TOWNSHIP OF BERLIN

Continuing Generations...













2027

EMPLOYEE BENEFITS GUIDE

For the coverage period ending on December 31, 2027

WELCOME TO BERLIN TOWNSHIP!



At Berlin 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.

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QUESTIONS?

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

ENROLLING IN BENEFITS

WHAT YOU NEED TO KNOW

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

WHO IS ELIGIBLE TO ELECT BENEFITS?

Full-time employees who work 35 or more hours per week are eligible to enroll in the benefits described in this guide.

WHEN DO WAITING PERIODS END?

Eligible employees are covered after 60 days of full-time employment.



QUALIFIED LIFE EVENTS (QLE)

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 with the exception of Birth which has been extended to 90 days.

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

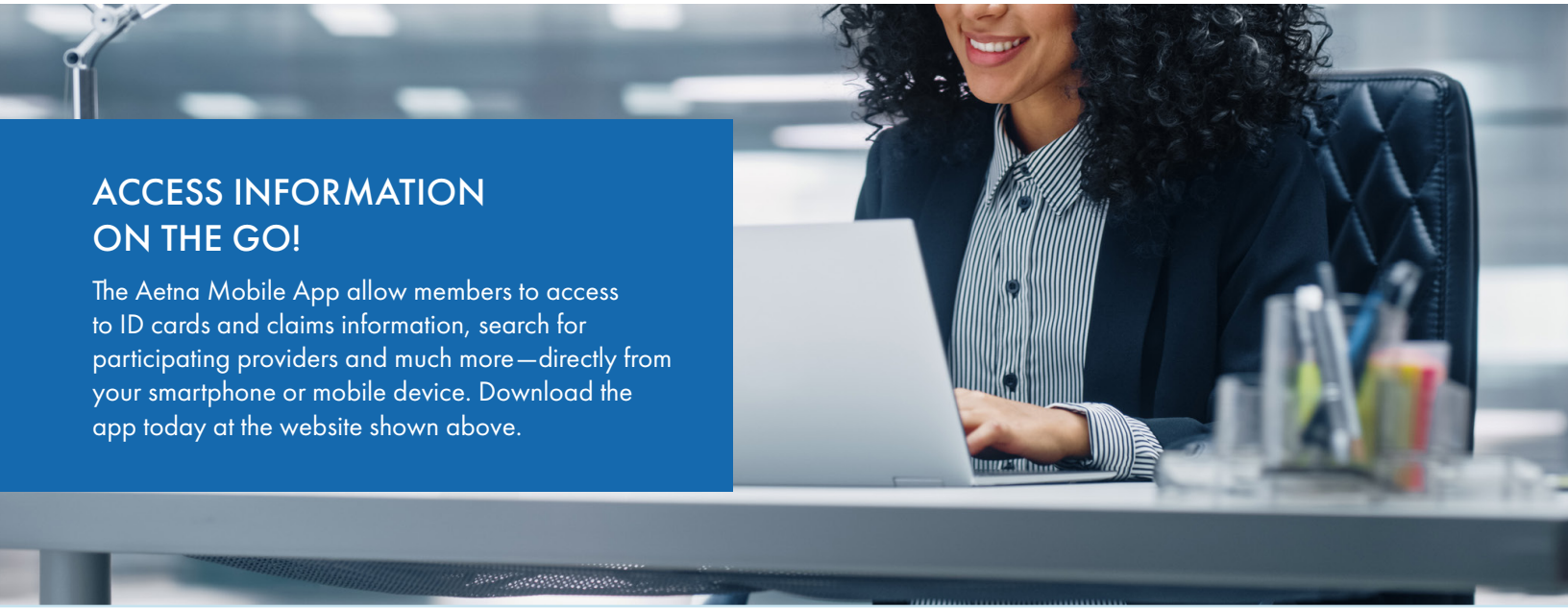
- An eligible individual and any eligible dependents (child(ren)/spouse/domestic partner) may enroll regardless of health status, age, or requirements for health services within 60 days of the eligibility date (birth/marriage/adoption, etc.)
- Newly eligible individuals and eligible dependents may enroll within 60 days of the eligibility date.
- Eligible individuals or dependents who do not enroll within the first 60 days following eligibility may be enrolled during any subsequent Open Enrollment period.

HAVE QUESTIONS?

WHO TO CALL...

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

QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE/ADDRESS
ELIGIBILITY, ENROLLMENT, PLAN OPTIONS, CONTRIBUTIONS, QUALIFYING LIFE EVENTS, ETC.	Member Advocacy	800.563.9929	www.connerstrong.com/memberadvocacy
MEDICAL BENEFITS (Claims, locating a provider, ID cards)	Aetna	800.370.4526	www.aetna.com
PRESCRIPTION BENEFIT	Express Scripts	800.467.2006	www.express-scripts.com
DENTAL BENEFITS	Delta Dental	800.452.9310	www.deltadentalnj.com
TELEMEDICINE	CVS Virtual Care	888.607.4287	www.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.

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 Business Office at least 31 days prior to termination. The carrier will review and make the determination.
- Under the Patient Protection and Affordable Care Act: A child is defined as an enrollee's child until age 26, regardless of marital, 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 & Prescription Coverage:** Young adults will be covered through the end of the year in which they turn age 26.
- **Dental Coverage:** Young adults will be covered through the end of the year in which they turn age 26.

DEPENDENT 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 parent's coverage to elect to remain covered until age 31, if certain other eligibility standards are met.

Visit **state.nj.us/dobi/division_consumers/du31.html** for more information. Please note: the young adult would be billed directly for coverage. Contact Human Resources for monthly premium rates and enrollment forms.

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 for the following family status changes:

- Marriage, or civil union partner
- 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
- Death of a family member

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

EMPLOYEE RESOURCES

BENEFITS MEMBER ADVOCACY CENTER (BENEFITS MAC)

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 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**

MEDICAL BENEFITS

AETNA

See additional plans and notes on the following page of this guide.

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

	AETNA CHOICE POS II $10	AETNA CHOICE POS II $15	AETNA CHOICE POS II $15/$25
ABOUT THE PLAN OPTIONS			
REPLACES SHBP PLAN	NJ Direct / Aetna Freedom $10	NJ Direct / Aetna Freedom $15	NJ Direct / Aetna Freedom $15/$25
SERVICE AREA	Nationwide	Nationwide	Nationwide
SPECIALIST REFERRAL	Not required	Not required	Not required
IN-NETWORK BENEFITS			
DEDUCTIBLE (Individual / Family)	None	None	None
COINSURANCE	You pay 10%	You pay 10%	You pay 10%
OUT-OF-POCKET MAXIMUM (Individual / Family)	$400 / $1,000	$400 / $1,000	$400 / $1,000
PCP OFFICE VISITS	$10 copay	$15 copay	$15 copay
ANNUAL PHYSICAL (In-Network Only)	$0	$0	$0
CVS VIRTUAL CARE (TELEMEDICINE)	$0	$0	$0
SPECIALIST OFFICE VISIT	$10 copay	$15 copay	$25 copay
ROUTINE VISION EXAM	$10 copay	$15 copay	$25 copay
CHIROPRACTIC CARE	$10 copay	$15 copay	$25 copay
PHYSICAL/SPEECH/OCCUPATIONAL THERAPY	$10 copay	$15 copay	$25 copay
DIAGNOSTIC LAB, X-RAY/IMAGING (MRI, CT-Scan)	$0	$0	$0
INPATIENT / OUTPATIENT FACILITY	$0	$0	$0
OUTPATIENT BEHAVIORAL HEALTH	$10 copay	$15 copay	$25 copay
DURABLE MEDICAL EQUIPMENT	You pay 10%	You pay 10%	You pay 10%
URGENT CARE CENTER	$10 copay	$15 copay	$25 copay
EMERGENCY ROOM	$25 copay	$50 copay	$75 copay
AMBULANCE	You pay 10%	You pay 10%	You pay 10%
OUT-OF-NETWORK BENEFITS			
DEDUCTIBLE (Individual / Family)	$100 / $250	$100 / $250	$100 / $250
COINSURANCE	You pay 20% after deductible	You pay 30% after deductible	You pay 30% after deductible
OUT-OF-POCKET MAXIMUM (Individual / Family)	$2,000 / $5,000	$2,000 / $5,000	$2,000 / $5,000
INPATIENT HOSPITAL	$200 / stay	$200 / stay	$200 / stay

MEDICAL BENEFITS

AETNA

See additional plans on the previous page of this guide.

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

	AETNA HMO $10	AETNA WHOLE HEALTH PLAN	
ABOUT THE PLAN OPTIONS		**TIER 1 (NJ ONLY)**	**TIER 2 (NATIONWIDE)**
REPLACES SHBP PLAN	Horizon / Aetna HMO $10	Horizon OMNIA / Aetna Liberty	
SERVICE AREA	HMO Network	NJ Only	Nationwide
SPECIALIST REFERRAL	Required	Not required	
IN-NETWORK BENEFITS (NO OUT-OF-NETWORK BENEFITS)		**TIER 1 (NJ ONLY)**	**TIER 2 (NATIONWIDE)**
DEDUCTIBLE (Individual / Family)	$100 (DME only)	None	$1,500/$3,000
COINSURANCE	None	None	You pay 20% after deductible
OUT-OF-POCKET MAXIMUM (Individual / Family)	$7,360/$14,720	$2,500 / $5,000	$4,500 / $9,000
PCP OFFICE VISITS	$10 copay	$5 copay	$20 copay
ANNUAL PHYSICAL (In-Network Only)	$0 copay	$0 copay	
CVS VIRTUAL CARE (TELEMEDICINE)	$0 copay	$0 copay	
SPECIALIST OFFICE VISIT	$10 copay	$15 copay	$30 copay
ROUTINE VISION EXAM	$10 copay	$15 copay	$30 copay
CHIROPRACTIC CARE	$10 copay	$15 copay	$30 copay
PHYSICAL/SPEECH/OCCUPATIONAL THERAPY	$10 copay	$5 office / $15 oupatient	$20 office / 20% after deductible outpatient
DIAGNOSTIC LAB, X-RAY/IMAGING (MRI, CT-Scan)	$0 copay	$15 copay outpatient / $0 copay freestanding	20% after deductible outpatient / $0 copay freestanding
INPATIENT / OUTPATIENT FACILITY	$0 copay	$150 per admission	20% after deductible
OUTPATIENT BEHAVIORAL HEALTH	$10 copay	$15 copay	$30 copay office / 20% after deductible outpatient
DURABLE MEDICAL EQUIPMENT	$100 deductible, then covered in full	$0 copay	
URGENT CARE CENTER	$10 copay	$15 copay	$30 copay
EMERGENCY ROOM	$35 copay	$100 copay	
AMBULANCE	$0 copay	$0 copay	

Notes:

- Preauthorization may be required for certain services.
- All plans with an out-of-network benefit have specified dollar limits for out-of-network chiropractic ($35), physical therapy ($52), and acupuncture ($60).
- Out-of-Pocket Maximum shown is the combined Copay + Deductible + Coinsurance limit.
- This overview is provided as a convenient reference tool and is not a complete description of the benefits offered. If there is any discrepancy between this overview and the official plan documents, the language of the official plan documents shall prevail.

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 — appropriate for:

- Cold/Flu, Allergies, Animal/insect bite
- Bronchitis, Skin problems, Respiratory infection
- Sinus problems, Strep throat, Pink eye / Eye irritation
- Urinary issues

Urgent Care Center — appropriate for:

- 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

Emergency Room — appropriate for:

- 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

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). 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, consult your insurance carrier at the customer service number on the back of your ID card.

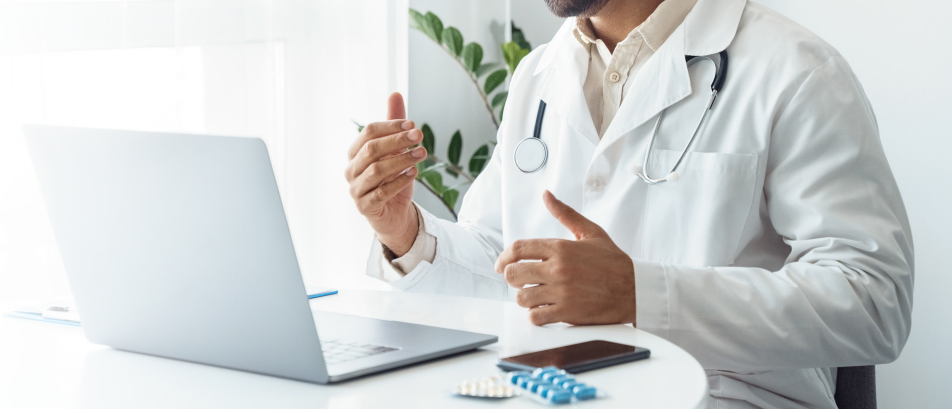
Contact CVS Virtual Care:

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



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 — 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 low-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. Members have 24/7 video access to licensed psychiatrists, therapists, and psychologists to help treat a broad range of issues. Common conditions members may utilize the services for are:

- Anxiety / Stress
- Depression
- Work pressures
- ADHD

Services are confidential, secure, and available at a $0 copay* to all employees currently enrolled in benefits.

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

GET STARTED WITH CVS VIRTUAL CARE TODAY

Visit **www.CVS.com/virtual-care** or scan the QR code.

MAXIMIZE YOUR BENEFITS



ALWAYS CONSIDER YOUR IN-NETWORK OPTIONS FIRST

You will typically pay less for covered services when providers are in-network with your medical plan. In-network providers agree to discounted fees. You are responsible only for any copay or deductible included in your plan design.

The amount you are required to pay out-of-pocket for out-of-network services may be significant.

To locate participating in-network providers:

Visit **www.aetna.com** and select "Find a Doctor."

Make sure you are using in-network labs:

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



IN-PATIENT OR OBSERVATION

The difference between inpatient and observation status is important because benefits and provider payments are based on the status. Patients admitted under observation status are considered outpatients, even though they may stay in the hospital and receive treatment in a hospital bed.

Hospital admission status may affect coverage for services such as skilled nursing. Some health plans, including Medicare, require a three-day hospital inpatient stay minimum before covering the cost of rehabilitative care in a skilled nursing care center. Observation stays — regardless of length — do not count toward the requirement.

A new law requires hospitals to give Medicare patients notice of an observation status within 36 hours. This status determines how the hospital bills your health plan. Even if you are **NOT** under Medicare, when you or your family member arrives at the hospital, you can ask questions like:

- Is the patient's status inpatient or observation?
- How long will the hospital stay be?
- Will there be a need for specialized skilled or rehab care after discharge?

Asking these questions throughout the hospital stay is important because hospitals can change the status from one day to the next. You can ask to have the status changed, but it is important to do so while still in the hospital. If necessary, you can request the hospital's patient advocate for assistance.

FIND AN IN-NETWORK PROVIDER

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 make the correct selection:

IF YOU ARE ENROLLING IN...	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
AETNA WHOLE HEALTH	Category Heading: Aetna Whole Health Plans Plan Name: (NJ) Aetna Whole Health New Jersey Choice POSII

MINUTE CLINICS AND HEALTH HUBS



CVS MINUTE CLINICS

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 HEALTH HUBS

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

Health Hubs Offer the Following Services:

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

HealthHUB®

PRESCRIPTION DRUG BENEFITS

EXPRESS SCRIPTS

If you enroll in one of the Aetna medical plans, you receive the prescription coverage corresponding to your plan in the table below.

	AETNA CHOICE POS II $10; AETNA CHOICE POS II $15; AETNA HMO $10	AETNA CHOICE POS II $15/$25; AETNA WHOLE HEALTH
EXPRESS SCRIPTS PLAN	**$3/$10/$10**	**$7/$16/$35**
RETAIL PHARMACY		
GENERIC DRUG	$3 copay	$7 copay
PREFERRED BRAND DRUG	$10 copay	$16 copay
NON-PREFERRED BRAND DRUG	$10 copay	$35 copay
BRAND DRUG W/ GENERIC EQUIVALENT	Member pays difference	Member pays difference
MAIL-ORDER PHARMACY		
GENERIC DRUG	$0 copay	$0 copay
PREFERRED BRAND DRUG	$15 copay	$40 copay
NON-PREFERRED BRAND DRUG	$15 copay	$88 copay
BRAND DRUG W/ GENERIC EQUIVALENT	Member pays difference	Member pays difference
ANNUAL OUT-OF-POCKET MAXIMUM		
PRESCRIPTION OUT-OF-POCKET MAXIMUM (Individual / Family)	$2,120 / $4,240	$2,120 / $4,240

Notes:

- Member Pays Difference: You pay the cost difference between the brand drug and the generic drug.
- 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. Refer to the Express Scripts formulary listing for more information or contact Express Scripts directly at 800.462.2006.



ADDITIONAL PRESCRIPTION INFO

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**.



UNDERSTANDING YOUR PRESCRIPTION DRUG PROGRAM

HOW TO GET STARTED WITH EXPRESS SCRIPTS HOME DELIVERY

Contact Express Scripts

- For transfers from a retail pharmacy, sign in at **www.Express-Scripts.com**, or
- Speak with speak with a prescription benefit specialist by calling **800.698.3757** (7:30 a.m. – 5 p.m., Central, Monday-Friday)

DIY—Do It Yourself

- Complete a home delivery order form
- Get a 90-day prescription from your doctor plus refills for up to one year (if applicable)
- Include your home delivery copayment(acceptable forms include credit/debit card, check or money order)
- Mail your form and prescription to Express Scripts at the address on the form. You can also have your doctor ePrescribe or fax your prescription.

Your medication will arrive by mail within 8 days of receipt of your initial prescription.

RECOMMENDED DRUG DOSING

Your Prescription Drug plan includes a program that reviews prescribed drug quantities to ensure your medications are being safely prescribed in accordance with FDA guidelines. The drug quantity review program provides the medications you need for good health, while making sure the dose you are receiving is considered safe.

For instance, if FDA guidelines allow one pill/dose per day the program will allow a maximum of 30 pills for a month's supply. This quantity will give you the right amount to take for a daily dose considered safe and effective.

SAVEON SP PROGRAM

The SaveOn SP program covers certain specialty medications at no cost for eligible members. The 150+ medications included in the program consist of products covering conditions such as Hepatitis C (Hep C), Multiple Sclerosis (MS), Psoriasis, Inflammatory Bowel Disease (IBD), Rheumatoid Arthritis (RA), Oncology, and others. To verify your eligibility please call **800.683.1074**.



DIGITAL ID CARDS

EXPRESS SCRIPTS

Due to the frequency in which plans and benefits can change, ESI will no longer issue physical ID cards. Digital ID cards are available at anytime, with the most up to date information.

CONNECT TO YOUR DIGITAL PRESCRIPTION ID CARD. ANYTIME. ANYWHERE.

No more digging through cards at the pharmacy counter. Easily create your digital profile at www.express-scripts.com or on the Express Scripts mobile app to gain instant access to your prescription ID card. You can view your card online or on the app, download it to your digital wallet, or even print a card from the Express Scripts site.

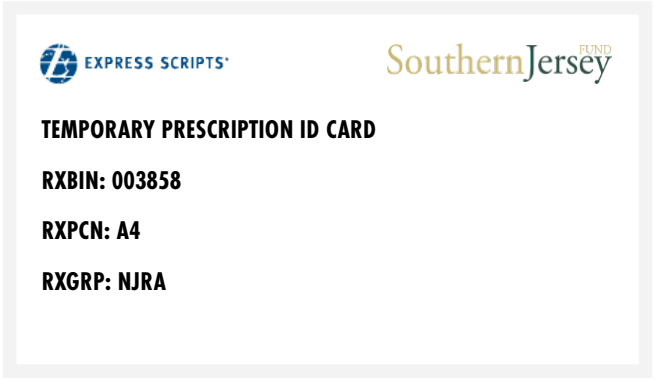
A digital profile also helps you connect to:

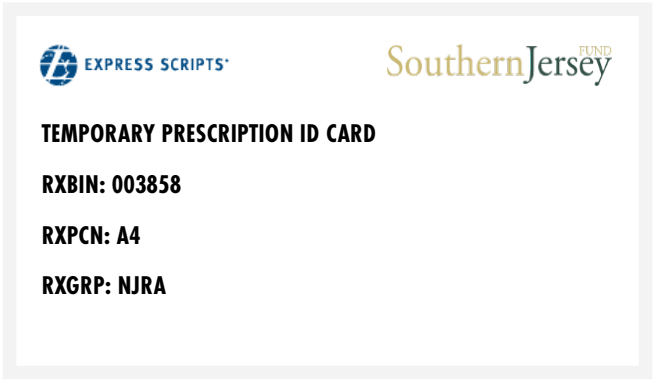
- Lower-cost medication options
- Nearby, in-network pharmacies
- More ways to manage your medications

TEMPORARY ID CARDS

For the temporary ID's to the right, when visiting a pharmacy make sure to ask the pharmacist to do the following when submitting a claim:

- Enter Bin Number
- Enter Processor Control Number
- Enter Rx Group Number
- Enter 9-digit member ID Number (Employee SSN)
- Enter the member's date of birth





* This is a temporary sample ID card. Please visit the Express Scripts website or download the Express Scripts app for your actual ID card.

DENTAL BENEFITS

DELTA DENTAL



Berlin Township offers two Delta Dental PPO Plus Premier / Advantage Program options. Maximum benefit is derived by utilizing the services of a participating dentist, although you may choose any fully licensed dentist to render necessary services. Over 300,000 dental offices nationwide participate in the Delta Dental network, and the Advantage Program adds a sub-network of New Jersey-only participating dental offices.

HIGH PLAN (GROUP #03603-00389):

- Two-tier benefit structure — pays a higher percentage when you use a Delta Dental PPO dentist and a slightly lower percentage when you use a Delta Dental Premier or non-participating dentist.
- $3,000 calendar year maximum per person when using a PPO dentist; $2,000 when using a Premier or non-participating dentist.
- Includes adult and child orthodontic coverage.

LOW PLAN (GROUP #03603-00385):

- Pays 50% on all covered services regardless of which dentist you use.
- $1,000 calendar year maximum per person.
- Orthodontic coverage is for dependent children only.

	HIGH PLAN		LOW PLAN	DELTA CARE USA DMO
DENTAL PLAN	**PPO DENTISTS**	**PREMIER/NON-PARTICIPATING DENTISTS**	**ALL DENTISTS**	
PREVENTIVE & DIAGNOSTIC (Exams, cleanings, bitewing X-rays — twice per calendar year; fluoride for children to age 19)	Plan pays 100%	Plan pays 90%	Plan pays 50%	Costs Vary
BASIC SERVICES (Fillings, extractions, endodontics, periodontics, oral surgery, sealants)	Plan pays 80%	Plan pays 70%	Plan pays 50%	Costs Vary
CROWNS & PROSTHODONTICS (Crowns, gold restorations, bridgework, full & partial dentures)	Plan pays 65%	Plan pays 55%	Plan pays 50%	Costs Vary
CALENDAR YEAR MAXIMUM (per person)	$3,000	$2,000	$1,000	Costs Vary
CALENDAR YEAR DEDUCTIBLE — PER PERSON (Waived on Preventive & Diagnostic)	$50	$75	None	Costs Vary
FAMILY AGGREGATE DEDUCTIBLE	$100	$150	None	Costs Vary
ORTHODONTIC COVERAGE	Plan pays 50% (Adult & Child)	Plan pays 50% (Adult & Child)	Plan pays 50% (Child only)	Costs Vary
ORTHODONTIC LIFETIME MAXIMUM – PER PATIENT	$1,000	$750	$800	Costs Vary

Notes:

- High Plan deductible is waived on Preventive & Diagnostic services.
- Participating dentists will be paid directly by Delta Dental to the extent that services are covered. Non-participating dentists will bill the patient directly, and Delta Dental will pay the member.
- This overview is provided as a convenient reference and does not include all benefits or limitations of the program. Complete details appear in the group contract between the plan sponsor and Delta Dental of New Jersey, Inc., which governs the benefits and operation of the program.

UNDERSTANDING YOUR DENTAL BENEFITS

CARRYOVER MAX

Carryover Max from Delta Dental is available on both plans and allows you to increase your benefits by carrying over a portion of your unused standard annual maximum into the next year and beyond. You can accumulate part of your unused benefit dollars from a healthy year and use it for services such as bridges, crowns, and root canals.

Carryover Max is easy and automatic:

- To qualify, you must receive at least one cleaning or one oral exam during the plan year. If you don't, you won't be eligible to carry over any benefit dollars to the following year, and any accumulated carryover will be lost.
- A covered person is eligible for the Carryover Max benefit if less than half of the standard annual maximum is used in the prior benefit year.
- You may carry over up to 25% of the unused portion of your standard annual maximum, up to a maximum of $500. (Example: if your standard annual maximum is $1,000 and you use $200, you can carry over $200.)
- The accumulated amount can never exceed your standard annual maximum.
- Standard annual maximum dollars are used first; Carryover Max dollars are used after the standard annual maximum is met.

ORAL HEALTH ENHANCEMENT OPTION

Delta Dental's Oral Health Enhancement Option enables you to receive up to four dental cleanings and/or periodontal maintenance procedures in any combination per benefit period if you have been treated for periodontal (gum) disease in the past. To qualify, you must have had periodontal surgery or periodontal scaling and planing in the past. Details on how to qualify can be found in your benefit booklet.

HOW TO USE YOUR DENTAL PLAN

- Visit your own dentist. If you do not have a dentist, a directory is available with your plan administrator listing participating dentists.
- You may call **1-800-DELTA-OK** (1-800-335-8265) and a list of participating dentists in your area will be mailed directly to your home, or visit **www.deltadentalnj.com**.
- During your **FIRST** appointment, tell your dentist that you are covered under this program. Provide the group name (Berlin Township), your Delta Dental Group Number (03603-00389 for the High Plan or 03603-00385 for the Low Plan), and your Member ID number.
- Customer Service is available Monday through Thursday, 8:00 a.m. to 6:30 p.m. ET, and Friday, 8:00 a.m. to 5:00 p.m. ET, at **1-800-452-9310**.



AETNA FITNESS BENEFIT PROGRAM AWARD

Through your participation in the SNJ Fund, insured members are able to take advantage of Aetna's reimbursement program for gyms and fitness.

A qualified health club is one that offers a variety of cardiovascular and strength-training exercise equipment. These include traditional health clubs, YMCAs, and JCCs.

The Fitness Program Award does not apply to martial arts centers; gymnastics facilities; country clubs; tennis, aerobic, or pool-only facilities; social clubs; and sports teams or leagues. It also does not apply to aerobic/fitness activity fees (including those paid for personal training, lessons, coaching, exercise equipment, or clothing) paid to a non-qualified health club.

You can simply complete the attached Fitness Program Award claim form and send it to the Aetna address at the top of the form, along with:

- **For Fitness Program Award reimbursement:** A copy of your health club agreement or contract that includes the name and address of the health club and the membership or completed log including class dates (see attached). A minimum of 12 visits per month must be completed **and/ or walk 10K steps a day** (or a combination there of). Member is limited to $240.00 reimbursement per year ($20 per month). Dependents must be over age 18 to be eligible.
- **Note:** Each 10K step day = one gym visit. Example: Submit 6 days of 10K steps and 6 days of Gym visits in a month would qualify as 1 monthly allowance. **ATTESTATION BOX MUST BE CHECKED FOR STEP CREDIT.**
- Photocopies of dated, paid receipts, or your bank or credit card statements, or paycheck stub if your club fees are automatically deducted from those accounts. Receipts or statements should include the name of the family member enrolled in the club and the individual charges for health club membership or class fees. Take a screen shot of your steps on your step tracking device i.e... phone, pedometer, smart watch.



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**



HOSPITAL SAFETY GRADE

LEAPFROG

KNOW WHERE TO GET CARE!

Before you decide which hospital to use for elective care; whether in your network or not, it is advisable to check the hospital's quality rating. You can do so by checking their Leapfrog Group ("Leapfrog") score.

Leapfrog is an independent, national not-for-profit organization founded more than a decade ago by the nation's leading employers and private health care experts. They strive to make giant "leaps" forward in the safety, quality, and affordability of health care in the U.S. by promoting transparency through our data collection and public reporting initiatives.

With their goal of saving lives by reducing errors, injuries, accidents, and infections, the Leapfrog Group focuses on measuring and publicly reporting hospital performance through the annual Leapfrog Hospital Survey.

The survey is a trusted, transparent, and evidence-based national tool in which over 2,300 hospitals voluntarily participate free of charge. The Leapfrog Group advocates for public access to quality and safety data from all U.S. hospitals. Their letter-based rating system (i.e., A, B, C, etc.) makes it easy for consumers and patients to make informed decisions about their quality and ability to deliver care effectively.

GETTING STARTED

Patients can check with their physician with questions about hospital quality. The service is free. To look up all Hospital Quality scores nationally, visit **www.hospitalsafetygrade.org**.



LEGAL NOTICES

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, 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

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:
Iowa Medicaid | Health & Human Services
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

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: http://www.state.nj.us/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

LEGAL NOTICES

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 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: 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 January 31, 2027, 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

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

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.

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.

1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

2 An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

3. Employee Name Berlin Township	4. Employer Identification Number (EIN) 21-0736046	
5. Employer Address 135 Route 73 South	6. Employer phone number 856-767-1854 ext. 211	
7. City West Berlin	8. State NJ	9. Zip Code 08091
10. Who can we contact about employee health coverage at this job? Lindsay Taylor	11. Phone number (if different from above):	12. Email address FinanceClerk2@berlintwp.com

TOWNSHIP OF BERLIN

Continuing Generations...

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.