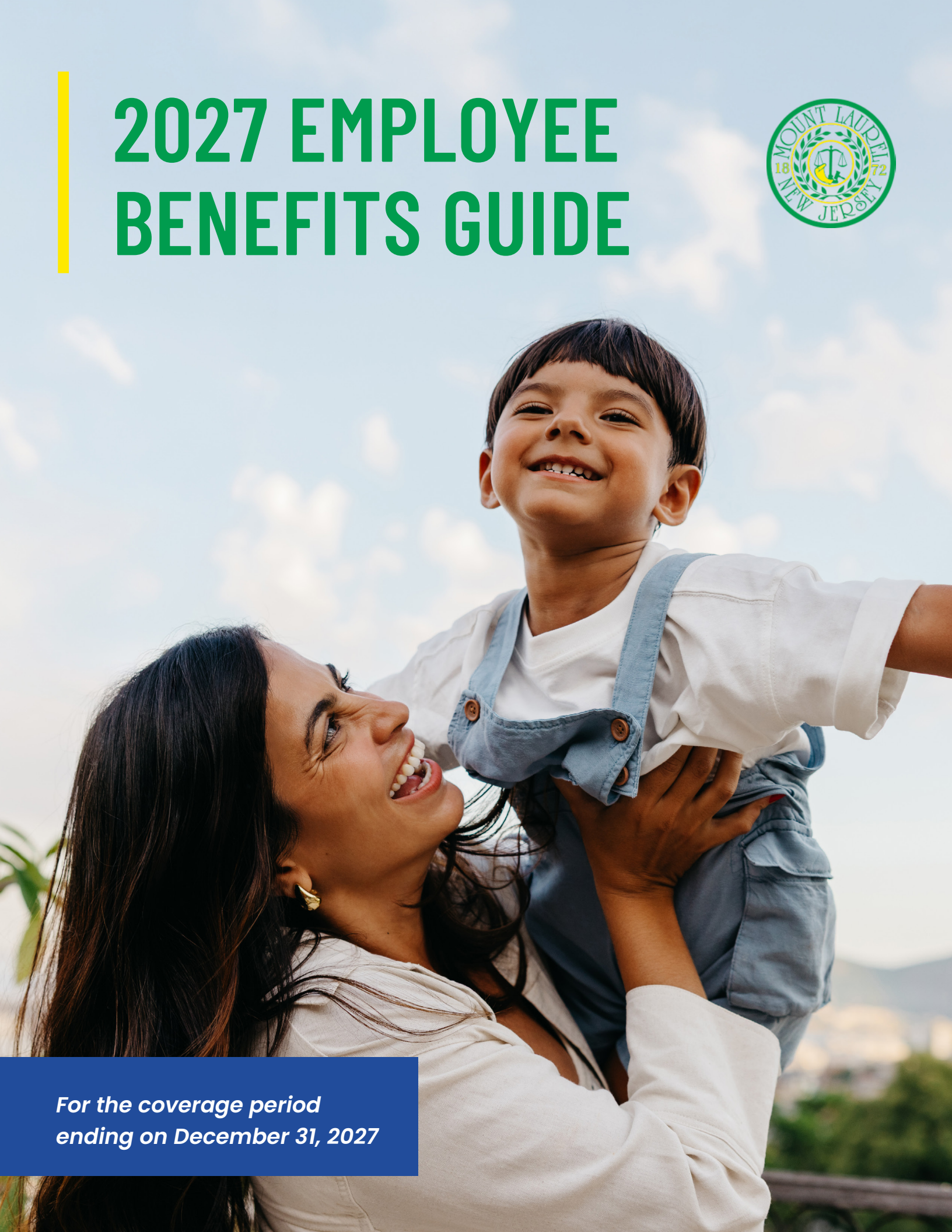
2027 EMPLOYEE BENEFITS GUIDE



For the coverage period ending on December 31, 2027

Welcome! At Mount Laurel Township, we are committed to providing a comprehensive benefits package that supports the health, well-being, and financial security of you and your family. Our employees are our greatest asset, and we are proud to offer valuable benefits to help meet your needs.

Please take a few moments to review this guide and familiarize yourself with your benefit options so you can make the choices that are right for you and your eligible dependents.

Questions?

If you have questions about the benefits outlined in this guide, please contact the Conner Strong & Buckelew Benefits Member Advocacy Center (Benefits MAC) at **800.563.9929** or submit a request online at **connerstrong.com/memberadvocacy**.

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Eligibility, Enrollment & Making Plan Changes

WHAT DO YOU NEED TO DO NOW?

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

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

WHO IS ELIGIBLE TO ELECT BENEFITS?

Full-time employees who work 30 or more hours per week.

WHEN DO WAITING PERIODS END?

Eligible employees are covered on the 1st of the month following 30 days of employment.

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.) with the exception of birth, which has been extended to 90 days
- Newly eligible individual and eligible dependents may enroll within 60 days of the eligibility date (marriage/adoption, etc.) with the exception of birth, which has been extended to 90 days
- Eligible individuals or dependents who are eligible for enrollment but do not enroll within the first 60 days following eligibility, may be enrolled during any subsequent Open Enrollment period.

MAKING PLAN CHANGES

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
- Death of a covered dependent
- Divorce



Dependent Information

WHO IS A DEPENDENT?

- Spouse, Domestic Partner, 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 if approved. Forms can be found on your BenePortal.
- Under the Patient Protection and Affordable Care Act: A child is defined as an enrollee's child until age 26, regardless of the child's martial, student, or financial dependency status even if the young adult no longer lives with his or her parents (for medical and prescription coverage).

CHILD DEPENDENT TIMEFRAMES

- **Medical & Prescription Coverage:** Young adults will be covered through the end of the year in which they turn age 26.
- **Dental Coverage:** Dependent children are covered until the end of the calendar year in which age 26 is attained.
- **Vision Coverage:** Dependent children are covered until the end of the month in which they turn 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 parents' coverage to elect to remain covered until age 31, if certain other eligibility standards are met.

Go to **https://state.nj.us/dobi/division_consumers/du31.html** for more information regarding dependent coverage to age 31. Please note, the young adult would be the one billed directly for coverage. Please contact the Human Resources department 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 pertaining to your pension and benefits for the following family status changes:

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

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

Medical Benefits: Aetna

Mount Laurel Township offers the below medical plan options (see additional plans on the following pages).

	CHOICE POS II $10 (OPEN ACCESS)	CHOICE POS II $15 (OPEN ACCESS)	CHOICE POS II $15/$25 (OPEN ACCESS)
IN-NETWORK BENEFITS	**NATIONWIDE**	**NATIONWIDE**	**NATIONWIDE**
Deductible *(Individual/Family)*	None	None	None
Coinsurance	You pay 10%	You pay 10%	You pay 10%
Total 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 Routine Physical	$0	$0	$0
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/Occupaitonal Therapy	$10 copay	$15 copay	$25 copay
Diagnostic Lab/X-Ray/Imaging *(MRC, CT-Scan)*	$0	$0	$0
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%
Inpatient/Outpatient Facility	$0	$0	$0
Outpatient Behavioral Health	$10 copay	$15 copay	$25 copay
Durable Medical Equipment (DME)	You pay 10%	You pay 10%	You pay 10%
OUT-OF-NETWORK BENEFITS			
Deductible *(Individual/Family)*	$100 / $250	$100 / $250	$100 / $250
Total Out-of-Pocket Maximum *(Individual/Family)*	$2,000 / $5,000	$2,000 / $5,000	$2,000 / $5,000
Coinsurance	You pay 20% after deductible	You pay 30% after deductible	You pay 30% after deductible
Inpatient Hospital	$200 / stay	$200 / stay	$200 / stay

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

Medical Benefits: Aetna

Mount Laurel Township offers the below medical plan options (see additional plans on the following pages).

	CHOICE POS II $20 (OPEN ACCESS)	CHOICE POS II $20/$35 (OPEN ACCESS)	HMO $10
IN-NETWORK BENEFITS	**NATIONWIDE**	**NATIONWIDE**	**NATIONWIDE AETNA HMO NETWORK**
Deductible *(Individual/Family)*	None	$200 / $500	See DME
Coinsurance	You pay 10%	You pay 20%*	See DME
Total Out-of-Pocket Maximum *(Individual/Family)*	$800 / $2,000	$2,000 / $5,000	$8,480 / $16,960
PCP Office Visits	$20 copay	$20 copay	$10 copay
Annual Routine Physical	$0	$0	$0
Telemedicine	$0	$0	$0
Specialist Office Visit	$20 copay	$35 copay	$10 copay ***(Referral Required)***
Routine Vision Exam	$20 copay	$35 copay	$10 copay
Chiropractic Care	$20 copay	$35 copay	$10 copay
Physical/Speech/Occupaitonal Therapy	$20 copay	Office Visit: $35 copay Outpatient Facility: You pay 20%*	$10 copay
Diagnostic Lab/X-Ray/Imaging *(MRC, CT-Scan)*	$0	You pay 20%*	$10 copay
Urgent Care Center	$20 copay	$35 copay	$10 copay
Emergency Room	$125 copay	$300 copay	$85 copay
Ambulance	You pay 10%	You pay 20%*	$0
Inpatient/Outpatient Facility	$0	You pay 20%*	$0
Outpatient Behavioral Health	$20 copay	Office Visit: $35 copay Outpatient Facility: You pay 20%*	$10 copay
Durable Medical Equipment (DME)	You pay 10%	You pay 20%*	$100 deductible, then covered in full
OUT-OF-NETWORK BENEFITS			
Deductible *(Individual/Family)*	$200 / $500	$800 / $2,000	No out-of-network coverage in this plan
Total Out-of-Pocket Maximum *(Individual/Family)*	$5,000 / $12,500	$6,500 / $13,000	
Coinsurance	You pay 30%	You pay 40%	
Inpatient Hospital	$500 / stay	$600 / stay	

**** After Deductible***

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

Medical Benefits: Aetna

Mount Laurel Township offers the below medical plan options (see additional plans on the previous pages).

	CHOICE POS II 2019	Whole Health Plan	
IN-NETWORK BENEFITS	**NATIONWIDE**	**NJ ONLY**	**NATIONWIDE**
Deductible *(Individual/Family)*	$100 / (N/A Family)	None	$1,500 / $3,000
Coinsurance	You pay 10%*	None	You pay 20%*
Total Out-of-Pocket Maximum *(Individual/Family)*	$800 / $2,000	$2,500 / $5,000	$4,500 / $9,000
PCP Office Visits	$15 copay	$5 copay	$20 copay
Annual Routine Physical	$0	$0	$0
Telemedicine	$0	$0	$0
Specialist Office Visit	$15 copay	$15 copay	$30 copay
Routine Vision Exam	$15 copay	$15 copay	$30 copay
Chiropractic Care	$15 copay	$15 copay	$30 copay
Physical/Speech/Occupaitonal Therapy	$15 copay	Office Visit: $5 copay Outpatient Facility: $15 copay	Office Visit: $20 copay Outpatient Facility: You pay 20%*
Diagnostic Lab/X-Ray/Imaging *(MRC, CT-Scan)*	$0	$15 copay Freestanding Facility: $0	You pay 20%* Freestanding Facility: $0
Urgent Care Center	$15 copay	$15 copay	$30 copay
Emergency Room	$50 copay	$100 copay	$100 copay
Ambulance	You pay 10%*	$0	$0
Inpatient/Outpatient Facility	$0	$150 copay per admission	You pay 20%*
Outpatient Behavioral Health	$15 copay	$15 copay	Office Visit: $30 copay Outpatient Facility: You pay 20%*
Durable Medical Equipment (DME)	You pay 10%*	$0	$0
OUT-OF-NETWORK BENEFITS			
Deductible *(Individual/Family)*	$400 / $1,000	No out-of-network coverage in this plan	
Total Out-of-Pocket Maximum *(Individual/Family)*	$2,000 / $5,000		
Coinsurance	You pay 30%*		
Inpatient Hospital	$500 / stay		

** After Deductible*

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

Find an In-Network Provider: Aetna

- **STEP 1:** Visit Aetna's website at **aetna.com**
- **STEP 2:** At the middle of the webpage on the right, click on *"Find a Doctor"*
- **STEP 3:** On right side of page under Guest, select *"Plan from an employer"* (1st choice on the list)
- **STEP 4:** Under Continue as Guest, enter your zip code, city, state or county
- **STEP 5:** You will be asked to *"Select a Plan"*, please refer to your ID card for correct plan selection

If You're 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 – Aetna Select Multi-Tier*

When you do your search, under the provider's name look under "Highlights & Recognitions"it will say if it is a Maximum or Standard savings provider.



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

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

HOW TO ACCESS TELEMEDICINE 24/7

$0 Cost Telemedicine vs. Virtual Office Visits

Telemedicine services are different from virtual/telephonic office visits with your participating provider. Most health plans have a $0 copay for CVS Virtual Care Telemedicine services. Visit **cvs.com/virtual-care** for more information.

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



Telemedicine: CVS Virtual Care

YOUR CARE. YOUR WAY

Convenient and affordable virtual care wherever you need it

From your therapy appointments to quick care, CVS Health Virtual Care has got you covered. You can use CVS Health Virtual Care in addition to your traditional network of providers. Access is included as part of your medical plan from Aetna, a CVS Health company because healthier happens together.

- **On-Demand Care:** Access 24/7 quick care for minor illnesses and injuries
- **Mental Health Services:** Get counseling for things like anxiety and stress, plus psychiatry services for medication management.
- Extend to in-person care when needed at nearby MinuteClinic locations or in-network provider clinics.

GET STARTED TODAY WITH CVS HEALTH VIRTUAL CARE

- Activate your virtual care benefit by visiting **cvs.com/virtual-care**
- Create an account and confirm your details
- Schedule a mental health appointment, or request on-demand care 24/7/365

Scan the QR code to activate your virtual care benefit!



Maximize Your Benefits

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. However, observation stays regardless of length, do not count towards 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 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 discharged?

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.

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 that is 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 In-Network Providers

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

Make Sure You Are Using In-Network Labs

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



Minute Clinic and Health HUB

CVS MINUTE CLINIC

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.

Highlights of CVS Minute Clinic:

- 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 7 days a week with convenient evening hours

CVS Minute Clinic practitioners can:

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

minute clinic®

HEALTHHUB

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**.

HealthHUB offers 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

Mount Laurel Township offers the following prescription plan options to their staff. If you enroll in one of the Aetna medical plans, you receive the prescription drug coverage corresponding to your plan below.

	CHOICE POS II $10, CHOICE POS $15, HMO $10	CHOICE POS II $15/$25, WHOLE HEALTH PLAN	CHOICE POS II 2019	CHOICE POS II $20	CHOICE POS II $20/$35
SNJFund/Express Scripts Plan	**$3/$10/$10**	**$7/$16/$35**	**$7/$16/DIFF**	**$3/$18/$46**	**$7/$21/DIFF**
Retail Pharmacy					
Generic Drug	$3 copay	$7 copay	$7 copay	$3 copay	$7 copay
Preferred Brand Drug	$10 copay	$16 copay	$16 copay	$18 copay	$21 copay
Non-Preferred Brand Drug	$10 copay	$35 copay	Member Pays Difference	$46 copay	Member Pays Difference
Brand Drug w/Genric Equivalent	Member Pays Difference	Member Pays Difference	Member Pays Difference	Member Pays Difference	Member Pays Difference
Mail Order Pharmacy					
Generic Drug	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Preferred Brand Drug	$15 copay	$40 copay	$40 copay	$36 copay	$52 copay
Non-Preferred Brand Drug	$15 copay	$88 copay	Member Pays Difference	$92 copay	Member Pays Difference
Brand Drug w/Genric Equivalent	Member Pays Difference	Member Pays Difference	Member Pays Difference	Member Pays Difference	Member Pays Difference
Annual Out-of-Pocket Maximum *(Individual/Family)*	$1,840 / $3,680	$1,840 / $3,680	$1,840 / $3,680	$1,840 / $3,680	$1,840 / $3,680

Member Pays Difference: You pay the cost difference between the brand drug and the generic drug.

PLEASE NOTE:

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



Additional Prescription 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: **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 **express-scripts.com**, or
- Speak with a prescription benefit specialist by calling **800.698.3757** (Monday - Friday, 7:30 am to 5:00 pm, CT)

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 make 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 PROGRAM

The SaveonSP 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

CONNECT TO YOUR DIGITAL PRESCRIPTION ID CARD

Anytime. Anywhere.

No more digging through cards at the pharmacy counter. Easily create your digital profile at **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.

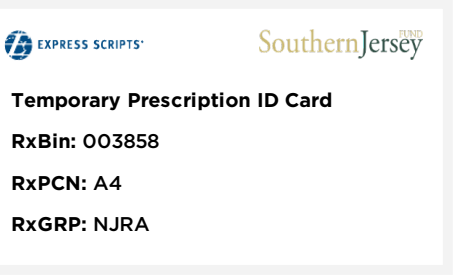
A digital profile also helps you connect to:

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

TEMPORARY ID

For the temporary ID below, 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 members 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

Below is a summary of the dental plan options available to you and your family, administered by Delta Dental. For additional information regarding your dental contributions, please refer to your Human Resources Office for assistance.

	DELTACARE PLAN	PPO PLUS PREMIER PLAN	
BENEFITS	**DELTACARE PROVIDERS ONLY** Members must visit a DeltaCare Provider for services. Members may not seek services out-of-network	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Deductible *(Individual/Family)*	None	$3,000	$2,000
Calendar Year Maximum *(per patient)*	None	$50 / $100 aggregate	$75 / $150 aggregate
Preventive & Diganostic Services *Exams, Cleanings, Bitewing X-rays, Sealants (permanent molars only), Fluoride Treatement*	$0 - $45 (depending on service)	Plan pays 100%	Plan pays 90%
Basic Services *Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Osseous Surgery*	$0 - $280 (dependent on service)	Plan pays 80%	Plan pays 70%
Major Services *Crowns, Gold Restorations, Bridgework, Full and Partial Dentures*	$0 - $240 (depending on service)	Plan pays 50%	Plan pays 40%
Orthodontia Benefits	Various copays apply to each stage and are covered for 24 months	Plan pays 50% (child only to age 19); $1,000 Lifetime Maximum	Plan pays 50% (child only to age 19); $1,000 Lifetime Maximum

FINDING A PROVIDER

DeltaCare Plan

- Customer Service: **800.422.4234**
- Provider Search: Visit **deltadentalins.com** and select ***"Find a Dentist"*** at the top, enter address, and select DeltaCare USA as your plan.

PPO Plus Premier Plan

- Customer Service: **800.452.9310**
- Provider Search: Call **800.335.8265** for a list of participating dentists located in your area or search online at **deltadentalnj.com**. Select ***"Online Tools"*** and then search for participating providers. Enter your address and PPO Plus Premier for the plan name.



Vision Benefits: NVA

Below is a summary of the vision plan option available to you and your family, administered by NVA. For additional information regarding your vision contributions, please refer to your Human Resources Office for assistance.

	NVA VISION PLAN	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK REIMBURSEMENT**
Vision Exam	$25 copay	Up to $45
Frames	Up to $130 allowance (20% discount off balance)*	Up to $70
Lenses		
Single Vision Lenses	Covered 100% after $25 copay	Up to $30
Bifocal Lenses	Covered 100% after $25 copay	Up to $50
Trifocal Lenses	Covered 100% after $25 copay	Up to $65
Lenticular Lenses	Covered 100% after $25 copay	Up to $100
Contact Lenses *(in lieu of lenses)*	Up to $130 allowance (15% discount off balance for conventional lenses; 10% off balance for disposable lenses)**	Up to $105
Frequency		
Vision Exam	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months

* Does not apply to Walmart/Sam's Club Locations or for certain proprietary brands.
** Does not apply to Walmart/Sam's Club, Contact Fill (NVA Mail Order) or certain locations at: Target and Pearle and may be prohibited by some manufacturers.

NVA ID CARDS

When you enroll in the NVA vision plan you will receive two ID cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA ID card to the provider or indicate that your benefit is administered by NVA.

The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

LOCATE PARTICIPATING PROVIDERS

To verify your benefit eligibility prior to visiting your eye care provider, visit e-nva.com or call 800.672.7723.

If you are not a registered subscriber, you can still search providers online by selecting the "Find a Provider" link on NVA's webisite. Enter the group number shown on your ID card and then enter your search parameters.



Life/AD&D and Disability Benefits: The Standard

GROUP BASIC LIFE/AD&D INSURANCE

Group Basic Life and AD&D insurance helps to provide financial protections by promising to pay a benefit in the event of an eligible member's covered death.

If you are an active employee of Mount Laurel Township and regularly work at least 35 hours each week, the cost of this insurance is paid by Mount Laurel Township.

GROUP LIFE/AD&D INSURANCE	
Life Benefit Amount	1x your annual earnings to a maximum of $50,000
AD&D Benefit	Equal to Basic Life amount
Benefit Reduction	65% at age 65 40% at age 70 25% at age 75 20% at age 80

GROUP SHORT-TERM DISABILITY (STD) INSURANCE

This coverage replaces a portion of your income when you can't work because of a qualifying disability. Even if you are healthy now, it's important to protect yourself and the people who count on your income. This insurance can help you pay the bills when you are unable to work.

SHORT-TERM DISABILITY (STD) INSURANCE	
Benefit Amount	60% of your eligible earnings
Maximum Weekly Benefit	$1,000 per week
Waiting Period	30 days
Duration of Benefits	30 days

GROUP LONG-TERM DISABILITY INSURANCE (LTD)

This coverage is designed to replace a portion of your income when you are disabled for an extended period of time due to a qualifying disability and help you get back to work when you are ready.

LTD insurance benefits can help you pay your bills and safeguard your savings when you are unable to work. Whether you are out for a few months or several years, this benefit can help you protect your income — and those who depend on it.

LONG-TERM DISABILITY (LTD) INSURANCE	
Benefit Amount	60% of your eligible earnings
Maximum Weekly Benefit	$10,000 per month
Waiting Period	180 days
Duration of Benefits	Until Social Security Normal Retirement Age (SSNRA)



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: **marketplace.huskwellness.com/connerstrong**

GOODRX

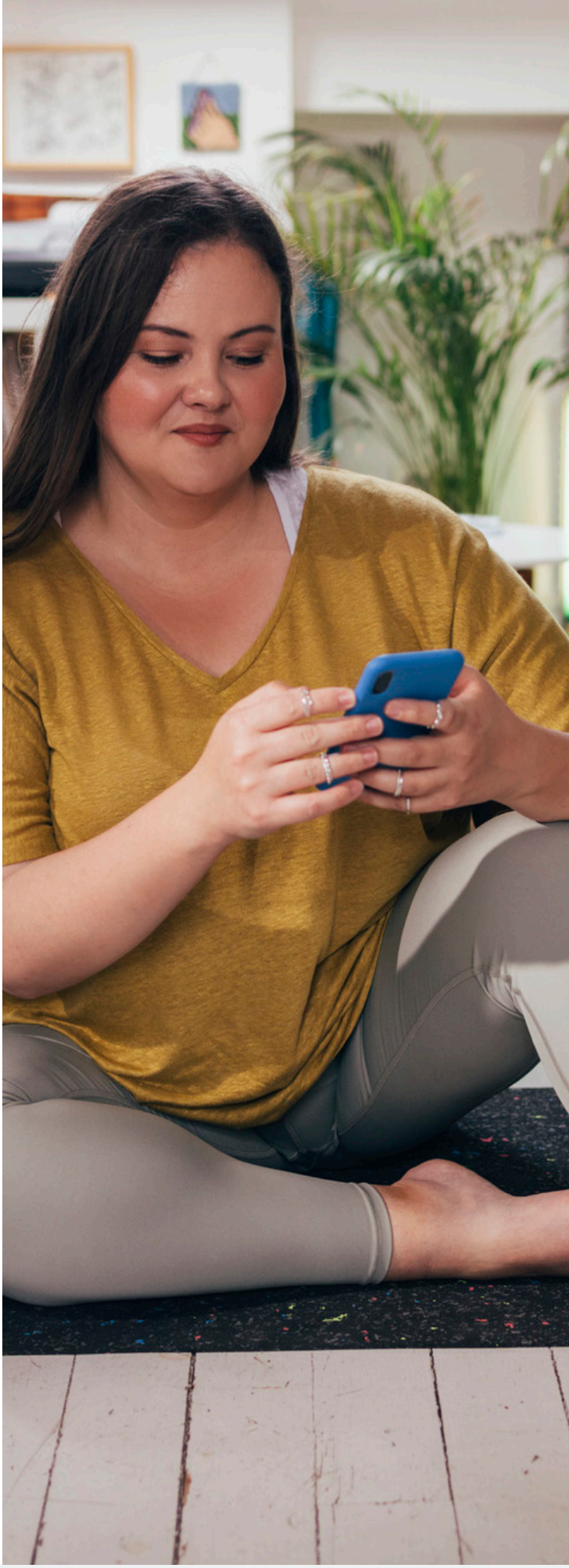
Compare drug prices at local and mail-order pharmacies and discover free coupons and savings tips.

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 **hospitalsafetygrade.org**.



Employee Resources

BENEFITS MAC

The Benefits Member Advocacy Center (Benefits MAC), provided by Conner Strong & Buckelew, allows you to speak to a specially trained Member Advocate who can help you get the most out of your benefits.

You can contact Member Advocacy for assistance if you:

- Believe your claim was not paid properly
- Need clarification on information from the insurance company
- Have a question regarding a medical bill
- Are unclear on how your benefits work
- Need help resolving a benefits problem you've been working on

You can contact Member Advocacy in any of the following ways:

- **Phone: 800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm
- **Web: connerstrong.com/memberadvocacy**
- **Email: cssteam@connerstrong.com**

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.

BENEPORTAL

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

By using BenePortal, our online tool that houses our benefit program information, you can:

- Review medical/prescription drug, vision, and dental plan options
- Explore additional employee resources available to you
- Find links to carrier websites
- Download plan documents, forms, etc.

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



Carrier Contacts

Have questions about your benefits? The following contacts and resources are available to you.

QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE
Eligibility, Enrollment, Plan Options, Contributions, Qualifying Life Events, etc.	Benefits MAC	800-563-9929	www.connerstrong.com/memberadvocacy
Medical Benefits *Benefit questions, claims, locating a provider, printing ID cards*	Aetna	800-370-4526	www.aetna.com
Prescription Drug Benefits	Express Scripts	800-467-2006	www.express-scripts.com
Dental Benefits	Delta Dental	DeltaCare Plan: 800-422-4234 PPO Plus Premier Plan: 800-452-9310	DeltaCare: www.deltadentalins.com PPO Plus Premier: www.deltadentalnj.com
Vision Benefits	NVA	800-672-7723	www.e-nva.com
Telemedicine	CVS Virtual Care	888-607-4287	www.CVS.com/virtual-care
Life/AD&D and Disability Benefits	The Standard	888-937-4783	www.standard.com



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

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

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

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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/

Legal Notices

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

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

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

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

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

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

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

Legal Notices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Insurance Marketplace Notice

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer Name Mount Laurel Township	4. Employer Identification Number (EIN) 22-1915868	
5. Employer Address 750 Centerton Road	6. Employer phone number (856) 234-0001	
7. City Mount Laurel	8. State NJ	9. Zip Code 08054
10. Who can we contact about employee health coverage at this job? Gayle McCormick	11. Phone number (856) 234-0001 x 1225	12. Email address gmccormick@mountlaurel.com

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.



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.