IMPORTANT DATES:

April 27, 2022 ~ Open Enrollment Begins

May 6, 2022 ~ Open Enrollment Closes

July 1, 2022 ~ COVERAGE EFFECTIVE DATE

EXPLANATION OF DOCUMENTS

1. Benefit Information/Employee Authorization – **ALL EMPLOYEES MUST COMPLETE and RETURN with selection, signature, date and any required documents.**

2. Waiver – To be used if waiving **some or all** benefits offered. Please be sure to make Selections on page (1) and sign/date page (2).

3. Health Benefits/Prescription
    a. Plan AETNA HDHP – Single coverage only (*may add dependents at additional cost*)
    b. Rate Chart— This is the monthly rate charged to the Board of Education—your percentage is based on salary. The employee contribution for the AETNA HDHP is calculated according to Chapter 78 Guidelines (see attachment)
    c. Enrollment/Application form required for any changes (remember to sign & date)
    d. Open Enrollment Guide is a (10)-page document explaining benefit features

4. Delta Dental
    a. Plan features
    b. Rate Chart (email me for individual percentage and monthly cost)
    c. Enrollment/Application form required for any changes (remember to sign & date)

5. VSP (Vision Coverage)
    a. Explanation of benefits and plan features
    b. Rate Chart (this is the monthly rate charged to the Board of Education--your percentage based on salary)
    c. Enrollment/Application form required for any changes (remember to sign & date)

If you have any questions, please email me at ngibbins@wtsd.org. PLEASE remember to submit your information prior to **FRIDAY, MAY 6, 2022**. You may scan/email documents to me OR send via interoffice. **DO NOT REPLY TO THIS EMAIL, BUT SEND A NEW EMAIL TO THE ABOVE EMAIL ADDRESS.** I will send a response verifying I have received your email and documents. If you do not hear from me within (3) days, I have not received your information.

Thank you for your time and attention. I appreciate your cooperation and welcome your questions. Hoping everyone is safe and healthy!

Nancy

Benefit Information
Employee Authorization
July 1, 2022 – June 30, 2023

☐ No changes to existing benefits plan **AND** you **DO NOT** waive any benefits offered
**** Please check box and sign below***

☐ No changes to existing benefits plan and you waive some or all benefits offered
**** Please check box, complete waiver and sign below***

☐ Waive **ALL** benefits offered
[Must complete even if you have waived in prior years]
**** Please check box, complete waiver and sign below***

☐ A change of benefit plan selection
[Examples: Delta Premiere to Delta Preferred, *AETNA HNO $10* to *AETNA HNO $15*, AETNA 10 to NJ Educator's Health Plan, etc.]
**** Please check box, complete appropriate application and sign below***

Changes to be made:_____
_____
_____

☐ Addition/deletion of dependents
[Examples: adding spouse or child to vision plan, eliminating spouse from HB/Rx plan]
**** Please check box, complete appropriate application and sign below***

Changes to be made:_____
_____
_____

_____
Please Print Employee Name

_____ _____
Employee Signature Date

WATERFORD TOWNSHIP BOARD OF EDUCATION

WAIVER UNDER CAFETERIA PLAN OF PARTICIPATION

WHEREAS, in accordance with the cafeteria plan (the "Plan"), the Employee has elected to waive coverage for himself or herself and his or her eligible dependents of the health plans for which the Employee would otherwise be entitled to receive, and

WHEREAS, such waiver is knowing and voluntary on the part of the Employee;

Please choose the following insurance plans to opt out:

- ☐ Health Insurance
- ☐ Prescription Insurance
- ☐ Dental Insurance
- ☐ Vision

NOW, THEREFORE, in consideration of the promises contained herein, and subject to the provisions of the Plan, it is hereby agreed as follows:

1. Waiver of Participation in the selection of health insurance – In accordance with the Plan, the Employee, for himself or herself, his or her heirs, assigns, successors, spouse, and dependents hereby waives any right on his or her part of his or her part and the part of his or her spouse and dependents to participate in the benefits maintained by the Employer. In making this knowing and voluntary waiver, Employee on behalf of himself or herself, his or her spouse and dependents understands and agrees that they will have no coverage or benefits whatsoever under the selected plans(s) from above and that this waiver may not be revoked during the plan year, except to the extent permitted under the Plan in the event of a change in status or in the event of retirement.

2. Release and Indemnification – The Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents covenants and agrees never to make a claim under the insurance plans(s) selected above and further fully releases the Employer, its officers, directors, employees and agents and insurance carriers from any liability arising in connection with any claim by the Employee, his or her heirs, assigns, successors, spouse and dependents for any benefits or coverage under the above selected plan(s), and the Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents agrees to defend and indemnify the Employer, its officers, directors, employees and agents from any liability, loss, damages, costs or expenses (including, but not limited to attorneys' fees) arising in connection with this Waiver or any claim for benefits or coverage under the above selected plan(s). The employee also agrees to sign any waiver required by the State Health Benefits Program Coverage.

3. Waiver Irrevocable During the Plan Year, Except Upon a Change in Status or in the Event of Retirement – Employee acknowledges and agrees that his or her decision to enter into this Waiver is knowing and voluntary, that he or she fully understands all the provisions of the Waiver and that this Waiver may be revoked during the plan year only to the extent permitted under the Plan in the event of a change in status or in the event of a retirement.

The following events are considered a change in status:

a. legal marital status – marriage, death of spouse, divorce, legal separation or annulment;

b. number of dependents – birth, adoption, placement for adoption or death of a dependent;

c. employment status – termination or commencement of employment by the employee, spouse or dependent;

d. work schedule – including a switch between part-time and full-time, a strike or lockout, a reduction or increase in hours or unpaid leave of absence;

e. change in dependent's status – a dependent satisfies or ceases to satisfy the requirements for coverage due to age, student status or similar circumstances;

f. residence or worksite – a change in the place of residence or work of the employee, spouse or dependent.

4. No Representations by Employer as to Possible Tax Consequences – Employer had made no representations to Employee with regard to the tax consequences of the Agreement and the Employer shall have no liability with regard to any such tax consequences.

5. Certification of Other Insurance – The Employee hereby certifies that he or she has existing and in effect other health and hospitalization insurance which provides coverage for himself or herself and for his or her eligible dependents.

_____

Employee Name (print)

_____ _____

Employee Signature Date

HEALTH

AND

PRESCRIPTION

SouthernCoastal FUND

WATERFORD TWP BOE

	AETNA HNO $10		AETNA HNO $15		AETNA HNO NJEHP		Aetna HMO ($10)	AETNA HDHP [HSA Compatible]		AETNA HNO GSHP	
	Only Available to employees hired before 7/1/2020		Only Available to employees hired before 7/1/2020				Only Available to employees hired before 7/1/2020	Only Available to employees hired before 7/1/2020		THIS PLAN USES A RESTRICTED NEWTORK OUT OF STATE PROVIDERS ARE NOT COVERED	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible											
Individual	None	$100	None	$100	None	$350	$100 on select services	$1,500.00		None	$350
Family	None	$250	None	$250	None	$700		$3,000.00		None	$700
Out of Pocket Annual Limit											
Individual	$400	$2,000	$5,880	$2,000	$500	$2,000	$5,880	$2,500	$3,500	$500	$2,000
Family	$1,000	$5,000	$11,760	$5,000	$1,000	$5,000	$11,760	$5,000	$7,000	$1,000	$5,000
Out of Network Restrictions	n/a	none	n/a	none	n/a	**Chiropractic, Acupuncture & PT have Limited Fee Schedule*** **	n/a	n/a	none	n/a	**Chiropractic, Acupuncture & PT have Limited Fee Schedule*** **
Referreal by Primary Care Physician Required	Not Required	Not Applicable	Not Required	Not applicable	Not Required	Not applicable	[1] See footnote	Not Required	Not applicable	Not Required	Not applicable
Preventive Care											
PrevCare/Screenings/Immunizations (as per ACA Guidelines	$0 copay	20% after Deductible	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	$0 copay	Not Covered	$0 copay	Not Covered
Physician's Office Visit											
Primary Care Services	$10 Copay	20% after Deductible	$15 copay	30% after Deductible	$10 copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible	$10 copay	30% after Deductible
Specialist Services	$10 Copay	20% after Deductible	$15 copay	30% after Deductible	$15 copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible	$15 copay	30% after Deductible
Maternity OB Visit	$10 copay for first visit, then 100%	20% after Deductible	$15 copay for first visit, then 100%	30% after Deductible	$15 copay for first visit, then 100%	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible	$15 copay for first visit, then 100%	30% after Deductible
Emergency Medical Care											
Urgent Care	$10 copay	20% after Deductible	$15 Copay	30% after Deductible	$15 Copay	30% after Deductible	$10 Copay	20% after Deductible	40% after Deductible	$15 Copay	30% after Deductible
Emergency Room (medical emergencies & accidents)	$25 copay	$25 copay	$50 copay	$50 copay	**$125 copay**	$125 copay	$35 Copay	20% after Deductible	20% after Deductible	**$125 copay**	$125 copay
Ambulance	10%	20% after Deductible	10%	30% after Deductible	10%	30% after Deductible	No Charge	20% after Deductible	40% after Deductible	10%	30% after Deductible
Inpatient Hospital Care											
Inpatient Coverage including Mental Health Services	No Charge	20% after Deductible	No Charge	30% after Deductible	No Charge	30% after Deductible	No Charge	20% after Deductible	40% after Deductible	No Charge	30% after Deductible
Other Services											
Durable Medical Equipment	10%	20% after Deductible	10%	30% after Deductible	10%	30% after Deductible	100% after $100 Ded	20% after Deductible	40% after Deductible	10%	30% after Deductible
Pharmacy											
Maximum Out of Pocket**	$1,430 Indiv / $2,860 Family		$1,430 Indiv / $2,860 Family		$1,600 Indiv / $3,200 Family		$1,430 Indiv / $2,860 Family	Included in the In Ntwrk Medical Max Out of Pocket		$1,600 Indiv / $3,200 Family	
Retail (30 day supply)	$3 Generic / $10 Brand		$3 Generic / $10 Brand		**RETAIL (30day supply):** $5 Generic; $10 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*		$3 Generic / $10 Brand	20% after Deductible		**RETAIL (30day supply):** $5 Generic; $10 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*	
Mail Order (90 day supply)	$3 Generic / $10 Brand		$3 Generic / $10 Brand		**MAIL ORDER (90day supply):** $10 Generic; $20 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*		$3 Generic / $10 Brand	20% after Deductible		**MAIL ORDER (90day supply):** $10 Generic; $20 Brand w/NO Generic available; For Brand name drugs that have a Generic Available member pays the Difference between Brand and Generic*	
					Utilization Programs Required:					**Utilization Programs Required:**	
					Mandatory Generic*					**Mandatory Generic***	
					Step Therapy*					**Step Therapy***	
					Closed Formulary*					**Closed Formulary***	
					*Policy allows clinical review to access desired medication at corresponding cost share					*Policy allows clinical review to access desired medication at corresponding cost share	

[1] Deductible is only durable medical equipment and appliances

*****Chiropractic, Acupuncture & Physical Therapy have a different fee schedule.**
Reimbursement will be capped as follows:
Chiropractic $35; Acupuncture $60; Physical Therapy $52

Waterford Township Board of Education
2022 Contract Rates

HEALTH	
COASTAL HIF	
7/1/2022-6/30/2023	
Aetna HNO $15	
single	$856.00
parent/ch(n)	$1,589.00
couple	$1,709.00
family	$2,446.00
dep 31	$750.00
Aetna HNO $10	
single	$899.00
parent/ch(n)	$1,671.00
couple	$1,797.00
family	$2,569.00
dep 31	$788.00
Aetna EPO $10	
single	$ 822.00
parent/ch(n)	$ 1,533.00
couple	$ 1,648.00
family	$ 2,355.00
dep 31	$721.00
Aetna ACPOS II HDHP 1500	
single	$699.00
parent/ch(n)	$1,302.00
couple	$1,400.00
family	$2,002.00
dep 31	$614.00
Aetna - Educators Plan	
single	$887.00
parent/ch(n)	$1,648.00
couple	$1,774.00
family	$2,536.00
dep 31	$777.00
Aetna - GSHP	
single	$854.00
parent/ch(n)	$1,586.00
couple	$1,706.00
family	$2,439.00
dep 31	$748.00

PRESCRIPTION	
Express Scripts	
7/1/2022-6/30/2023	
$3/$10/$10	
single	$ 208.00
parent/ch(n)	$ 388.00
couple	$ 418.00
family	$ 598.00
dep 31	$ 184.00
NJEHP/GSHP	
single	$ 186.00
parent/ch(n)	$ 347.00
couple	$ 374.00
family	$ 535.00
dep 31	$ 165.00

NOTE: Rates are illustrative. Please refer to actual renewal.

HEALTH BENEFITS CONTRIBUTION FOR SINGLE COVERAGE (Chapter 78)
(Percentage of Premium)

SALARY RANGE	PERCENTAGE
Less than $20,000	4.50 %
$20,000 -- $24,999.99	5.50 %
$25,000 -- $29,999.99	7.50 %

SouthernCoastal FUND

c/o PERMA PO BOX 99106
Camden, NJ 08101

Benefits Enrollment Form

Employer Name:___________________________________

EMPLOYEE/PARTICIPANT INFORMATION (Employee or Dep. 31)

Please PRINT and fill this section out COMPLETELY

Social Security #:	Last Name:		First Name:	M.I.:
Gender: ☐ Male ☐ Female	Date of Birth:	Address:		
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:		PCP # (if required):	Division (if any):	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Requested Effective Date:		

DEPENDENT INFORMATION (Spouse, Child or Children)

Please PRINT and fill this section out COMPLETELY

Please list all eligible dependents only.

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender: ☐ Male ☐ Female	PCP # (if required):	
Relationship:			

PLAN SELECTIONS

Medical Coverage

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

Prescription Coverage (If Prescription is through Coastal/Express-Scripts)

Carrier Name:_____ **Plan Name:**_____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

Dental Coverage

Carrier Name:_____ **Plan Name:**_____

Type of Coverage: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child(ren)

TYPE OF ACTIVITY

☐ New Hire Date: _____ ☐ Open Enrollment Date: _____ ☐ Rehire Date: _____

☐ Termination of Employment
Date: _____

☐ COBRA (please check box indicating reason for COBRA eligibility):
- ☐ Employment Terminated ☐ Reduction in hours ☐ Divorce
- ☐ Spouse/dependent child of deceased employee ☐ Loss of dependent child status under plan rules
- ☐ Spouse/dependent's loss of coverage due to employee's Medicare entitlement

Addition of Dependent (legal documentation required)

☐ Marriage ☐ Civil Union ☐ Birth ☐ Adoption/Guardianship/Foster Care Date of Event: _____

Add Coverage: ☐ Medical ☐ Rx ☐ Dental

Deletion of Dependent **Date of Event:** _____ **Dependent Name:** _____

☐ Divorce (legal documentation required) ☐ Death of spouse or child ☐ Child over age limit/ineligible

Remove Coverage: ☐ Medical ☐ Rx ☐ Dental

Other

☐ Dependent Age 31 ☐ Newly Eligible (PT or FT)

☐ Death (Name of Deceased): _____ Date of Death: _____

☐ Other (Give Reason):

EMPLOYEE CERTIFICATION

I certify that all of the information supplied on this form is true to the best of my knowledge. I understand if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment. I understand that there is no guarantee of continuous participation by medical service providers, doctors or facilities in the Plans. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the medical plans or assignee may require. I also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the Plan. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the Plan that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties. I further agree that the SHIF may, at any time, request that I supply evidence that substantiates the eligibility status of any person I cover as a dependent under the Plan.

Print Name: _____ Employee Signature: _____

Date:_____

SouthernCoastal FUND

2022-2023

OPEN ENROLLMENT GUIDE

Through membership in the Southern Coastal Health Insurance Fund, 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 SHIF and choose the best coverage for you and your family.

Important Information regarding

$0 cost telemedicine

SEE PAGE 4 FOR DETAILS

IT'S TIME TO REVIEW YOUR BENEFITS FOR 2022

Enrollment Deadline:
MAY 13, 2022

THE FUND WILL HOLD A PASSIVE OPEN ENROLLMENT

"Passive" open enrollment means if you are currently enrolled in benefits, your current plan elections will remain in place from July 1, 2022 through June 30, 2023, unless you elect to make a change.

To obtain enrollment forms to make a change, please contact your Benefits Administrator.

WHAT IS THE SOUTHERN COASTAL HEALTH INSURANCE FUND?

The Fund was established to provide public entities with a platform to purchase health insurance coverage in a shared-services environment.

New!

The Garden State Health Benefit Plan will now be available for all Employer Group Plans effective July 1, 2022.

ENROLLMENT INSTRUCTIONS

You must complete an enrollment form and return it to your benefits administrator by May 13, 2022 if:

- You wish to add coverage for an eligible dependent
- You are currently enrolled and wish to terminate coverage for yourself or a covered dependent
- You would now like to elect coverage for yourself and your eligible dependent(s) in your employer's health benefits effective on July 1, 2022
- 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 July 1, 2022

QUALIFIED LIFE EVENTS

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

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

ID CARDS

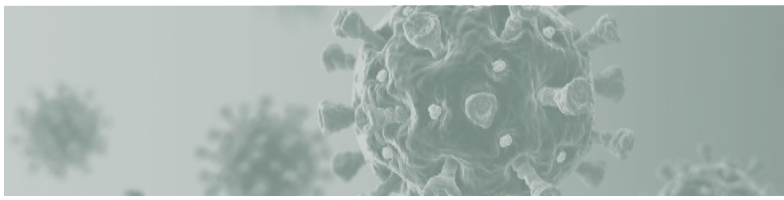
New ID card will only be issued if you making changes to your plan elections for 2022.

BENEFITS CONTACTS & RESOURCES

QUESTIONS REGARDING	CONTACT	PHONE NUMBER	WEBSITE/ADDRESS
Eligibility, enrollment, plan options, contributions, Qualifying Life Events, etc.	Please contact your entity's Human Resources/Benefits Office		
Medical Benefits - Aetna Benefit questions, claims, locating a provider, printing new ID Cards	Aetna	800.370.4526	www.aetna.com
Prescription Drug Benefits	Express Scripts	800.467.2006	www.express-scripts.com
Dental Benefits	Please see the reverse side of your ID card		
Benefit Specialists / Open Enrollment Guide	Shared Health Alliance	855.742.6577	

All plans above may not be offered by your employer. If you are not sure in which plan you are enrolled and/or eligible to elect, please refer to your ID card or contact your employer.

COVID-19 RESOURCES



STATE OF NJ

- www.covid19.nj.gov - For up-to-date information, resources, and guidance on questions about getting tested for COVID-19, contact tracing and, traveling to or from State of New Jersey.
- www.covid19.nj.gov/vaccine - For up-to-the-minute information on vaccine distribution.

STATE OF PENNSYLVANIA: www.health.pa.gov- Up-to-the-minute information on vaccine distribution.

AETNA: https://www.aetna.com/individuals-families/member-rights-resources/covid19.html

EXPRESS SCRIPTS: https://www.express-scripts.com/corporate/coronavirus-resource-center

CONNER STRONG & BUCKELEW: https://www.connerstrong.com/insights/covid-19-resource-center Comprehensive database of COVID-19 resources available to all Fund members.

SAVE TIME AND MONEY!

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

KNOW WHERE TO GET CARE

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

Telemedicine	Urgent Care	Emergency
• 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	• 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

HOW TO ACCESS TELEMEDICINE 24/7

$0 COST TELEMEDICINE VS. VIRTUAL OFFICE VISITS

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

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.

TELADOC (Aetna members)

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

HOW TO FIND IN-NETWORK PROVIDERS

TO FIND PARTICIPATING AETNA PROVIDERS:

- STEP 1: Visit Aetna's website at www.aetna.com
- STEP 2: At the middle of the 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 a Guest, enter your zip code, city, state or county
- STEP 5: You will be asked to "Select a Plan". Use the Key below to help you make the correct selection:

IF YOU'RE ENROLLING IN...	DOCFIND PLAN SELECTION IS...
All PPO Plans: PPO Admin, PPO 15, PPO 10, EHP	Category Heading = Aetna Open Access Plans Plan Name = Aetna Choice POS II (Open Access)
Aetna Garden State Plan (SI GSHP AWH CPII Docfind Lookup: CLICK HERE)	Category Heading = Aetna Whole Health Plan Plan Name = (NJ) Aetna Whole Health New Jersey Choice POS II

GET TO KNOW GUARDIAN NURSES

Struggling with a healthcare issue?

GUARDIAN NURSES CAN HELP

The services of our Mobile Care Coordinator Nurses are available to members of the Schools Health Insurance Fund and their covered dependents. All services are free, voluntary and confidential.

Schools Health Insurance Fund
Mobile Care Coordinator®
Powered by Guardian Nurses Healthcare Advocates

GUARDIAN NURSES®
Healthcare Advocates

GUARDIAN NURSES CAN:

- VISIT YOU AT HOME or in the hospital to assess your care needs.
- BE YOUR GUIDE, coach and advocate for any healthcare issue.
- MAKE APPOINTMENTS so you can be seen as quickly as possible.
- GO WITH YOU to see doctors, to ask questions and to get answers.
- IDENTIFY PROVIDERS for all care needs and second opinions.
- GET THINGS YOU NEED such as healthcare equipment.
- PROVIDE DECISION SUPPORT when considering treatments or surgery.
- EXPLAIN A NEW DIAGNOSIS to help you make informed decisions.

To request help from our Mobile Care Coordinators or the team at Guardian Nurses, call 609.472.3273 or 609.472.1797.

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 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.

CVS MINUTE CLINICS AND HEALTH HUBS*

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.

- 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 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

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.

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

* *Prior to visiting a Minute Clinic or Health Hub, please check with your medical insurer to find out which facilities in your area may be participating with your plan.*

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 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 PARTICIPATING IN-NETWORK PROVIDERS:

- Aetna Participants: Visit www.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.

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 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 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.

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.

The 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 January 31, 2022. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/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 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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

LEGAL NOTICES

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

GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 Press 1
GACHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 678-561-1162 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

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

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: https://www.maine.gov/dhhs/ofi/applications-forms
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 realy 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

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

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/oii/hipp.htm
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: http://www.nd.gov/dhs/services/medicalserv/medicaid/
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
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

PLEASE NOTE: This communication only applies to the benefits that your employer has through the Schools Health Insurance Fund.

EXPRESS SCRIPTS®

2022
National Preferred Formulary Exclusion List Changes

The excluded medications shown below are not covered on the Express Scripts National Preferred Formulary beginning July 1, 2022, unless otherwise noted. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price.

Single-Source Brand Exclusions

Drug Class	Excluded Medications	Preferred Alternatives
ANTIINFECTIVES Antivirals (Oral)	SITAVIG*, XERESE	acyclovir oral or cream, famciclovir, valacyclovir
AUTONOMIC & CENTRAL NERVOUS SYSTEM Miscellaneous Antidepressants	BUPROPION XL 450MG, FORFIVO XL	bupropion xl 150 mg or 300 mg
CARDIOVASCULAR Beta Blockers & Combinations	HEMANGEOL	propranolol solution
Diuretics	CAROSPIR	spironolactone
Fenofibrates	ANTARA	fenofibrate, fenofibric acid
DERMATOLOGICAL Agents for Hyperhidrosis	DRYSOL*, QBREXZA	Over-the-Counter aluminum chloride containing products
Oral Agents for Acne	ABSORICA LD	isotretinoin capsules
Rosacea Agents (Oral)	DOXYCYCLINE 40 MG CAPSULES*, ORACEA	Oral: doxycycline hyclate, doxycycline monohydrate Topical: azelaic acid, ivermectin, metronidazole
Rosacea Agents (Topical)	NORITATE	metronidazole
Topical Agents for Acne	FABIOR, TAZAROTENE FOAM*	tazarotene cream, tretinoin
Topical Antifungals	ECOZA*, ERTACZO, LULICONAZOLE*, SULCONAZOLE*, XOLEGEL*	ciclopirox, clotrimazole, econazole, ketoconazole, naftifine, oxiconazole
Topical Corticosteroids	IMPEKLO*, HALOBETASOL 0.05% FOAM, IMPOYZ, LEXETTE, SERNIVO, ULTRAVATE	betamethasone, clobetasol, desoximetasone, diflorasone, fluocinonide, fluocinolone, halcinonide, halobetasol, mometasone, triamcinolone
Miscellaneous Topical Dermatological Agents	TAZORAC 0.05% CREAM	tazarotene 0.1% cream
	TAZORAC GEL	tazarotene 0.1% cream, tretinoin
	VEREGEN	imiquimod 5% cream, podofilox solution
GASTROINTESTINAL Antiemetics (Oral)	BONJESTA	doxylamine-pyridoxine hcl

* Current 2022 exclusion in this class

2022
National Preferred Formulary Exclusion List Changes

Drug Class	Excluded Medications	Preferred Alternatives
MUSCULOSKELETAL & RHEUMATOLOGY Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	INDOCIN SUPPOSITORIES	etodolac, flurbiprofen, ibuprofen, indomethacin, ketoprofen, meloxicam, nabumetone, naproxen
	INDOCIN SUSPENSION	ibuprofen suspension, naproxen suspension

* Current 2022 exclusion in this class

Multi-Source Brand Exclusions

The generic equivalents of the following brand-name medications are covered on the National Preferred Formulary. FDA-approved generic medications meet strict standards and contain the same active ingredients as their corresponding brand-name medications, although they may have a different appearance.

AFINITOR, AFINITOR DISPERZ

DUREZOL

DENTAL

DELTA DENTAL

DELTA DENTAL OF NEW JERSEY, INC.
WATERFORD TOWNSHIP BOARD OF EDUCATION
Group # 7232

Plan Design	Delta Dental Premier® Program 7232-0003	Delta Dental PPO℠ Program 7232-0003	DeltaCare® Plan NJ6 7232-0001
Preventive & Diagnostic	100%	100%	$0.00*
Basic	80%	80%	$0.00
Crowns	80%	80%	$75.00-$200.00
Prosthodontics	60%	60%	$60.00-$300.00
Orthodontics	N/A	N/A	$2,400.00
			* $20.00 for Sealants
Annual Maximum	$2,000.00	$2,000.00	None
Lifetime Ortho Maximum	N/A	N/A	See Above
Deductible	$25	$25	None

Visit your own dentist. If you do not have a dentist, there is a directory available with your plan administrator listing participating dentists. You may call 1-800-DELTA-OK and a list of participating dentists located in your area will be mailed directly to your home or you may access our Website at www.deltadentalnj.com.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Social Security number. Your dependents, if covered, should give YOUR SOCIAL SECURITY NUMBER.

If you have any questions regarding your dental benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST, at 1-800-452-9310.

This comparison contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of New Jersey, Inc. which governs the benefits and operation of your program. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this comparison.

2017

Delta Dental Premiums

Effective 7/1/22 - 7/1/23

Delta Dental Premier

Single	$ 57.25
Family	173.37

Delta Dental Preferred

Single	$ 45.79
Family	138.67

DeltaCare/Flagship

1 Party	$ 28.36
2 Party	54.00
3 Party	87.11

ENROLLMENT / CHANGE REQUEST

Employer Group Information
Group Name: _____

To be completed by Employer
Group Number: _____

Sublocation /
Store Location: _____

[A]

TYPE OF ACTIVITY – (Employer complete)

1. Enrollment: _____ New Enrollee / Subscriber Effective Date: _____ Date of Hire: _____

2. Change (check all that apply):

	Date of Event:
_____ Add Spouse	_____
_____ Add Domestic Partner	_____
_____ Add Dependent Child	_____
_____ Name Change	_____
_____ Change Plan	_____
_____ Other	_____
_____ Add/Change Office ID #'s	_____

3. Remove or Terminate (check all that apply):

	Effective Date:
_____ Remove Spouse*	_____
_____ Remove Domestic Partner*	_____
_____ Remove Dependent Child	_____
_____ Employee Withdrawal / Termination	_____

NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage
* Please complete Add/Change/Remove and Name columns in Section D.

*****_**PROVIDE REASON FOR SELECTIONS IN #2 OR #3 ABOVE**_:_____

4. Continuation of coverage, ie. COBRA, State, Total disability. Not all options are available or applicable. Contact Employer for available options.

Coverage for: _____Employee _____Dependents

Length of Continuation: _____ 12 months _____18 months _____29 months _____ 36 months _____Total Disability –Attach proof of total disability.

Date of loss of coverage: _____ Date of Qualifying Event: _____

Billing: _____ Home _____Group

[B]

EMPLOYEE INFORMATION (Employee to complete sections B-G)

Last Name, First Name, Middle Initial: _____ Social Security Number: _____ Home Phone: _____

Email Address: _____ Home Address:_____ Apt. #: _____ City:_____ State: ____ Zip: _____

Employer Name: _____ Date of Employment: _____/_____/_____ Hours worked per week: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

[C]

PLAN OPTION

Delta Dental Premier _____ Delta Dental PPO (Preferred) _____ DeltaCare (Flagship) _____

[D] **INDIVIDUALS COVERED**

List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time, post-secondary student, or disability.

	A (add) C (change) R (remove)	Last Name, First Name, Middle Initial	Sex M / F	Birthdate MM/DD/YYYY	Social Security No.	Other Health Coverage Check if Yes	Previous Coverage Check if Yes
Employee	_____	_____	_____	_____	_____	_____	_____
Domestic Partner **	_____	_____	_____	_____	_____	_____	_____
Spouse	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____

**(if coverage offered)

[E] **OTHER / PREVIOUS INSURANCE**

Is your spouse employed? ( ) NO ( ) YES If you answered 'YES', please provide the following:

--Name of spouse's employer: _____ Address of spouse's employer: _____

If you checked 'yes' to Other Health Coverage (Section D), please provide the following:

--Name of insurance carrier, HMO, or other source:_____ Policy Number:_____

--If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#: _____

If you checked 'yes' to Previous Coverage (Section D), please provide the following:

--Name(s) of persons:_____ Effective Date:_____ Date Coverage Terminated:_____

-- Name of previous carrier:_____ Plan Number: _____

[F] **DEPENDENT INFORMATION**

Does any dependent listed in Section D live at a different address that the Employee? ( ) NO ( ) YES If you checked 'YES', please provide the following:

--Who and at what address? _____

-- Explain the circumstances_____

If any dependent's last name differs from yours, explain the circumstances: _____

[G] **EMPLOYEE SIGNATURE**

If you have any questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Service Agent at 1-800-452-9310 before signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on this Employee Enrollment/Change Request.

I authorize deductions from my earnings for any required contributions.

Employee Signature – Required: _____ **Date:** _____ **Email Address**: _____

[H] **EMPLOYER VERIFICATION (to be completed by employer)**

Employer Signature – Required:_____ **Title**:_____ **Date**:_____

EMPLOYER INSTRUCTIONS

Complete the Employer Group Information in the upper left corner of the form.

Section A / Type of Activity –

- Check boxes indicating reason(s) for submitting application

Section H / Employer Verification

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed

EMPLOYEE INSTRUCTIONS (complete sections B-G)

Section B / Employee Information

- Complete all information in order for your application to be processed

Section C / Plan Option

- Check one Plan Option box

Section D / Individuals Covered

- Add/Change/Remove-use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section 'F'-Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID# for the dentist (if applicable). Indicate office ID# selection(s) on the form.

Section E / Pre-Existing Conditions Statement

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in the group coverage in a group of 2-5 employees and by late entrants.

Section F / Other-Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, a a church plan or Medicare.

Section G / Dependent Information

- Complete this section for all new enrollments or coverage changes.

Section H / Employee Signature

- Complete this section for all new enrollments, coverage changes and terminations
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I / Employer Verification

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

CONDITIONS OF ENROLLMENT

Application Acknowledgment and Agreements

1. On behalf of myself and the dependents listed on page two I agree to the following:
   a) I authorize the sources stated below to give Delta Dental of New Jersey, Inc. or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or medical condition. Authorization sources are any physician or medical professional, any hospital, clinic or other medical care institution; any carrier any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Delta Dental of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) In know that I have the right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Delta Dental of New Jersey, Inc. plan or group policy coverage is provided by Delta Dental of New Jersey, Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Delta Dental of New Jersey, Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject criminal and civil penalties.

VISION

A LOOK AT YOUR VSP VISION COVERAGE

VSP Vision care for life

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM WATERFORD TOWNSHIP BOARD OF EDUCATION AND VSP.

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.
With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

PREMIER PROGRAM

Like shopping online? Go to eyeconic.com and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.
You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

PROVIDER NETWORK:
VSP Signature

EFFECTIVE DATE:
03/01/2021

BENEFIT	DESCRIPTION	COPAY
	YOUR COVERAGE WITH A VSP PROVIDER	
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Every 12 months	$0
PRESCRIPTION GLASSES		$20
FRAME	• $140 featured frame brands allowance • $120 frame allowance • 20% savings on the amount over your allowance • $60 Walmart®/Sam's Club®/Costco® frame allowance • Every 24 months	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 24 months	Included in Prescription Glasses
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements • Every 24 months	$0 $80 - $90 $120 - $160
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts, copay does not apply • Contact lens exam (fitting and evaluation) • Every 24 months	Up to $60
PRIMARY EYECARE℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details. • As needed	$0 $20 per exam
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Routine Retinal Screening** • No more than a $30 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Contact us:

800.877.7195 or **vsp.com**

THE ULTIMATE PROVIDER PLAYLIST

The right song can set the mood, and the right vision provider can set the tone for a great eye care experience. With VSP, your employees have the freedom to choose a provider they can really groove with.

MORE CHOICES MORE FREEDOM

VSP NETWORK PROVIDERS
UP TO 100K ACCESS POINTS

VSP Vision Care

When it comes to choices, VSP® has your employees and their eyes covered with a huge network of independent doctors, popular retailers, and an online option.

Independent Doctors

- Largest network of independent doctors
- 24-hour access to emergency care
- Integrated medical management with VSP Healthy Innovations

Premier Providers

- VSP Premier program locations, where employees can maximize their benefits, include both private practice doctors and more than 700 Visionworks retail locations nationwide.

VSP PREMIER PROGRAM

Visionworks

*Log in to confirm in-network locations based on plan type

Retail Options

VSP provides a truly personalized network for your employees. In addition to Visionworks, your employees have access to retail chains including:

Visionworks

Walmart

COSTCO OPTICAL

PEARLE VISION

eyeMed VISION CARE

COHEN'S Fashion Optical

Buy Online, Anytime!

VSP members can shop the latest designer glasses and name brand contacts online at **eyeconic.com®** with their VSP benefits.

eyeconic

Enjoy the sweet song of member satisfaction with true freedom of choice from VSP.

VSP Monthly Rates

(vision coverage)

July 1, 2022 – June 30, 2023

Single =	**$ 9.08**
Couple =	**14.52**
Parent/Child(ren) =	**14.83**
Family =	**23.91**

VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT APPLICATION

SSN	MEMBER LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

ADDRESS	APT	CITY	STATE	ZIP CODE

EMAIL ADDRESS

I authorize payroll deductions for: ☐ Employee only ☐ Employee + spouse ☐ Employee + children ☐ Employee + family ☐ Decline
I agree to remain enrolled for the entire enrollment period, assuming I remain employed, unless I experience an IRS qualifying event. Premium rates for subsequent 12-month renewals are subject to negotiation between my employer and Vision Service Plan.

Signature: Date:

PLEASE LIST ALL OF YOUR COVERED DEPENDENTS IF FAMILY COVERAGE IS SELECTED

LAST NAME	FIRST NAME	M.I.	SSN	DATE OF BIRTH

PLEASE MARK APPROPRIATE BOX:
☐ New enrollment ☐ Change current coverage ☐ Reinstate ☐ Cancel coverage