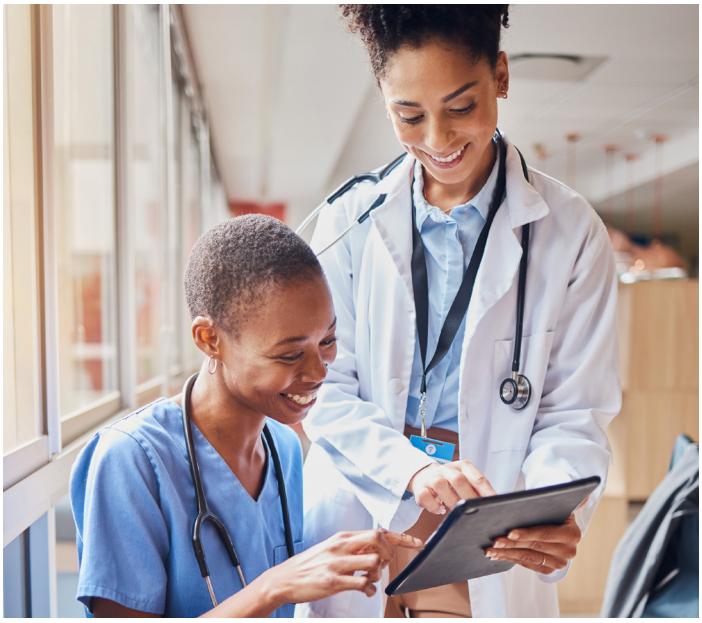
RIVERSIDE
TOWNSHIP













2027 EMPLOYEE BENEFITS GUIDE

For the coverage period ending on December 31, 2027



Welcome To Riverside Township!

Questions?

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



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Welcome



At Riverside Township we are committed to providing our employees with a comprehensive, valuable benefits package and the resources you need to understand all the options available to you.

As an employer, we recognize that our team members are our most valuable asset. The health and well-being of our team members and that of your families is important to us as is the overall health and well-being of the organization. This is why we are committed to sustaining the high value benefit plans we make available.

We encourage you to carefully review this guide to familiarize yourself with our 2027 benefit offerings and ensure that you are making the best benefits decisions for you and your eligible family members.

What Do You Need to Do Now?

In order to enroll in medical, prescription, and/or dental coverage, you must submit an enrollment form to Human Resources. Please refer to your BenePortal site to obtain a copy of the enrollment form.

For questions regarding your monthly employee contributions please reach out to Human Resources.

Who is Eligible to Elect Benefits?

Full-time employees who work 32 or more hours per week.

When Do Waiting Periods End?

Eligible employees are covered 60 days from date of hire.

Qualified Life Events

You cannot make changes to your elections or covered dependents during the plan year until the next Open Enrollment period unless you experience a qualified life event. To make a change, you must contact your personnel department within 60 days of the event. Qualified life events include:

- Marriage
- Loss or reduction of coverage for
- you or your spouse
- Birth or adoption of a child (90 Days)
- Death of a covered dependent
- Divorce

General Enrollment

- An eligible individual and any eligible dependents (Child(ren)/Spouse) may enroll regardless of health status, age, or requirements for health services within 60 days and extended to 90 days for Birth.
- Newly Eligible individual and eligible dependents may enroll within 60 days, extended to 90 days for Birth.
- Eligible individuals or dependents who are eligible for enrollment but do not enroll within the first 60 days following eligibility, may be enrolled during any subsequent Open Enrollment period.



About Dependents

Who is a Dependent?

- Spouse or Civil Union Partner
- A newborn child is covered for 90 days from the date of birth. To continue coverage beyond this initial period, the newborn child must be enrolled within the initial 90 day period.
- To continue coverage for a handicapped child evidence of the child's incapacity and dependency must be provided to the carrier at least 31 days prior to the termination of coverage.
- Under the Patient Protection and Affordable Care Act: A child is defined as an enrollee's child until age 26, regardless of the child's martial, student, or financial dependency status even if the young adult no longer lives with his or her parents (for medical and prescription coverage).

Child Dependent Coverage Timeframes

- **Medical Coverage:** Young adults will be covered through the end of the year in which they turn age 26.
- **Prescription Coverage:** Young adults will be covered through the end of the year in which they turn 26.
- **Dental Coverage:** Dependent children are covered until the end of the calendar year in which age 26 is attained.

Dependents Coverage to Age 31

Your dependent(s) under 31 can be covered by electing to continue coverage for young adults after age 26. DU31 is a New Jersey law that allows children older than the child-dependent age in a parents' coverage to elect to remain covered until age 31, if certain other eligibility standards are met. Go to **www.state.nj.us/dobi/division_consumers/du31.html** for more information regarding dependent coverage to
age 31.

Family Status Change

A family status change is a personal event that can have an impact on many aspects of your employee benefits (pension, life insurance, health insurance, etc.). Use this as a guide to updating information pertaining to your pension and benefits for the following family status changes:

- Marriage, civil union, or domestic partnership;
- Addition of a newborn child, adopted child, stepchild, foster child, or legal ward to your family;
- Divorce or dissolution of a civil union or domestic partnership; or
- Death of a family member

In the event of a family status change, you should immediately update your personnel records with your Human Resources representative or Benefits Administrator.

Employee Resources

Benefits Member Advocacy Center

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits MAC can help guide the way!

The Benefits Member Advocacy Center (Benefits MAC), provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

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

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

How to Contact Member Advocacy?

- 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**
- Via fax: **856.685.2253**

BenePortal

Online Benefits Information

At Riverside Township, you have access to a full-range of valuable employee benefit programs. With BenePortal, you are able to review your current employee benefit plan options online, 24 hours a day, 7 days a week!

- By using BenePortal, our online tool that houses our benefit program information, you can:
- Review medical/prescription drug, vision, and dental plan options
- Explore additional employee resources available to you
- Find links to carrier websites
- Download plan documents, forms, etc.

Logging into BenePortal is easy! Simply visit **www.riversidetownshipbenefits.com** from your computer, tablet or smartphone!





Medical Plan Benefits
Aetna

Riverside Township offers the following medical plan options to their staff, administered by Aetna.

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

	Aetna Choice POS II $10 (Open Access)	Aetna Choice POS II $15 (Open Access)	Aetna HMO $10 Copay
IN-NETWORK BENEFITS			
Deductible Individual / Family	None	None	$100 for DME Only
Out-of-Pocket Maximum Individual / Family	$400/$1,000	$400/$1,000	$6,960/$13,920
Preventive Care Services	No Charge	No Charge	No Charge
PCP Office Visits	$10 copay	$15 copay	$10 copay
Specialist Office Visit	$10 copay	$15 copay	$10 copay
Diagnostic Laboratory	No Charge	No Charge	No Charge
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	No Charge	No Charge	No Charge
Emergency Room	$25 copay	$50 copay	$35 copay
Urgent Care Center	$10 copay	$15 copay	$10 copay
Inpatient Hospital	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	No Charge
OUT-OF-NETWORK BENEFITS			
Deductible Individual / Family	$100/$250	$100/$250	N/A
Out-of-Pocket Maximum Individual / Family	$2,000/$5,000	$2,000/$5,000	N/A
Coinsurance	20%	30%	N/A

* The above overview is being provided as a reference and does not contain all the benefits or limitations of the plan. Please refer to the carrier plan documents for further details.



Telemedicine
CVS Virtual Care

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. CVS Virtual Care provides lost cost telemedicine that can help improve outcomes, speed recovery and eliminate wait time.

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

When to Use CVS Virtual Care

CVS Virtual Care doctors can treat a wide range of non-emergency conditions, including:

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

Mental Healthcare Services

Telemedicine services include mental healthcare. This allows members to have 24/7 video access to licensed psychiatrists, therapists, and psychologists to help treat a broad range of issue. Common conditions members may utilize the services for are:

- Anxiety/Stress
- Depression
- Work Pressures
- ADHD

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

Get Started With CVS Virtual Care Today

To take advantage of this great benefit, contact CVS Virtual Care in any of the following ways:

- Via the web: **CVS.com/virtual-care**

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

Maximize Your Benefits

Using In-Network Providers

Consider Your In-Network Options First

You will typically pas less for covered services when you visit providers that are part of your medical plan'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 case 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 mount you are required to pay out-of-pocket may be significant.**

Using In-Network Labs

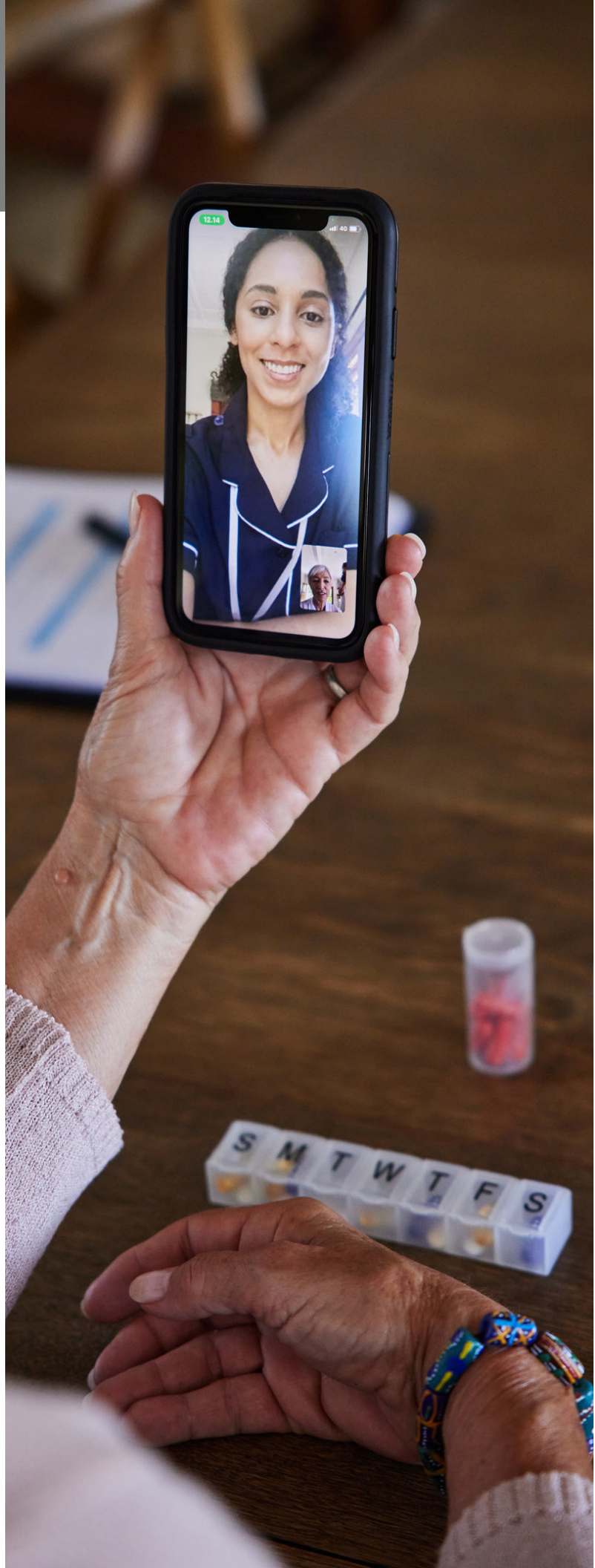
Aetna plan members may us either Quest Diagnostics or LabCorp for lab work.

Save Time and Money With Urgent Care Centers!

Urgent Care Centers are a convenient, cost-effective medical care alternative when your primary care physician is unavailable. Urgent Care Centers copay match your Specialist copay. 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.

To find a clinic near you, contact your medical carrier to locate a facility.

If your medical need is more than urgent or life-threatening, please go right to the Emergency Room.



How to Find In-Network Providers
Aetna

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

STEP 2: At the middle of the webpage on the right, click on "**Find a Doctor**"

STEP 3: On the right side of the page under Guest, select "**Plan from an employer**" (1st choice on the list)

STEP 4: Under Continue as a Guest, enter your zip code, city, state or county

STEP 5: You will be asked to "**Select a Plan**". Use the key below to help you make the correct selection:

IF YOU ARE ENROLLING IN AN....	DOCFIND PLAN SELECTION IS...
Aetna Choice POS II Plan	Category Heading: Aetna Open Access Plans Plan Name: Aetna Choice POS II (Open Access)
Aetna HMO	Category Heading: Aetna Standard Plan Plan Name: HMO







Minute Clinics & Health Hubs

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

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

CVS Minute Clinic Practitioners Can:

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

minute clinic®

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

Health Hubs Offer the Following Services:

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

HealthHUB®

Prescription Drug Benefits
Express Scripts

Riverside Township offers the following prescription plan options to their staff, administered by Express Scripts.
NOTE: Dependents are eligible for benefits until the end of the year that he/she turns 26.

RETAIL	UP TO A 30-DAY SUPPLY
Generic	$3 copay
Brand Without Generic Alternative	$10 copay
Brand With Generic Alternative	Member pays the applicable brand copay plus the cost difference between the brand drug & generic
MAIL ORDER	**UP TO A 90-DAY SUPPLY**
Generic	$0 copay
Brand Without Generic Alternative	$15 copay
Brand With Generic Alternative	Member pays the applicable brand copay plus the cost difference between the brand drug & generic

* The above overview is being provided as a reference and does not contain all the benefits or limitations of the plan. Please refer to the carrier plan documents for further details.

Mandatory Mail Order Program

Employees must use the mail order program through Express Scripts for maintenance medications. Once the initial prescription and two refills are filled at the retail pharmacy, the mail order program is mandatory for coverage of the ongoing prescriptions. This means you are required to transition to mail order or pay the full cost of the medication.

Please Note:

- The prescription drug plan has dispensing limits when you receive your medication from a retail pharmacy. You may receive up to a 30 day supply at a retail pharmacy.
- Prior authorizations, clinical review and step therapy may apply to certain medications. Please refer to the Express Scripts formulary listing for more information or contact Express Scripts directly at 800.462.2006.



Additional Prescription Information
Express Scripts

The following additional features will apply to prescription drug coverage:

- **Mandatory Generics:** Pharmacists must dispense the generic equivalent medication when available. If a member fills the brand name drug instead, they will be responsible for the brand drug copay plus the difference in cost between the brand and generic medication.
- **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.
- **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 tatus if a generic version becomes available during the year. For the most up to date version, please visit the Express Scripts website using the following link: www.express-scripts.com.





Get Quality Care from Anywhere

Save Time and Money!

Avoid long waits at the Emergency Room and reduce your out-of-pocket costs by utilizing Telemedicine and Urgent Care Centers for ailments that are not life-threatening. Both of these options provide fast, effective care—when you need care fast.

Know Where to Get Care

Visits to the ER can be very costly, so before you go to the ER, consider whether your condition is truly an emergency or if you can receive care from Telemedicine or at an Urgent Care Center instead.

Telemedicine	Urgent Care Center	Emergency Room
• Cold/Flu • Allergies • Animal/ insect bite • Bronchitis • Skin problems • Respiratory infection • Sinus problems • Strep throat • Pink eye/ Eye irritation • Urinary issues	• Allergic reactions • Bone x-rays, sprains or strains • Nausea, vomiting, diarrhea • Fractures • Whiplash • Sports injuries • Cuts and minor lacerations • Infections • Tetanus vaccinations • Minor burns and rashes	• Heart attack • Stroke symptoms • Chest pain, numbness in limbs or face, difficulty speaking, shortness of breath • Coughing up blood • High fever with stiff neck, confusion or difficulty breathing • Sudden loss of consciousness • Excessive blood loss

How to Access Telemedicine 24/7

$0 Cost Telemedicine VS. Virtual Office Visits

Please note that Telemedicine services are different from virtual/telephonic office visits with your participating provider. Most Health Plans have a $0 copay for the Telemedicine services (CVS Virtual Care) listed below.

Virtual/Telephonic Office Visits with your participating provider may require a copay or coinsurance in accordance with your specific health plan. For more information on your cost-share for virtual office visits, please consult your insurance carrier at the customer service number on the back of your ID card.

Contact CVS Virtual Care

- Visit **www.CVS.com/virtual-care**

Dental Benefits
Delta Dental

Below is a summary of the dental plan option available to you and your family, administered by Delta Dental. For additional information regarding your dental contributions, please refer to Human Resources for assistance.
NOTE: Dependent children are eligible for benefits from age 2 until the end of the year in which they turn 26.

	PPO PLUS PREMIER ADVANTAGE PROGRAM
BENEFITS	**IN-NETWORK**
Calendar Year Deductible Individual Family Aggregate	 $50 $150
Calendar Year Maximum (per patient)	$2,000
Preventive Care Exams, Cleanings, Bitewing X-rays (each twice in a calendar year) Fluoride Treatment (once in a calendar year, children to age 19)	100%
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	80%
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	50%
Orthodontia Benefits (children age 19 and below)	50%
Orthodontia Lifetime Maximum (per patient)	$1,000

NOTE: This summary 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. Over 300,000 participating dental offices nationwide participate with the national Delta Dental system, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member. Maximum benefit may be derived by utilizing the services of a participating dentist.

* The above overview is being provided as a reference and does not contain all the benefits or limitations of the plan. Please refer to the carrier plan documents for further details.

Finding a Dental Provider

- Visit **www.deltadental.com**
- Once there, you may sign into your account or continue as a guest.
- Choose a plan to start (i.e. Delta Dental Premier Advantage Program).
- Click Search by Current Location and enter your ZIP Code to limit options.



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.

Visit: **https://connerstrong.corestream.com**

HUSK Wellness

HUSK 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 HUSK by visiting **www.huskwellness.com/connerstrong**

GoodRX

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

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

HealthyLearn

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

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





Questions?
Who to Call

QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE/ADDRESS
Eligibility, enrollment, plan options, contributions, Qualifying Life Events, etc.	Member Advocacy	800.563.9929	www.connerstrong.com/memberadvocacy
Medical Benefits	Benecard	888-907-0070	www.benecardpbf.com
Benefit questions, claims, locating a provider, printing new ID Cards	Aetna	800.370.4526	www.aetna.com
Prescription Benefit	Express Scripts	800.467.2006	www.express-scripts.com
Dental Benefits	Delta Dental	Please see reverse side of your ID card	Please see reverse side of your ID card
Telemedicine	CVS Virtual Care	888-607-4287	CVS.com/virtual-care

Access Information On the Go!

The Aetna Mobile App allow members to access to ID cards and claims information, search for participating providers and much more—directly from your smartphone or mobile device. Download the app today at the website shown above.

Legal Notices

Premium Assistance Under Medicaid & 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, 2026. Contact your State for more information on eligibility –

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

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

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

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

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

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

Illinois – Medicaid
Illinois Medicaid Premium Assistance Information
Medicaid application website: https://abe.illinois.gov
HIPP Hotline Number: 217-524-8268
HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/medicaid/plans-programs/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

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

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

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

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

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

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

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

Legal Notices

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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

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

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

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

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

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

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

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

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

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

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

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

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

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

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

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

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

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

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Insurance Marketplace Notice

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

How Can I Get More Information?

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

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer Name Riverside Township	**4. Employer Identification Number (EIN)** 2160001068	
5. Employer Address 237 S. Pavilion Ave	**6. Employer phone number** (856)461-1460	
7. City Riverside	**8. State** NJ	**9. Zip Code** 08075
10. Who can we contact about employee health coverage at this job? Meghan Jack, Township Administrator		
11. Phone number (if different from above) (856)461-1460, ext. 4	**12 Email address** mjack@riversidetwp.org	

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.



ABOUT THIS BENEFITS SUMMARY

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