services	
Fillings, Extractions	100%
Endodontics (root canal)	100%
Periodontics, Oral Surgery	100%
Major Services	
Crowns, Gold Restorations	100%
Bridgework	50%
Full and Partial Dentures	50%
Orthodontic Benefits	
Full Comprehensive Treatment (Children Only)	50%
Lifetime Maximum (per patient)	$1,000

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

DENTAL PLAN ENHANCEMENTS

DELTA DENTAL OF NEW JERSEY

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 two 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 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.

BENEPORTAL

ONLINE BENEFITS RESOURCE

At Lumberton 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.lumbertonboebenefits.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**.

MEMBER ADVOCACY

CONNER STRONG & BUCKELEW

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 a dependent
- Need help to resolve a problem you've been working on

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

How to Contact Member Advocacy?

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

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

VALUE-ADDED SERVICES

CONNER STRONG & BUCKELEW

Benefit Perks

This feature provides a broad array of services, discounts and special deals on consumer services, travel services, recreational services and much more. Simply access the site and register and you can begin using it now.

Learn more at: **www.connerstrong.corestream.com**

GlobalFit Gym Discount Program

GlobalFit offers discounts at more than 10,000 gyms nationwide. Members also get exclusive savings on home health and fitness products from top brands nationwide!

Learn more about GlobalFit by calling **800.294.1500** or visit **www.globalfit.com/connerstrong**

GoodRX

Compare drug prices at local and mail-order pharmacies and discover free coupons and savings tips.

Learn more at: **www.goodrx.com**

HealthyLearn

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

Learn more at: **www.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
Benefit Inquiries	**Please contact your school district's Business Office**		
Medical Benefits Benefit questions, claims, locating	**Aetna** - QPOS **Aetna** - ACPOSII	800-370-4526 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.benecard.com/pbf
Dental Benefits Benefit questions, claims, locating a provider, printing new ID cards	**Delta Dental**	800-452-9310	www.deltadentalnj.com
Plan Options, Benefit Questions and Claims Issues	**Member Advocacy**	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 Betsy Zeng, Payroll/Benefits, 609-267-1406, ext. 6907. 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 Lumberton Township Board of Education		4. Employer Identification Number (EIN) 21-6000244
5. Employer Address 33 Municipal Drive		6. Employer phone number 609-267-1406
7. City Lumberton	8. State NJ	9. Zip Code 08048
10. Who can we contact about employee health coverage at this job? Betsy Zeng, Payroll/Benefits		
11. Phone number (if different from above) 609-267-1406 ext. 6907	12. Email address BZeng@lumberton.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. Eligible employees are: All full-time contracted staff working at least 30 hours per week. Support staff employees working at least 30 hours per week.
- With respect to dependents:
  - We do offer coverage. Eligible dependents are: Dependent children to the end of the year they turn 26. Spouse, Civil Union, or Domestic Partner.
- 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.

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.

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 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.

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

LEGAL NOTICES

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:	March 2021
Sender:	Lumberton Township Board of Education
Contact:	Business Office
Address:	33 Municipal Drive Lumberton, NJ 08048
Phone Number:	(609) 267-1406

Newborns' and Mothers' Health Protection Act
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. 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

LEGAL NOTICES

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

CALIFORNIA - Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-445-8322
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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
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
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: 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
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

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://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

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

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
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: http://www.mass.gov/eohhs/gov/departments/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

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

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 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://dma.ncdhhs.gov/
Phone: 919-855-4100

LEGAL NOTICES

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

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

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: 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
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

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

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/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, 2021, 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

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