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B E N E F I T S G U I D E

WELCOME

to Cherry Hill Township!

As a new benefits-eligible employee, you may elect to enroll in the health and welfare plans described in this guide, following 60 days of employment.



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Cherry Hill Township 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.

Questions?

*If you have questions about your benefits, please contact our Member Advocacy Team at **800.563.9929** (Monday through Friday, 8:30 am to 5:00 pm ET) or go to **www.connerstrong.com/memberadvocacy** and complete the fields.*

What You Need to Know Before Enrolling in Benefits

When Does Coverage Begin?

Coverage will be effective following 60 days of employment.

To Enroll in Benefits

To enroll in one or more of the benefits detailed in this Guide you must submit enrollment forms to the Human Resources Department. Enrollment forms may be found via www.CherryHillTwpBenefits.com under the **New Hires** tab.

If you are enrolling a spouse and/or child(ren) dependents, you must provide the necessary substantiation documents. A list of requirements can be found via www.CherryHillTwpBenefits.com under the **New Hires** tab.

Making Plan Changes

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

If an eligible dependent had other coverage and such coverage is lost, the eligible dependent may be eligible for enrollment during a "special enrollment period", which is usually the 31-day window following the date that other coverage was lost, due to a qualified change in status. Please provide proof from the other plan that coverage is being lost, such as a termination letter.

To Waive Benefits

Full time employees who are eligible for Township benefits may elect to receive a rebate if they waive medical/prescription drug insurance coverage and/or dental coverage. Rebate amounts and the timeline for reimbursement can be found on the Insurance Rebate Request Form which is available via

www.CherryHillTwpBenefits.com.

If you are waiving benefits and applying for a rebate, you must complete the following forms:

- Insurance Rebate Request Form
- Cafeteria Plan Waiver Form

Eligibility requirements:

If your dependents do not or no longer meet the eligibility requirements below, they will not be considered "**dependents**" when determining your rebate status.

- In order for your spouse to be covered under benefits/rebate, you must be legally married **and** file taxes as married/jointly or married/separately.
- Children under two are not eligible for dental benefits/rebate.
- Children between the age of 19 and 23 that are not enrolled as full-time students are not eligible for dental benefits/rebate.
- Children over age 26 are not eligible for medical, prescription, or dental rebate.

Member Advocacy & BenePortal

Member Advocacy

Employee benefits can be complex, making it difficult to fully understand your coverage and use it properly. Member Advocacy allows you to speak to a specially trained Member Advocate who can answer your questions and help you get the most out of your benefits.

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**.

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.

BenePortal

BenePortal is a valuable online resource that houses all of our benefit program information. It is your one-stop-shop for:

- All benefits-related information and downloads, including benefit summaries and detailed plan documents.*
- Quick links to carrier websites.
- Enrollment forms and wellness forms.*
- And much more!

You and your family can access BenePortal anytime at **www.CherryHillTwpBenefits.com**.

* If you do not have access to a printer and would like paper copies of forms or plan summaries, please request from Human Resources.



Medical Benefits: Horizon BCBS of NJ

Eligible employees have the option of enrolling in one (1) of five (5) Horizon BCBS of NJ (Horizon) medical/prescription drug plans, which are outlined below and on the following page. For more detailed plan summaries please visit www.CherryHillTwpBenefits.com.

To find a participating provider within the Horizon network, please visit:

<https://doctorfinder.horizonblue.com>.

	DIRECT ACCESS DESIGN 8	DIRECT ACCESS DESIGN 8 (NO DEDUCTIBLE)**
MEDICAL SERVICES	IN-NETWORK	
Calendar Year Individual/Family	\$100*	\$0/\$0
Out-of-Pocket Maximum Individual/Family	\$800/\$2,000	\$800/\$2,000
Preventive Care Services	100% covered	100% covered
PCP Office Visit	100% covered after \$15 copay	100% covered after \$15 copay
Specialist Office Visit	100% covered after \$15 copay	100% covered after \$15 copay
Telemedicine	100% covered after \$15 copay	100% covered after \$15 copay
Diagnostic Laboratory Office, Preferred Lab, or Outpatient Facility	100% covered	100% covered
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	100% covered	100% covered
Emergency Room	\$100 facility copayment	\$100 facility copay
Urgent Care Center	100% covered after \$15 copay	100% covered after \$15 copay
Inpatient Hospital	100% covered	100% covered
Outpatient Surgery	100% covered	100% covered
Short Term Therapies Physical, Occupational, Speech, Respiratory	100% covered after \$15 copay	100% covered after \$15 copay
Therapeutic Manipulation/Chiropractic Care 30 visit maximum per calendar year	100% covered after \$15 copay	100% covered after \$15 copay
Durable Medical Equipment	10% coinsurance after deductible	10% coinsurance after deductible
OUT-OF-NETWORK BENEFITS		
Calendar Year Individual/Family	\$400/\$1,000	\$400/\$1,000
Out-of-Pocket Maximum Individual/Family	\$2,000/\$5,000	\$2,000/\$5,000
Preventive Care Services	30% coinsurance (no deductible)	30% coinsurance (no deductible)
MONTHLY PREMIUMS (MEDICAL & PRESCRIPTION DRUG)		
Employee Only	\$1,208.90	\$1,214.48
Employee & Spouse	\$2,417.82	\$2,428.96
Employee & Child(ren)	\$2,163.95	\$2,173.92
Family	\$3,372.86	\$3,388.40

* There is no separate family deductible.

**This plan is only available to those hired prior to 7/1/2019.

You can save money when you choose to receive care from providers that participate in the Horizon BCBSNJ networks. Generally, if you have services performed at an out of network facility or by an out of network provider, your out of network benefits will apply. This means that you will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service and this may result in significant out of pocket costs. You will be responsible to pay for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using our Horizon-BCBSNJ network providers, you keep your health care costs down.

Medical Benefits: Horizon BCBS of NJ

To find a participating provider within the Horizon network, please visit:

<https://doctorfinder.horizonblue.com>.

	DIRECT ACCESS DESIGN 7	HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
MEDICAL SERVICES	IN-NETWORK	IN-NETWORK
Calendar Year Individual/Family	\$0/\$0	\$1,650/\$3,300**
Out-of-Pocket Maximum Individual/Family	\$800/\$2,000	\$2,600/\$5,200
Preventive Care Services	100% covered	100% covered, no deductible
PCP Office Visit	100% covered after \$20 copay	20% coinsurance after deductible
Specialist Office Visit	100% covered after \$30 copay*	20% coinsurance after deductible
Telemedicine	100% covered after \$15 copay	20% coinsurance after deductible
Diagnostic Laboratory Office, Preferred Lab, or Outpatient Facility	100% covered	20% coinsurance after deductible
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	100% covered	20% coinsurance after deductible
Emergency Room	100% covered after \$100 copay	20% coinsurance after deductible
Urgent Care Center	100% covered after \$30 copay	20% coinsurance after deductible
Inpatient Hospital	100% covered	20% coinsurance after deductible
Outpatient Surgery	100% covered	20% coinsurance after deductible
Short Term Therapies Physical, Occupational, Speech, Respiratory	100% covered after \$20 copay	20% coinsurance after deductible
Therapeutic Manipulation/Chiropractic Care 30 visit maximum per calendar year	100% covered after \$30 copay	20% coinsurance after deductible
Durable Medical Equipment	10% coinsurance	20% coinsurance after deductible
OUT-OF-NETWORK BENEFITS		
Calendar Year Individual/Family	\$200/\$500	\$1,650/\$3,300**
Out-of-Pocket Maximum Individual/Family	\$5,000/\$12,500	\$3,600/\$7,200
Preventive Care Services	30% coinsurance (no deductible)	40% coinsurance (no deductible)
MONTHLY PREMIUMS (MEDICAL & PRESCRIPTION DRUG)		
Employee Only	\$1,190.89	\$1,005.87
Employee & Spouse	\$2,381.79	\$2,011.74
Employee & Child(ren)	\$2,131.70	\$1,800.51
Family	\$3,322.60	\$2,806.38

*The copayment for dependent children for specialists is the same as the PCP copayment.

** True Family Deductible: Entire family deductible must be met before any benefits are paid.

You can save money when you choose to receive care from providers that participate in the Horizon BCBSNJ networks. Generally, if you have services performed at an out of network facility or by an out of network provider, your out of network benefits will apply. This means that you will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service and this may result in significant out of pocket costs. You will be responsible to pay for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using our Horizon-BCBSNJ network providers, you keep your health care costs down.

Medical Benefits: Horizon BCBS of NJ

To find a participating provider within the Horizon network, please visit:

<https://doctorfinder.horizonblue.com>.

OMNIA STATE DEFECTOR

MEDICAL SERVICES	TIER 1	TIER 2
Calendar Year Individual/Family	\$0/\$0	\$1,500/\$3,000
Out-of-Pocket Maximum Individual/Family	\$2,500/\$5,000	\$4,500/\$9,000
Preventive Care Services	100% covered	100% covered
PCP Office Visit	100% covered after \$5 copay	100% covered \$20 copay
Specialist Office Visit	100% covered after \$15 copay	100% covered after \$30 copay
Telemedicine	100% covered after \$5 copay	100% covered after \$5 copay
Diagnostic Laboratory Office, Preferred Lab, or Outpatient Facility	100% covered	100% covered in office setting 20% coinsurance after deductible in outpatient facility
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	100% covered in office	100% covered in office setting 20% coinsurance after deductible in outpatient facility
Emergency Room	100% covered after \$100 facility copay (copay waived if admitted)	100% covered after \$100 facility copay (copay waived if admitted)
Urgent Care Center	100% covered after \$15 copay	100% covered after \$15 copay
Inpatient Hospital	\$150 copay per admission	20% coinsurance after deductible
Outpatient Surgery	\$150 copay	20% after deductible
Short Term Therapies* Physical, Occupational, Speech, Respiratory	100% covered after \$ 5 copay	100% covered after \$20 copay 20% coinsurance after deductible in outpatient facility
Therapeutic Manipulation/Chiropractic Care 25 visit maximum per calendar year	100% covered after \$15 copay	100% covered after \$30 copay
Durable Medical Equipment	100% covered	20% coinsurance after deductible
MONTHLY PREMIUMS (MEDICAL & PRESCRIPTION DRUG)		
Employee Only		\$999.26
Employee & Spouse		\$1,998.52
Employee & Child(ren)		\$1,788.68
Family		\$2,787.93

* 30 visits max per therapy per calendar year. Combined Tier 1 and Tier 2.

You can save money when you choose to receive care from providers that participate in the Horizon BCBSNJ networks. Generally, if you have services performed at an out of network facility or by an out of network provider, your out of network benefits will apply. This means that you will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service and this may result in significant out of pocket costs. You will be responsible to pay for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using our Horizon-BCBSNJ network providers, you keep your health care costs down.

Prescription Benefits: Horizon BCBS of NJ/Prime Therapeutics

If you elect to participate in one of the medical plans, you are automatically enrolled in the corresponding prescription plan, outlined below. For more detailed plan summaries, please visit www.CherryHillTwpBenefits.com.

	DIRECT ACCESS DESIGN 8	DIRECT ACCESS DESIGN 8 (NO DEDUCTIBLE)	DIRECT ACCESS DESIGN 7	HSA STATE DEFECTOR	OMNIA
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)					
Generic	\$3 copay	\$3 copay	\$3 copay	Prescription drug is integrated with medical; deductible and coinsurance applies for all prescription drugs	\$7 copay
Preferred Brand	\$18 copay	\$18 copay	\$18 copay		\$16 copay
Non-Preferred Brand	\$46 copay	\$46 copay	\$46 copay		\$35 copay
MAIL-ORDER PHARMACY (UP TO A 90-DAY SUPPLY)					
Generic	\$0 copay	\$0 copay	\$0 copay	Prescription drug is integrated with medical; deductible and coinsurance applies for all prescription drugs	\$0 copay
Preferred Brand	\$36 copay	\$36 copay	\$36 copay		\$40 copay
Non-Preferred Brand	\$92 copay	\$92 copay	\$92 copay		\$88 copay

You can save money when you choose to receive care from providers that participate in the Horizon BCBSNJ networks. Generally, if you have services performed at an out of network facility or by an out of network provider, your out of network benefits will apply. This means that you will be responsible for amounts exceeding Horizon BCBSNJ's allowable reimbursement for that particular service and this may result in significant out of pocket costs. You will be responsible to pay for this amount directly to the non-participating hospital, ambulatory surgery center or provider. By using our Horizon-BCBSNJ network providers, you keep your health care costs down.



Prescription Drug: Home Delivery

Amazon Pharmacy Prescription Home Delivery

Getting starting with Amazon Pharmacy is easy - and you can save time and money. Amazon Pharmacy is fully accredited and can fill most brand name and generic medications.

Amazon Pharmacy Offers:

- Easy online sign-up with the option of importing your medication history.
- An Amazon shopping experience with free two-day delivery for Amazon Prime members, or five-day delivery without Amazon Prime.
- 24/7/365 access to a pharmacist, or chat online with customer care for general questions.
- Clear pricing of medicines before checkout.

When you shop Amazon Pharmacy, you will also have access to the MedsYourWay discount card pricing, administered by Inside Rx. You will see the lowest available price - either your member copay, or the MedsYourWay discount price.



Sign Up for Amazon Pharmacy Today!

You can sign up for Amazon Pharmacy via:

- **www.HorizonBlue.com** by clicking on “**Doctor & Care**”, then “**Prescriptions**”, then “**Amazon Pharmacy**”.
- The **Horizon Blue app** by selecting “**Prescriptions**”, then “**Home Delivery**”, then “**Amazon Pharmacy**”.
- **<https://amazon.com/horizonblue>**.

Once you are on the Amazon Pharmacy site, click “**Get Started**”. You’ll need your member ID, RxBIN and RxPCN numbers, which are listed on your member ID card.

To fill a current prescription through Amazon Pharmacy, select the medicines you would like to fill. Amazon Pharmacy will contact your doctor for a prescription, and let you know when your order is ready for check out and delivery.

For new prescriptions, let your doctor know to send them to Amazon Pharmacy by:

- **ePrescribe:** Amazon Pharmacy Home Delivery.
- **Fax:** **512.884.5981**.
- **Phone:** **855.206.3605**, then press 1.
- **Mail:** 4500 S Pleasant Valley Rd, Suite 201 Austin, TX 78744.

Health Savings Account (HSA): Horizon BCBS of NJ/Further

If you participate in the qualified High Deductible Health Plan (HDHP) you may be eligible to participate in a Health Savings Account (HSA). An HSA is a great way to save money by allowing you to set aside pre-tax dollars, via payroll deductions, to efficiently pay for qualified healthcare, dental and vision expenses. The funds in your HSA never expire; you may utilize the money you accumulate in your account for future healthcare expenses, even if you change jobs or retire.

HSA Eligibility

In order to qualify for an HSA, you must be an adult who meets the following qualifications:

- You have coverage under an HSA-qualified, high deductible health plan (HDHP).
- You (or your spouse, if applicable) have no other health coverage (excluding other types of insurance, such as dental, vision, disability or long-term care coverage).
- Are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

HSA Contributions

The maximum amount that can be contributed to the HSA in a tax year is established by the IRS and is dependent on whether you have individual or family coverage in the HDHP plan. For 2025, the contribution limits are:

- **\$4,300** for individual coverage.
- **\$8,550** for family coverage.
- The annual catch-up contribution for age 55 and older is **\$1,000**.

HSA Advantages

- There is no “use it or lose it” provision with an HSA. If you don't use the money in your account by the end of the year, don't worry! Unused funds will roll over year after year.
- You can save and invest unused HSA money for future healthcare needs.
- Your HSA is portable. When you retire or leave the company, your HSA funds go with you.

HSA Qualified Healthcare Expenses

You can use the funds in your HSA to pay for qualified healthcare expenses such as:

- Doctor visits.
- Dental care, including extractions and braces.
- Vision care, including contact lenses, prescription sunglasses and LASIK surgery.
- Prescription medications.
- Chiropractic services.
- Acupuncture.
- Hearing aids and batteries.
- Over-the-counter (OTC) medications.
- Menstrual care products.

For a full list of qualified medical expenses, visit <https://www.irs.gov/pub/irs-prior/p502--2023.pdf>.

HorizonBlue.com & Horizon Blue App

HorizonBlue.com

HorizonBlue.com has been enhanced so members can find essential information quickly and effortlessly on your desktop computer, smartphone, or tablet. Through **HorizonBlue.com**, you can sign into Member Online Services to manage your health care, no matter which device you use. When you sign in, you can select from:

- **MY CLAIMS:** Review claim activity for all members covered under your plan.
- **MY COVERAGE:** Use our tools and resources to understand your plan and the insurance process.
- **ID CARDS:** Lost your member ID card? View it on your device or print a replacement one.
- **WELLNESS:** Learn about our programs, tools and resources that can help keep you and your family healthy.
- **GET CARE:** Use our **Online Doctor & Hospital Finder** to find in-network doctors and other health care Professionals.

Horizon Blue App

Horizon's new app connects you to care and support wherever you are. Horizon Blue is a 24/7 connection to all the ins and outs of your plan.

BENEFITS AND COVERAGE INFO - Instant access to coverage details.

CARE WHEN YOU NEED IT - Quick connection to health providers.

HORIZON SUPPORT IN YOUR HANDS - Fast answers to coverage questions.



***EASY TO GET AROUND, FREE TO
DOWNLOAD.***

*Text **GetApp** to 422-272 or download via
the Apple app store or via Google Play.*

Wellness & Discount Programs: Horizon BCBS of NJ

Wellness and Discount Programs that Earn you Rewards and Save you Money.

Get Fit with Horizon**bFit**

When you enroll in the Horizon**bFit** fitness incentive program, you can earn up to \$240 per year in rewards. Earn a \$20 reward for every month in which you:

- Work out at home 12 or more days a month, and record and submit your workout using the Fit-At-Home feature; or
- Walk 10,000 steps a day for at least 12 days a month; or
- Visit one of 4,000 participating fitness facilities 12 or more days a month; or
- Complete any combination of visiting a participating facility, working out at home or walking 10,000 steps for a total of at least 12 days a month.

ActiveFit, Horizon**bFit**'s free mobile app, makes syncing your step count and tracking your gym visits easy. Download the app for free from the App Store or Google Play.

Enrolling is Free and Easy!

Simply visit <https://HorizonbFit.com>. You can verify your eligibility using your Horizon member ID number to set up your account.



Save With Blue365

The Blue365 discount program saves you money on products and services that can help you live a well-balanced lifestyle. Blue365 discounted offers help you stay active, while saving money through popular retailers nationwide. Save on:

- Cookbooks, meal plans and nutrition programs.
- Fitness clothing and equipment.
- Child safety products.
- Glasses and contacts.
- Health magazines.
- And much more!

The Blue365 premier health and wellness discount program is free to join. To learn more or enroll, visit www.blue365deals.com.

Telemedicine: Horizon CareOnline

Virtual Care from the comfort of your home.

When you need to see a doctor or nurse – any time day or night – simply sign in to www.HorizonBlue.com or the **Horizon Blue app**. Get 24/7 access to doctors and registered nurses from the comfort of your home. Urgent medical care services for Horizon CareOnline are provided by U.S. board-certified, licensed doctors who average 15 years of experience in primary/urgent care.

Virtual Care Options

See a Doctor

Visit with a U.S. board-certified, licensed doctor without an appointment on a computer or mobile device through our telemedicine service, Horizon CareOnline. You can use this option when you need treatment for common health problems, such as:

- Fever.
- Colds and flu.
- Sinusitis.
- Skin irritations.
- Rashes.
- Abdominal pain.

Behavioral Health Services

You can also see a licensed psychiatrist, psychologist, or social worker for treatment for anxiety, depression and more. Professionals are available by appointment, every day, from 7 a.m. to 11 p.m.



How do I Register for Horizon CareOnline?

1. Go to **HorizonCareOnline.com**.
2. Enter your name and email, and create a password. Then click **"Sign Up"**.
3. Select your **"State"**, **"Date of Birth"** and **"Gender"**. Click **Enter**.
4. For **"Do you have health insurance?"**, enter **"Yes"**, then select **"Horizon Blue Cross Blue Shield of New Jersey"** as your health plan.
5. **IMPORTANT:** Enter the subscriber ID number from your member ID card.
6. For **"Are you the primary subscriber?"** select **"YES"** or **"NO"**.
 - If **NO**, add the subscriber's name, date of birth and your relationship to the subscriber.

24/7 Nurse Line: Horizon BCBS of NJ

Advice from a registered nurse is just a phone call away.

Horizon understands how important it is for members to get the health information they need quickly. The Horizon 24/7 Nurse Line makes it easy for members to get answers to everyday health questions - and if a more serious situation arises, to know what level of care may be best for their needs. Members can simply call **888.624.3096**.

Members Get Peace of Mind

The 24/7 Nurse Line provides trusted health information for getting and staying well at no cost to members. Nurses can answer questions and provide physician-approved information on a wide range of medical conditions to help guide health care decisions.

- **EXPERIENCE:** The 24/7 Nurse Line is staffed by caring, registered nurses with an average of 15 years of clinical experience.
- **CONFIDENTIALITY:** Members can be assured that the information they convey to nurses is kept confidential.
- **DIRECT ACCESS:** Members can connect with health care professionals at any time of the day or night, quickly and easily.

Registered Nurses Can Help Horizon Members Understand:

What level of care (such as urgent care or self-care) may be best for their needs

- A diagnosis from their doctor.
- Nutrition and exercise options that may be right for them.
- Health screening and immunization recommendations.
- General health education and information.

Members can simply call **888.624.3096** to use this free, confidential resource.



Dental Plan: Delta Dental of New Jersey

All eligible employees have the option of enrolling in one (1) of three (3) Delta Dental plans offered. Plan details are outlined below and on the following pages. For more detailed plan summaries please visit www.CherryHillTwpBenefits.com.

NOTE: Non-contractual employees are eligible for buy-up dental plans detailed on the next page.

	PPO (BASE PLAN)	PREMIER/ADVANTAGE (BASE PLAN)	FLAGSHIP DMO
DENTAL BENEFITS	IN-NETWORK & OUT-OF-NETWORK*		IN-NETWORK ONLY
Calendar Year Deductible	\$50/\$150	\$50/\$150	N/A
Calendar Year Maximum (per patient)	\$1,000	\$1,000	N/A
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays	100% covered	100% covered	You pay a copayment for each covered procedure. Please refer to the Summary of Benefits for a detailed listing of procedures and out-of-pocket costs.
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	20% coinsurance	50% coinsurance	
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	50% coinsurance	50% coinsurance	
Orthodontia Services Dependent children to age 19	50% coinsurance	50% coinsurance	
Orthodontia Lifetime Maximum (per patient)	\$1,000	\$1,000	N/A
MONTHLY PREMIUMS			
Employee	\$28.27	\$30.82	\$27.37
Employee + 1	\$47.87	\$52.89	\$53.15
Employee + 2	\$86.26	\$97.58	\$89.03

* Patients who select a non-Delta Dental dentist have benefits paid on a Delta Dental schedule of allowances and are responsible for any part of the dentist's fee which exceeds the allowance except that a Delta Dental participating dentist can only charge up to his/her filed fee or Delta Dental's maximum plan allowance, whichever is less. Maximum benefit may be derived by utilizing the services of a participating Delta Dental dentist.



Dental Plan: Delta Dental of New Jersey

Non-contractual employees have the option to enroll in one (1) of the two (2) buy-up dental plans outlined below. For more detailed plan summaries please visit www.CherryHillTwpBenefits.com.

DENTAL BENEFITS	PPO (BUY-UP PLAN)	PREMIER/ADVANTAGE (BUY-UP PLAN)
	IN-NETWORK & OUT-OF-NETWORK*	
Deductible (Calendar Year)	\$50/\$150 (Waived on Preventative & Diagnostic)	\$50/\$150 (Waived on Preventative & Diagnostic)
Calendar Year Maximum (per patient)	\$2,000	\$2,000
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays	100% covered	100% covered
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	20% coinsurance	50% coinsurance
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	50% coinsurance	50% coinsurance
Orthodontia Services Dependent children to age 19	50% coinsurance	50% coinsurance
Orthodontia Lifetime Maximum (per patient)	\$2,000	\$2,000
MONTHLY PREMIUMS		
Employee	\$32.47	\$35.40
Employee + 1	\$54.98	\$60.75
Employee + 2	\$99.06	\$112.05

* Patients who select a non-Delta Dental dentist have benefits paid on a Delta Dental schedule of allowances and are responsible for any part of the dentist's fee which exceeds the allowance except that a Delta Dental participating dentist can only charge up to his/her filed fee or Delta Dental's maximum plan allowance, whichever is less. Maximum benefit may be derived by utilizing the services of a participating Delta Dental dentist.



Finding a Dental Provider



How Do I Find Participating Dentists?

There are thousands of participating dentists and specialists to choose from nationwide. For a list of participating providers, please visit

www.deltadentalnj.com and click on “**Find a Dentist**” on the right side of the page.

- **Premier/Advantage Plan:** Make sure you select the “**Delta Dental Premier**” network.
- **PPO/Preferred Plan:** Make sure you select the “**Delta Dental PPO**” network.
- **Flagship Plan:** You must choose a primary care dentist who provides necessary dental care and coordinates rereferrals for specialty care. Make sure you select “**Flagship**” under network.

May I Choose a Non-Participating Dentist?

You are free to select the dentist of your choice, however, your out-of-pocket costs may be significantly higher if you choose a non-participating dentist. Non-participating dentists have not agreed to accept negotiated fees, therefore may charge you the difference between their fees and the plan’s benefit payment.

What Will My Out-of-Pocket Expenses Be?

You can ask for a pre-treatment estimate from your dental provider to help you prepare for any out-of-pocket cost for dental services. Usually, your dental provider will send Delta Dental a plan for your care and request an estimate of benefits. Contact your dental provider for more information.

Employee Assistance Program (EAP): ComPsych



All benefit eligible employees and family members are eligible for the Employee Assistance Program (EAP), regardless of location or relationship. You can access the program 24/7, 365 days a year through a dedicated toll-free line, website and mobile app.

Program Highlights

Up to five face -to -face confidential sessions with a counselor, financial planner, or attorney are available to you and your family members each calendar year. Sessions are per household and may be divided among the types of professionals.

Legal and Financial Services

- Financial consultation for unlimited number of issues.
- Legal consultation for unlimited number of issues, 25% discount for services beyond initial consultation.
- Online legal and financial resource center .

Online Resources and Tools

Get trusted, professional information about relationships, work, school, children, wellness, legal or financial issues, and more. Turn to GuidanceResources online for:

- Timely articles, tutorials, videos and self-assessments.
- "Ask the Expert" personal responses to your questions.
- Searches for child or elder care, attorneys and financial planners.

First-time users, follow these simple steps:

1. Go to **www.guidanceresources.com** and click "Register"
2. Provide your organization web ID: SYMETRA
3. Create a username and password

If you have problems registering or logging in, send an email to **memberservices@compsych.com** or call **888.327.9573**.

Long Term Disability: Symetra

Effective February 1st, 2025, Symetra Life Insurance Company will be the carrier for Cherry Hill Township’s Long-Term Disability Insurance. This valuable coverage has a benefit of 60% of your pre-disability earnings to a monthly maximum of \$9,572. Benefit payments will begin after you have been disabled for 180 days.*

Benefit Highlights

- **Benefit Amount:** 60% of Salary up to \$9,572 per month
- **Elimination Period:** 180 days (number of days you must be disabled to collect disability benefits)
- **Accumulation of Elimination Days:** You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

MAXIMUM PAYMENT DURATION

SOCIAL SECURITY NORMAL RETIREMENT AGE (SSNRA)	
AGE AT DISABILITY	MAXIMUM PAYMENT DURATION
Less than age 60	To SSNRA
60	60 months or to SSNRA, greater of
61	48 months or to SSNRA, greater of
62	42 months or to SSNRA, greater of
63	36 months or to SSNRA, greater of
64	30 months or to SSNRA, greater of
65	24 months
66	21 months
67	18 months
68	15 months
69 or more	12 months

*In order to qualify for Long-Term Disability benefits, you must, due to illness or injury, be unable to perform the duties of your regular occupation and have a loss of income of 20% or more.



Flexible Spending Accounts: WEX

Cherry Hill Township provides you with the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through the Flexible Spending Accounts (FSA). The FSA plan year runs from January 1st through December 31st of each year.

Healthcare FSA

The Healthcare FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. The maximum you can contribute to the Healthcare FSA is **\$2,550**.

Eligible Expenses Include:

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

Dependent Care FSA

The Dependent Care FSA is used to reimburse expenses related to the care of eligible dependents. The maximum that you can contribute to the Dependent Care FSA \$5,000 if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is **\$2,500**.

Eligible Expenses Include:

- Au pair.
- After school programs.
- Baby-sitting/dependent care to allow you to work or actively seek employment.
- Day camps and preschool.
- Adult/eldercare for adult dependents.

How Much Should I Contribute?

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period. If you do not use the money you contributed, it will not be refunded to you or carried forward to a future plan year. This is the use-it-or-lose-it rule.

Grace Period

You have 2.5 months after the end of the plan year to incur claims. The deadline for the 2025 plan year is March 15, 2026. You have until March 31, 2026 to submit for reimbursement.



Legal Notices

Newborns' and Mothers' Health Protection Act Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Women's Health and Cancer Rights Act Notice

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 medical and surgical benefits provided under this plan. Therefore, based on your plan, deductibles and coinsurance could apply. If you would like more information on WHCRA benefits, please contact your Plan Administrator.

Special Enrollment Notice

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 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.

Loss of eligibility 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 (CHIP) 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 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 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. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

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, please contact your employer.

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan

Legal Notices

Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if

you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your employer's Human Resources/Benefits Department. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov. Keep your Plan informed of address changes.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Please contact your employer's Human Resources or Benefits Department for further information regarding the Plan and COBRA continuation coverage.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

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

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

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

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

Legal Notices

CALIFORNIA - MEDICAID

Health Insurance Premium Payment (HIPP) Program

<http://dhcs.ca.gov/hipp>

Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center:

1-800-221-3943/State Relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mychihibi.com/>

HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA - Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, Press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: 678-564-1162, Press 2

INDIANA - Medicaid

Health Insurance Premium Payment Program

All other Medicaid Website: <https://www.in.gov/medicaid/>

<http://www.in.gov/fss/dfr/>

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA - Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

HIPP Phone: 1-888-346-9562

KANSAS - Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY - Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA - Medicaid

Website: www.medicicaid.la.gov or www.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - Medicaid

Enrollment Website: www.mymaineconnection.gob/benefits/s/?language=en_US

Phone: 1-800-442-6003 TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 800-977-6740 TTY: Maine relay 711

MASSACHUSETTS - Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840 TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA - Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

MISSOURI - Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 1-573-751-2005

MONTANA - Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HHSHIPPProgram@mt.gov

NEBRASKA - Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 855-632-7633

Lincoln: 402-473-7000

Omaha: 402-495-1178

NEVADA - Medicaid

Medicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

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

Legal Notices

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

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

PENNSYLVANIA – Medicaid and CHIP

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

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

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

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 1-800-562-3022

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 800-251-1269

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

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice

This Guide is intended to provide you with the information you need to choose your benefits for the plan year including details about your benefits options and the actions you need to take. It also outlines additional sources of information to help you make your enrollment choices. If you have questions about your benefits or the enrollment process, contact your employer's Human Resources or Benefits Department. The information presented in this Guide is not intended to be construed to create a contract between your employer and any one of its employees or former employees. In the event that the content of this Guide or any oral representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document are controlling. Your employer reserves the right to amend, modify, suspend, replace or terminate any of its plans, policies or programs, in whole or in part, including any level or form of coverage by appropriate company action, without your consent or concurrence.



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