camden county
Board of Social Services

Southern Jersey FUND

2025 OPEN ENROLLMENT GUIDE

Through membership in the Southern New Jersey Regional Employee Benefits Fund, Camden County Board of Social Services offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your benefit options and choose the best coverage for you and your family.

Open Enrollment Dates:
November 6, 2024 through November 22, 2024

It's Time to Review Your Benefits for 2025!

What is the Southern New Jersey Regional Employee Benefits Fund (SNJREBF)?

The Southern New Jersey Regional Employee Benefits Fund (and Health JIF) was founded in 1992 to provide public entities with a platform to purchase health insurance coverage in a shared-services environment. The Health JIF is a public entity that allows local public entities in the State of New Jersey to purchase collectively, thus taking advantage of economies of scale.

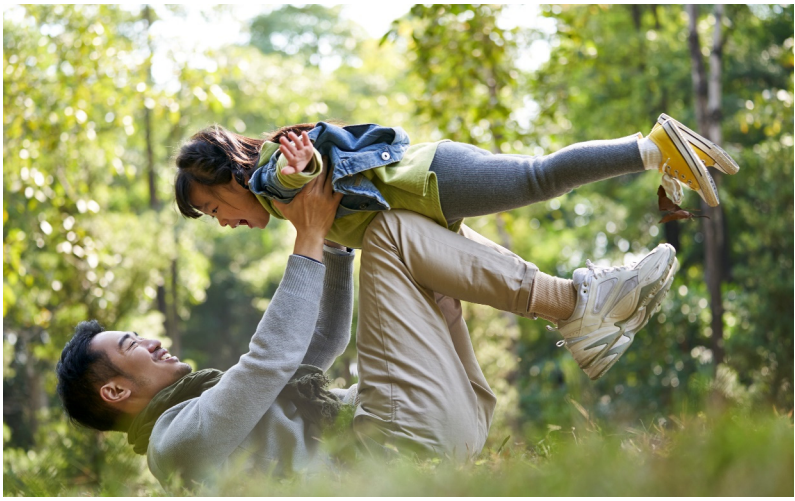
Through membership in the SNJREBF, your employer offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your benefit options through your employer's membership with the SNJREBF and choose the best coverage for you and your family.

The SNJREBF will hold a passive Open Enrollment, which means that if you are currently enrolled for benefits, your current plan elections will remain in place from January 1 through December 31, 2025, unless you elect to make a change.

Enrollment Instructions

You must complete and return an enrollment form to your benefits administrator if any of the following apply to you:

- You wish to add coverage for an eligible dependent;
- You wish to terminate coverage for a dependent that's currently enrolled;
- You are currently enrolled in coverage but you wish to waive it effective January 1, 2025;
- You have previously declined benefits but would like to now enroll for coverage for yourself and your eligible dependent(s) if applicable, effective January 1, 2025;
- You are an employee, non-Medicare retiree or COBRA participant that is currently enrolled in coverage and you wish to change your current plan elections, effective January 1, 2025.



Please contact your Benefits Administrator for all enrollment forms should you decide to change your benefit plan.

Qualified Life Events

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

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

Other Life Events:

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

- Death of a covered dependent
- Divorce

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.

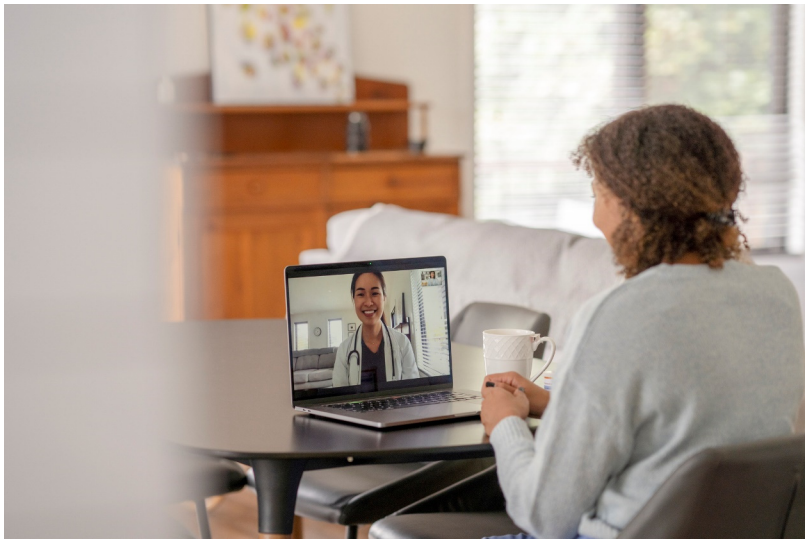
Visits to the ER can be very costly - consider your alternatives for emergent care. When you keep non-life threatening emergencies out of the ER, you help keep your health care costs down.

Know Where to Get Care

Before you go to the ER, consider whether your condition is truly an emergency or if you can receive care from Telemedicine or Urgent Care instead.

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

Please note: This communication is not intended to provide medical advice. If your medical need is more than urgent or life-threatening please go to the Emergency Room or call 9-1-1.



Access to High-Quality care at a lower cost - with $0 Copay*

Teladoc (Aetna & AmeriHealth members)

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

**If you are currently participating in a High Deductible Health Plan (HDHP), your copay may be more if you have not satisfied your in-network deductible.*

Maximize Your Benefits

In-Network Providers

Consider Your In-Network Options First
You will typically pay less for covered services when you visit providers that are part of your medical plan's network. In-network providers agree to discounted fees. You are responsible only for any co-pay or deductible that is included in your plan design. To verify that your providers are in-network, call the number on the back of your ID cards.

Limit Your Use of Out-of-Network Providers
The percentage of costs covered for out-of-network care is based on the plan allowance. If the plan allowance is less than the provider's actual charge, the provider may bill you for the difference between these two amounts. **The amount you are required to pay out-of-pocket may be significant.**

To Locate In-Network Providers

For participants of the **Aetna** plan, visit **www.aetna.com** and select "**Member Support**" and then "**Account Management**". Then click, "**Find a Doctor**". From there, you can search by zip code and mile radius to find a provider based on location, health conditions and more. When searching, be sure to choose either the ACPOSII or HMO network depending on your plan.

For participants of the **AmeriHealth Administrators** plan, visit **www.myahatpa.com**, select "Members" and then **"Find a Provider."** You can select a provider based on your region or by provider type.

Using In-Network Labs

Participants of **Aetna** plans may use either **Quest Diagnostics** or **LabCorp** for lab work.

For participants of the **AmeriHealth Administrators** plans, please be sure your provider sends your blood work to a **LabCorp** location or other free standing labs for results. Quest Diagnostics is **not participating** in the AmeriHealth Administrators network.

Maximize Your Benefits

In-Patient of Observation

Knowing the Difference is Important!

When a Hospital Stay Isn't a Stay

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 for several days 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. However, observation stays regardless of length, do not count towards the requirement.

Knowing the Level of Care

There are a few things you can do to protect yourself financially. Under Medicare, a new law requires hospitals to give Medicare patients verbal and written notice of an observation status within 36 hours. Even if you are NOT under Medicare you can request the status. This status determines how the hospital bills your health plan. When you or your family member arrives at the hospital, you can also 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.

Medical & Prescription Benefits

	AETNA/ AMERIHEALTH HMO	AETNA/AMERIHEALTH PPO 10		AETNA/AMERIHEALTH PPO 15		AETNA/ AMERIHEALTH HMO 1525	AETNA/AMERIHEALTH PPO 1525		AETNA/AMERIHEALTH PPO 2030		AETNA/AMERIHEALTH HMO 2035
MEDICAL PLAN BENEFITS	**In-Network ONLY**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network ONLY**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network ONLY**
Calendar Year Deductible	$100 for selected services	None	$100 individual $250 family	None	$100 individual $250 family	$100 for selected services	None	$100 individual $250 family	None	$200 individual $500 family	$200 individual $500 family
Medical Plan Out-of-Pocket Maximum	$7,360 individual $14,720 family	$400 individual $1,000 family	$2,000 individual $5,000 family	$7,360 individual $14,720 family	$2,000 individual $5,000 family	$7,360 individual $14,720 family	$7,360 individual $14,720 family	$2,000 individual $5,000 family	$7,360 individual $14,720 family	$5,000 individual $12,500 family	$7,360 individual $14,720 family
Preventive Services	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Not covered	Plan pays 100%
PCP Office Visit	$10 copay	$10 copay	Plan pays 80%*	$15 copay	Plan pays 70%*	$15 copay	$15 copay	Plan pays 70%*	$20 copay	Plan pays 70%*	$20 copay
PCP Required	Yes	No	No	No	No	Yes	No	No	No	No	Yes
Specialist Office Visit	$10 copay	$10 copay	Plan pays 80%*	$15 copay	Plan pays 70%*	$25 copay	$25 copay	Plan pays 70%*	$30 copay	Plan pays 70%*	$35 copay
Referral Required for Specialist Visit?	Yes	No	No	No	No	Yes	No	No	No	No	Yes
Diagnostic Lab & X-ray	Plan pays 100%	Plan pays 100%	Plan pays 80%*	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 70%*	Plan pays 80%*
Inpatient Hospital	Plan pays 100%	Plan pays 100%	$200 per stay then plan pays 80%*	Plan pays 100%	$200 per stay then plan pays 70%*	Plan pays 100%	Plan pays 100%	$200 per stay then plan pays 70%*	Plan pays 100%	$500 per stay then plan pays 70%*	Plan pays 80%*
Outpatient Surgery	Plan pays 100%	Plan pays 100%	Plan pays 80%*	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 100%	Plan pays 70%*	Plan pays 100%	Plan pays 70%*	Plan pays 80%*
Urgent Care Center	$10 copay	$10 copay	Plan pays 80%*	$15 copay	Plan pays 70%*	$25 copay	$25 copay	Plan pays 70%*	$30 copay	Plan pays 70%*	$35 copay
Emergency Room **	$85 copay	$75 copay		$75 copay		$75 copay	$100 copay		$125 copay		$300 copay
Vision	Exam: $10 copay Materials: Not Covered	Exam: $10 copay Materials: Not Covered	Not covered	Exam: $15 copay Materials: Not Covered	Not covered	Exam:$5 copay Materials: Plan pays $200 every 2 years	Exam:$25 copay Materials: Plan pays $200 every 2 years	Not covered	Exam:$30 copay Materials: Plan pays $200 every 2 years	Not covered	Exam:$35 copay Materials: Plan pays $200 every 2 years
EXPRESS SCRIPTS PRESCRIPTION DRUG BENEFITS (Retail: Up to a 30-day supply/Mail Order: Up to a 90-day supply)											
Retail: Generic/Brand/Non-Preferred	$3 / $10 / You pay difference***	$3 / $10 / You pay difference***		$3 / $10 / You pay difference***		$7 / $16/ You pay difference***	$7 / $16 / You pay difference***		$3 / $18 / You pay difference***		$7 / $21 / You pay difference***
Mail Order: Generic/Brand/Non-Preferred	$0 / $15 / You pay difference***	$0 / $15 / You pay difference***		$0 / $15 / You pay difference***		$0 / $40/ You pay difference***	$0 / $40 / You pay difference***		$0 / $36 / You pay difference***		$0 / $52 / You pay difference***
Prescription Drug Out-of-Pocket Maximum	$1,840 individual $3,680 family	$1,840 individual $3,680 family		$1,840 individual $3,680 family		$1,840 individual $3,680 family	$1,840 individual $3,680 family		$1,840 individual $3,680 family		$1,840 individual $3,680 family

* After deductible
** Emergency room copay waived if admitted
*** You pay the applicable generic copayment as listed above, plus the cost difference between the brand drug and the generic drug.

Note: Deductible waived for well baby and child exams/immunizations and routine GYN exam

Lower Cost Medical & Prescription Plans

	AMERIHEALTH 3-TIER PPO $15/30			AETNA SAVINGS PLUS 2-TIER PLAN	
MEDICAL PLAN BENEFITS	**Tier 1**	**Tier 2**	**Out-of-Network**	**Savings Plus - Tier 1**	**ACPOS II - Tier 2**
Calendar Year Deductible	None	$200 individual $1,000 family	$3,500 individual $7,000 family	None	$1,500 individual $3,000 family
Medical Plan Out-of-Pocket Maximum	$2,000 individual $4,000 family	$5,000 individual $10,000 family	$10,000 individual $30,000 family	$2,500 individual $5,000 family	$4,500 individual $9,000 family
Preventive Services	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%
PCP Office Visit	$15 copay	$45 copay	Plan pays 50%*	$5 copay	$20 copay
PCP Required	No	No	No	No	No
Specialist Office Visit	$30 copay	$60 copay	Plan pays 50%*	$15 copay	$30 copay
Referral Required for Specialist Visit?	Yes	No	No	No	No
Diagnostic Lab & X-ray	Plan pays 100%	Plan pays 70%*	Plan pays 50%*	$15 copay	Plan pays 80%*
Inpatient Hospital	$50 per day/$250 max per admission	Plan pays 70%*	Plan pays 50%*	$150 copay per admission	Plan pays 80%*
Outpatient Surgery	Plan pays 100%	Plan pays 70%*	Plan pays 50%*	$150 copay	Plan pays 80%*
Urgent Care Center	$30 copay	$60 copay	Plan pays 50%*	$15 copay	$30 copay
Emergency Room	$200 copay (waived if admitted)			$100 copay (waived if admitted)	
Vision	Exam: Plan pays 100%; Materials: Not Covered			Not covered	Not covered
EXPRESS SCRIPTS PRESCRIPTION DRUG BENEFITS (Retail: Up to a 30-day supply/Mail Order: Up to a 90-day supply)					
Retail: Generic/Brand/Non-Preferred	$10 / $25 / You pay difference****			$7 / $16 / You pay difference****	
Mail Order: Generic/Brand/Non-Preferred	$20 / $50 / You pay difference****			$18 / $40 / You pay difference****	
Prescription Drug Deductible	N/A			N/A	
Prescription Drug Out-of-Pocket Maximum	$3,000 individual $6,000 family			$1,840 individual $3,680 family	

* After deductible
** Deductible waived for well baby and child exams/immunizations and routine GYN exam
*** Emergency room copay waived if admitted
**** You pay the applicable generic copayment as listed above, plus the cost difference between the brand drug and the generic drug.

Understanding Your Prescription Drug Program

Express Scripts Home Delivery—How to Get Started

Contact Express Scripts

For transfers from a retail pharmacy, sign in at

Express-Scripts.com

Or speak to a prescription benefits specialist

1.800.698.3757

(7:30 a.m. – 5 p.m., Central, Monday-Friday)

OR

DIY—Do It Yourself

1. Complete a home delivery order form
2. Get a 90-day prescription from your doctor plus refills for up to one year (if applicable)
3. Include your home delivery copayment (acceptable forms include credit/debit card, check or money order)
4. 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.

SaveOnSP

In collaboration with SaveOnSP, ESI has introduced a pioneering copay assistance program, resulting in substantial cost savings by concentrating on expensive, frequently prescribed medications. SaveOnSP employs plan-design modifications to classify specific drugs as non-essential health benefits, leading to maximum cost reductions for both the healthcare plan and its members. In 2020, plan sponsors who enrolled in this program, experienced an impressive initial-year cost decrease of –7.2%, a significant improvement when compared to the 9.6% cost trend seen in ESI's overall business. Additionally, patients affected by this initiative incurred no out-of-pocket expenses.

Prescription Drug Program

ID Card Update

Due to the frequency in which plans and benefits can change, effective April 1, 2023, 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

For the temporary ID's below, make sure when visiting a pharmacy 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 members date of birth**

EXPRESS SCRIPTS® SouthernJersey FUND

Temporary Prescription ID Card

RxBin: 003858

RxPCN: A4

RxGRP: NJRA

EXPRESS SCRIPTS® SouthernJersey FUND

Temporary Prescription ID Card

RxBin: 003858

RxPCN: A4

RxGRP: NJRA

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

Urgent Care Centers

Did you know that your Urgent Care copay matches your medical plan's Specialist copay?

Urgent care centers are:

- A convenient, cost-effective medical care alternative when your primary care physician is unavailable.
- Typically no appointments are necessary, you can walk in.
- Extended hours are offered earlier and later than your primary care physician and most are open 7 days a week.

Urgent care centers are useful and appropriate for medical services that are not an emergency and require additional treatment such as:

- Allergies
- Asthma
- Stitches
- Sore Throat
- Strep Throat
- Ear Infection

Below is a chart showing the emergency room copay, the urgent care center copay and your estimated savings.

Plan	ER Copay	Urgent Care Copay	Estimated Savings
HMO 10	$85	$10	**$75**
PPO 10	$75	$10	**$65**
PPO 15	$100	$15	**$85**
HMO/PPO 1525	$100	$25	**$75**
HMO/PPO 2030	$125	$30	**$95**
HMO 2035	$300	$35	**$265**
3-Tier PPO 15/30	$200	$30	**$170**
Aetna 2-Tier	$100	$15	**$85**
PPO $4,000	$150	$80	**$70**

To find an Urgent Care Center near you, contact your medical carrier to locate a network facility.

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

Dental Benefits

Below is an overview of the Horizon Dental Plans, effective January 1, 2025 through December 31, 2025.

	DENTAL OPTION PLAN	HDC PLAN B	TOTALCARE
	In & Out-of-Network	**In-Network Only**	**In-Network Only**
Annual Deductible	$50 single / $150 family	None	None
Calendar Year Maximum (per patient)	$1,000	None	None
Orthodontia Lifetime Maximum (per patient)	$1,000	50% of treatment (child only)	None (child only)
Exams and Preventive Services* • Eligible Exams • Fluoride Treatments (child) • Sealant application • Prophylaxis	Plan pays 100%	Plan pays 100%	Plan pays 100%
X-rays* • Panoramic • Full-mouth X-rays	Plan pays 100%	Plan pays 100%	Plan pays 100%
Space Maintainers • Space Maintainers - fixed unilateral/bilateral	Plan pays 80%	Plan pays 50%	Plan pays 100%
Restorations and Repairs • Amalgam restorations • Composite restorations (other than for molars)	Plan pays 80%	Plan pays 100%	Plan pays 100%
Endodontics • Pulp cap/Pulpotomy • Root canal therapy- anterior, bicuspid • Root canal therapy molar • Denture adjustments and repairs	Plan pays 80% Plan pays 80%	Plan pays 100% Plan pays 50%	Plan pays 100% Plan pays 100%
Periodontics • Scaling and root planing • Gingivectomy • Soft tissue grafts • Periodontal maintenance • Osseous Surgery	Plan pays 80% Plan pays 80%	Plan pays 100% Plan pays 50%	Plan pays 100% Plan pays 100%
Oral Surgery • Routine extractions • Soft tissue surgical extractions • Incision and drainage of abscess • Surgical extraction - impacted	Plan pays 80% Plan pays 80%	Plan pays 100% Plan pays 50%	Plan pays 100% Plan pays 100%
Major Restoration - Crowns	Plan pays 50%	Plan pays 50%	Plan pays 100%
Dentures - Complete and partial	Plan pays 50%	Plan pays 50%	Plan pays 100%
Fixed Bridges -Retainers and pontics	Plan pays 50%	Plan pays 50%	Plan pays 100%
Orthodontia Procedures	Plan pays 50%	Plan pays 50% (child only)	Plan pays 100% (child only)

Note: Under the Dental Option Plan, members who obtain services from an Out-of-Network provider may be balance-billed.

NJ Coverage for Adult Dependents to Age 31

New Jersey Chapter 375 has been amended to provide qualified adult children under the age of 31 the chance to continue coverage as a dependent on their parent's medical and prescription coverage.

Does my child qualify to enroll in our plan?

Adult children may request enrollment as a dependent under your plan if the child meets the following criteria:

- Under the age of 31
- Had previously maintained creditable coverage from any state
- Unmarried
- Has no children or dependents of their own
- Lives in New Jersey or, if not a New Jersey resident, is a full-time student at an accredited institution of higher education
- Not eligible for Medicare and is not actually covered under another group or individual health plan

Must I reside in New Jersey to be eligible?

No, but you must be covered by a New Jersey fully insured health plan and your adult child must be a resident of the state or a full-time student at an accredited school in any state or country.

When can my child enroll or re-enroll under the terms of NJ's Adult Dependent law?

Eligible adult children who reach the limiting age under their parent's coverage may make an enrollment request at any time. Through this continuous open enrollment, an eligible young adult may enroll at any time with proof of prior creditable coverage. The coverage does not have to be from immediately prior to the enrollment.

How do I request enrollment for my child?

Contact the Camden County Board of Social Services Personnel Department to obtain an enrollment packet that will include an application and rate information. The dependent must enroll in the same plan as the employee and coverage is available for medical and prescription drug. Each dependent will be billed directly at their home. Employers do not make any contributions to adult dependent coverage and it cannot be billed as a payroll deduction to the employee. Please return the completed application to Tameka Medley in Personnel.

How does this law impact COBRA?

If your child ages-out of your health plan, they have the option of electing COBRA for 36 months OR electing coverage under the NJ Dependent Coverage law. You will need to weigh the pros and cons of each option before enrolling. While COBRA coverage will last for up to 36 months, it is important to note that coverage under NJ Chapter 375 is contingent upon you as the employee remaining covered and on your child maintaining their qualifications under the criteria above. NJ Chapter 375 coverage is partially subsidized by the state and the rates are lower than the cost of COBRA coverage. Losing coverage under NJ's law will not create a new COBRA qualifying event.

Your Wellness Resources

HealthyLearn

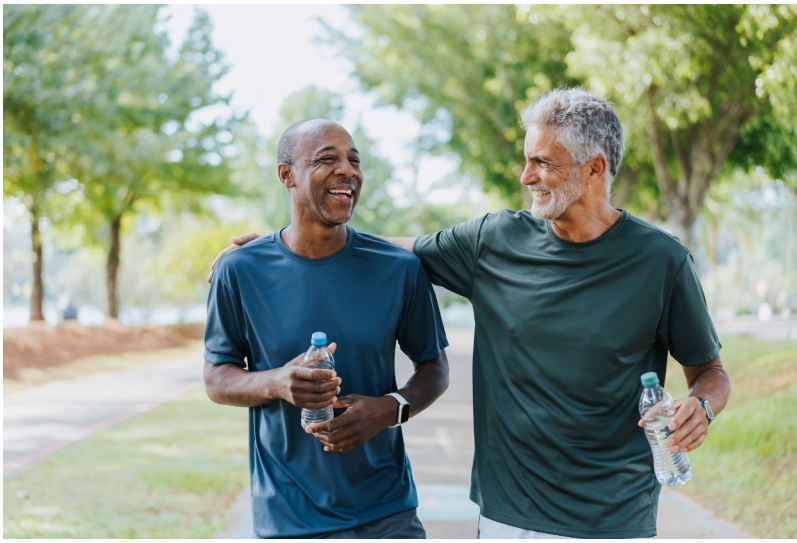
Online Health and Wellness Resource

Available to all Fund members, the HealthyLearn website provides over a thousand health and wellness topics in a simple, straightforward manner. The data and information is laid out in an easy-to-follow format. HealthyLearn includes the following interactive features and services:

- COVID-19 Resources
- Ask the Coach
- Rotating Health Tip-of-the-Day
- Symptom Checker
- Health News
- Medical Self-Care Guides
- Wellness and Disease Management
- Tobacco Cessation
- Stress Management
- Nutrition and Weight Loss
- Health Trackers
- Monthly Wellness Newsletter
- And much more!

The HealthyLearn On-Demand Library offers all of the content you'd expect delivered on a site so user friendly you may never go anywhere else for health information.

*Learn more and get started on your path to wellness today by visiting HealthyLearn at **healthylearn.com/connerstrong**.*



Ramp Health

Camden Board of Social Services is pleased to offer wellness coaching for employees through Ramp Health.

Our Wellness Coach, Kathryn Friedman, provides one-on-one coaching sessions to educate employees on topics such as:

- Nutrition
- Healthy Eating
- Exercise
- Weight Loss
- Stress
- Blood Pressure
- Smoking Cessation

Kathryn is available for sessions every week Monday – Friday from 8:30am to 4:30pm. Wednesday and Thursday sessions are typically dedicated to nutrition and dietary coaching. If you would like to schedule an appointment with Kathryn, please email Kathryn at **kfriedman@ramphealth.com** or call **856.433.1545**.

CVS 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 appointment 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 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

Health HUB

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

Health Hubs offer the following services:

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

Questions? Who to Call...

The resources identified below are available to assist you with any questions that you may have about your benefits. If you are unsure of which plan you are enrolled in, please refer to your medical ID card.

QUESTIONS REGARDING	PHONE NUMBER	WEBSITE/ADDRESS
Medical Benefits Aetna	800.370.4526	www.aetna.com
Medical Benefits AmeriHealth Administrators	844.352.9198	www.ahatpa.com
Prescription Drug Benefits Express Scripts	888.327.9791	www.express-scripts.com
Dental Benefits Horizon Blue Cross Blue Shield	800.433.6825	www.horizonblue.com
Benefits Member Advocacy Center Conner Strong & Buckelew	800.563.9929	www.connerstrong.com/memberadvocacy

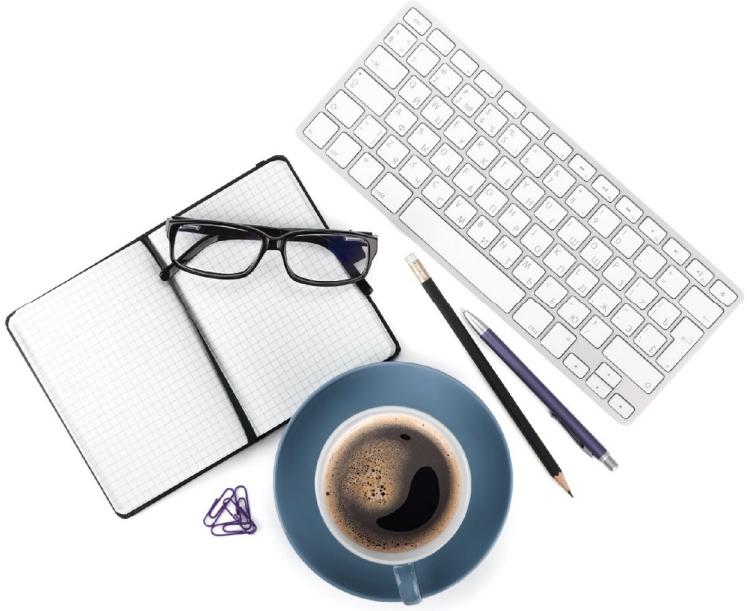
BenePortal

Online Benefits Resource

Beneportal is your virtual employee benefits portal, providing access to company benefits programs, health and wellness information, recommended links, and pertinent forms and guides.

Beneportal features include:

- Secure online access
- Mobile optimized site
- Direct links to specific insurance carrier sites
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!



Beneportal is available 24/7 to employees and their dependents. Simply go to **www.CamdenBossBenefits.com** to access your benefits information today!

Legal Notices

Availability of Summary Health Information
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Southern New Jersey Regional Employee Benefits Fund offers a series of health coverage options. You should receive a Summary of Benefits and Coverage (SBC) during Open Enrollment. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions or did not receive your SBC.

Patient Protection and Affordable Care Act
Please note: the Fund medical plans are considered compliant with the Patient Protection and Affordable Care Act. There are no annual limits, dependent children can be covered to age 26 and preventive care is covered at 100% with no member cost-sharing and the pre-existing exclusion limitations have been removed.

As new Health Care Reform requirements become effective, the Fund plans will be modified. We are fully committed to complying with all regulations and intend to notify you as soon as possible of any change(s).

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

Women's Health and Cancer Rights Act
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. 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
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 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
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
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

Legal Notices

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

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

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

MAINE – Medicaid
Enrollment Website:
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: 617-886-8102
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

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

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

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

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

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

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

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

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

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

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
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
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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
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-MyWVHIPP (1-855-699-8447)

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

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

To see if any other states have added a premium assistance program since July 31, 2023, 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

PLEASE NOTE: *This communication only applies to the benefits that your employer has through the Southern New Jersey Regional Employee Benefits Fund.*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Board of Social Services


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