2026

OPEN ENROLLMENT GUIDE

For the coverage period beginning on January 1, 2026

Welcome to Evesham Township

Inside this guide

Making Plan Changes

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

If an eligible dependent had other coverage and such coverage is lost, the eligible dependent may be eligible for enrollment during a "special enrollment period," which is usually the 60-day period following the date that other coverage was lost, due to a qualified change in status.

Questions?

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

What You Need to Know for Open Enrollment

New 2026 enrollments and changes are due to Human Resources by **Friday, November 7th**. This Open Enrollment will be **PASSIVE**, meaning if you do not make any changes your current benefit elections will roll over into the new plan year, except for Flexible Spending Accounts (FSA), Health Savings Account (HSA), Dependent Care Spending Accounts, and Township Waiver forms. **For these items, action is required each year.**

The benefits you elect now will be effective until December 31, 2026. Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified life event (see **Making Plan Changes** section).

How to Enroll

Please return your enrollment forms to the Township's Human Resources department.

2026 Benefit Highlights

- **Medical:** Your medical benefits are administered by the Southern New Jersey Regional Employee Benefits Fund (SNJ HIF), which utilizes the AmeriHealth Administrators Network. Please note the deductible is increasing on the Bronze plan, this is due to an increase to the statutory minimum deductible for Qualified High Deductible Health Plans. If you do not make any changes your current plan selection will automatically roll over to the new plan year. Please see page 4 for more details.
- **Prescription Drug:** Your prescription drug benefits are administered by the Southern New Jersey Regional Employee Benefits Fund (SNJ HIF), which uses the Express Scripts pharmacy network. Please see page 7 for more details.
- **Dental:** Your dental plans are administered by Delta Dental and use the PPO Plus Premier and PPO networks. Your dental benefits will be effective the 1st of the month following 90 days of employment. See page 11 for more details.
- **Vision:** Your voluntary vision benefit is administered through Superior Vision. Your voluntary vision benefits will be effective the 1st of the month following 60 days of employment. See page 12 for more details.

Medical Benefits

AmeriHealth Administrators

Southern NJ Health Insurance Found

	Platinum	Gold Plus	Gold	Silver	Bronze QHDHP w/ HSA
In-Network Benefits					
Deductible Individual/Family	N/A	$250 / $500	$250 / $500	$500 / $1,000	$1,700 / $3,400
Out-of-Pocket Maximum Individual/Family	$400 / $1,000	$2,000 / $4,000	$2,500 / $5,000	$5,000 / $10,000	$2,500 / $5,000
Coinsurance (% Plan Pays)*	100%	100%	100%	90%	80%
Preventive Care Services	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
PCP Office Visits	$10 copay	$10 copay	$25 copay	Covered 90% after $25 copay	Covered 80% after deductible
Specialist Office Visit	$10 copay	$10 copay	$45 copay	Covered 90% after $45 copay	Covered 80% after deductible
Inpatient Hospital	Covered 100%	Covered 100% after deductible	Covered 100% after deductible	Covered 90% after deductible	Covered 80% after deductible
Outpatient Surgery	Covered 100%	Covered 100% after deductible	Covered 100% after deductible	Covered 90% after deductible	Covered 80% after deductible
Outpatient Lab & X-Ray	Covered 100%	Covered 100% after deductible	Covered 100% after deductible	Covered 90% after deductible	Covered 80% after deductible
Emergency Room	$75 copay	$75 copay	$100 copay	$100 copay	Covered 80% after deductible
Urgent Care	$10 copay	$10 copay	$25 copay	Covered 90% after $25 copay	Covered 80% after deductible
Out-of-Network Benefits					
Deductible Individual/Family	$100 / $250	$500 / $1,000	$1,000 / $2,000	$1,000 / $2,000	$1,700 / $3,400
Out-of-Pocket Maximum Individual/Family	$2,000 / $5,000	$4,000 / $8,000	$10,000 / $20,000	$10,000 / $20,000	$3,600/$7,200
Coinsurance* (% Plan Pays)	80% after deductible	80% after deductible	80% after deductible	80% after deductible	60% after deductible

*Please refer to the Schedule of Benefits for specific services, which is located on the Beneportal.

How to Find In-Network Providers

To Find Participating Amerihealth Administrators Providers:

- **STEP 1:** Visit the AHA website at **www.myahabenefits.com**
- **STEP 2:** At the bottom of the webpage on the right, click on "Find A Doctor"
- **STEP 3:** Search providers by category, specialty and much more!

Once you search for a list of doctors, you can click on the provider's name and then view information such as:

- Credentials
- Hospital affiliations
- Reviews from other members
- Office hours
- Gender
- Specialty
- Language spoken
- National Provider Number (NPI)

Easily compare up to five doctors and hospitals at once. You can compare specialties, education, board certifications, quality reviews, and more.

Health Savings Account (HSA)

American Fidelity

What is a High Deductible Health Plan?

A high deductible health plan (HDHP) is a type of health plan with lower monthly premiums and a higher deductible than a traditional health plan. The Township's Bronze plan is a qualified high deductible health plan (QHDHP).

This type of plan is designed to incentivize consumers to make more educated choices when it comes to their health care. The participant pays out-of-pocket for health care services until they meet their deductible, and then the plan kicks in. The plan does not cover any services before the deductible is met, besides in-network preventive care.

What is a Health Savings Account?

A Health Savings Account (HSA) is a tax-advantaged account that works in conjunction with an HSA-eligible health plan that meets IRS guidelines and allows the participant to save tax-free money for eligible medical expenses. The Township's Bronze plan is an HSA-eligible health plan. Participants do not pay federal taxes on the money they put in or spend on eligible medical expenses. Unused funds in an HSA roll over year after year and continue to grow tax-free. The account is owned by the participant even if they change jobs or health plans. There is no use-it-or-lose-it rule.

Limited Purpose FSA

If you are enrolling in the High Deductible Health Plan (HDHP) and elect the HSA, the IRS rules prohibit you from participating in the Healthcare FSA. However, you may elect up to $3,400 in a Limited Purpose FSA, which can be used for dental and vision expenses only.

What is the Maximum HSA Contribution?

You elect the amount you would like to contribute toward your HSA and Evesham Township will deduct that money from your paycheck pre-tax. The total annual amount you can contribute towards an HSA tax-free for 2026 is:

- **Single:** $4,400
- **Family:** $8,750
- **Catch-up (age 55+):** $1,000

What Expenses are Eligible?

Any out-of-pocket and unreimbursed medical expenses allowed under Section 213(d) of the Internal Revenue Code, including:

- Medical out-of-pocket expenses until you reach your deductible
- Copayments, coinsurance and prescription drugs
- Dental and vision care expenses not covered by your plans

Prescription Benefits
Express Scripts

Southern NJ Health Insurance Found

If you elect to participate in one of the HIF medical plans, you are automatically enrolled in the prescription drug plan that corresponds with the medical plan of choice.

	Platinum	Gold Plus	Gold	Silver	Bronze
Prescription Benefits					
Out-of-Pocket Maximum Individual/Family	$1,430 / $2,860	$1,430 / $2,860	$1,430 / $2,860	$1,430 / $2,860	Combined w/ Medical
Retail Pharamacy: Up to a 30-day supply					
Generic **Formulary Brand** **Non-Formulary Brand**	$3 $10 $10	$3| $10 $10	$5 $25* $25*	$5 $25* $25*	Covered 80% after deductible
Mail Order: Up to a 90-day supply					
Generic **Formulary Brand** **Non-Formulary Brand**	$5 $15 $15	$5 $15 $15	$5 $25* $25*	$5 $25* $25*	Covered 80% after deductible

* $35 if generic equivalent is available

Mail Order and Prior Authorizations

If you are currently taking a drug that is delivered from the mail order pharmacy, your provider needs to submit prescriptions to Express Scripts Home Delivery Pharmacy. Please see information on page 8. Additionally, if you are taking a drug that is subject to prior authorization, your prescribing doctor needs to submit authorization to Express Scripts.

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** (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, HSA/FSA 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.

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 for please call **800.683.1074.**

Express Scripts ID Cards

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

Connect to your Digital Prescription ID Card. Anytime. Anywhere.

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

A digital profile also helps you connect to:

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

For the temporary ID's 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

EXPRESS SCRIPTS® SouthernJersey FUND

Temporary Prescription ID Card

RxBin: 003858

RxPCN: A4

RxGRP: NJRA

EXPRESS SCRIPTS® SouthernJersey FUND

Temporary Prescription ID Card

RxBin: 003858

RxPCN: A4

RxGRP: NJRA

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

Flexible Spending Accounts

American Fidelity

Evesham Township provides you with the opportunity to pay for out-of-pocket medical, prescription drug, dental, vision and dependent care expenses with pre-tax dollars through the Flexible Spending Accounts (FSA). If you elect the FSA, your funds will be available the 1st of the month following 60 days of employment.

Healthcare FSA

The Healthcare FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. The maximum you can contribute to the Healthcare FSA is $3,400.

Eligible expenses include:

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

Dependent Care FSA

The Dependent Care FSA is used to reimburse expenses related to the care of eligible dependents. The maximum that you can contribute to the Dependent Care FSA is $7,500 if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is $3,750.

Eligible expenses include:

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

How Much Should I Contribute?

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

CARRYOVER: You may carryover up to $680 of unused funds into the next plan year. Any FSA balance over $680 will be forfeited at the end of the plan year.

Filing a Claim

You can file a claim in the following ways:

- Use your American Fidelity FSA debit card to pay at point of service.
- Submit a claim online via your American Fidelity member account.

Creating an Account

You can create an account by visiting **www.americanfidelity.com** or by downloading the mobile app AFMobile.

Enrolling in the FSA

You **MUST** visit the American Fidelity website **www.afenroll.com** to enroll in the FSA each year.

- **User ID:** Full Social Security number **(no dashes)**
- **PIN:** Last 4 digits of Social Security Number + 8 digits of birthdate. Ex. SSN ends in 1234 & birthdate is Oct. 15,1999; PIN should be **123410151999**.

Limited Purpose FSA

If you are enrolling in the High Deductible Health Plan (HDHP) and elect the HSA, the IRS rules prohibit you from participating in the Healthcare FSA. However, you may elect up to $3,400 in a Limited Purpose FSA, which can be used for dental and vision expenses only.

Dental Benefits

Delta Dental

Evesham Township offers three dental plan options to our employees, all administered by Delta Dental. The Fixed Copay fee schedule can be found on **www.eveshamtownshipbenefits.com**.

	PPO Plus Premier	PPO Fixed Copay 5	PPO Fixed Copay Complete
Services	**In-Network**	**In-Network ONLY**	**In-Network ONLY**
Calendar Year Deductible (Individual/Family)	$25 / $75	N/A	N/A
Calendar Year Maximum (per patient)	$2,000	N/A	N/A
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year) Fluoride Treatment (once in a calendar year, children to age 19)	Plan pays 100% after deductible	Plan pays 100%	Plan pays 100%
Basic Services Fillings, Extractions Endodontics (root canal) Periodontics, Oral Surgery Sealants Crowns, Gold Restorations	Plan pays 70%-100% after deductible	Please see fee schedule	Plan pays 100%
Major Services Bridgework Full and Partial Dentures Prosthodontics	Plan pays 50% after deductible	Please see fee schedule	Plan pays 100%
Orthodontia Benefits	50% (children age 26 and below)	24 months of comprehensive treatment (Adults and children)	24 months of comprehensive treatment (Adults and children)
Orthodontia Lifetime Maximum (per patient)	$500	Please see fee schedule	N/A

How Do I Find Participating Dentists?

There are thousands of participating dentists to choose from nationwide. To locate participating providers, please go to **www.deltadentalnj.com** and click on "**Find a Dentist**" on the right side of the page.

Can I Find Out What My Out-of-Pocket Expense Will Be Before Receiving Care?

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

Delta Dental Mobile

Download from the App Store to:

- View or share your ID card
- See your coverage information (including deductibles and plan maximums)
- Utilize the Dental Care Cost Estimator
- Search for a participating dentist
- Schedule appointments
- View your recent claims

Voluntary Vision Benefits

Superior Vision

Below is the voluntary vision plan available to you, administered by Superior Vision.

	Superior Select Network	
Services	**In-Network Allowence**	**Out-of-Network Reimbursment**
Materials Copay	$10	$10 deducted from reimbursements
Frames (every 24 months)	$125 allowance	Reimbursed up to $70
Lenses (Every 12 months - Does not include lens "extras" such as tints or coatings)		
Single Vision	Covered 100%	Reimbursed up to $25
Bifocal	Covered 100%	Reimbursed up to $40
Trifocal	Covered 100%	Reimbursed up to $45
Progressive	Member pays difference*	Reimbursed up to $45
Lenticular	Covered 100%	Reimbursed up to $80
Contact Lenses (In lieu of glasses - every 12 months)		
Single Bifocal Trifocal Lenticular	$150 allowance	Reimbursed up to $80
Contacts (Medically necessary)	Covered 100%	Reimbursed up to $150

* Member pays difference between progressive and standard retail lined trifocal, plus applicable copay

How Do I Find Participating Provider?

To find a participating eye doctor visit **www.superiorvision.com/locator** and select "**Superior Select Network**".

Voluntary Benefits
American Fidelity

Below are some of the voluntary benefits that the Township of Evesham offers to our employees.

Disability Income Insurance

If your lifestyle requires a steady paycheck, then your life needs American Fidelity's Disability Income Insurance. Our disability income insurance can provide an income if you are unable to work due to a covered accident or sickness while under a doctor's care. Coverage can begin as soon as the 8th day absent and continue until Normal Social Security Retirement Age.

Limited Benefit Accident Only Insurance

Whether you're a weekend warrior with an active lifestyle or the stay-at-home type, accidents can happen to you or your family any time, anywhere without warning. Be prepared by having American Fidelity's Accident Solution Plan®, which is designed to help pay for unexpected medical expenses related to the medical treatment from an accidental injury. Coverage is on and off the job.

Hospital Indemnity

Cover your costs. Help protect your savings. Group Hospital indemnity provides an additional way to help employees manage their deductibles by providing benefits for hospitalization.

Critical Illness

If you are diagnosed with a covered Critical Illness such as a heart attack or stroke, this plan is designed to pay a lump sum benefit to help cover expenses. Employees can elect coverage for individual and family, extends coverage to children at no additional cost.

Additional Options

Other benefit options are available on American Fidelity's website. To learn more visit:

- https://americanfidelity.com/info/cancer
- https://americanfidelity.com/info/life

Benefits MAC

Conner Strong & Buckelew

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits MAC can help guide the way!

The Benefits Member Advocacy Center ("Benefits MAC"), provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

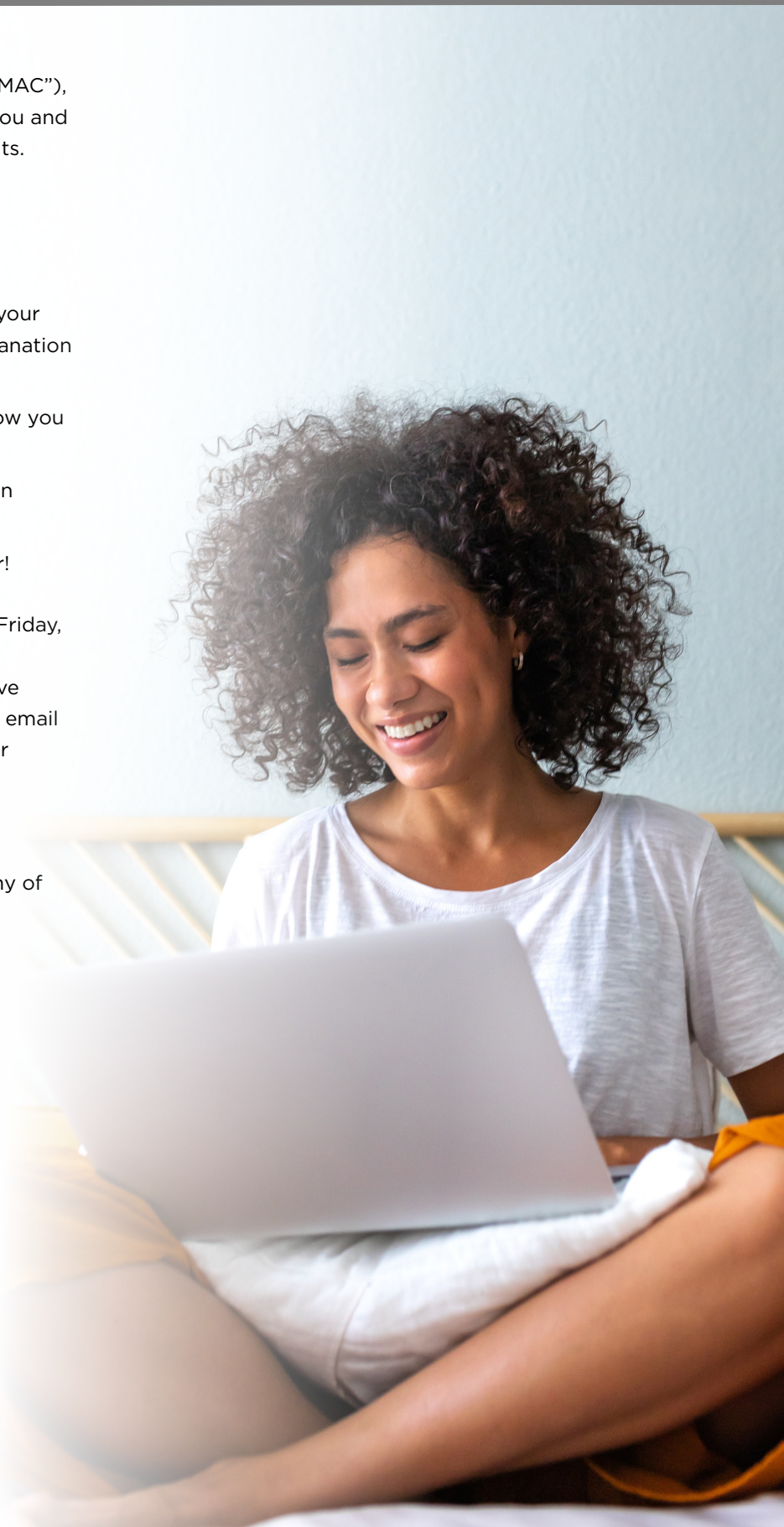
- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Guide you through the enrollment process or how you can add or delete coverage for a dependent
- Rescue you from a benefits problem you've been working on
- Discover all that your benefit plans have to offer!

Member Advocates are available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

Contact Member Advocacy

You may contact the Member Advocacy team in any of the following ways:

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Via the web: **www.connerstrong.com/memberadvocacy**
- Via fax: **856.685.2253**
- Via email: **cssteam@connerstrong.com**



BenePortal

Online Benefits Resource

Your Benefits Information in One Place

BenePortal, powered by WIX, is Evesham Township's virtual employee benefits portal, providing access to company benefits programs, health and wellness information, recommended links, pertinent forms and guides, and a wealth of additional tools and resources.

BenePortal is available 24/7 to Evesham Township's employees and their eligible dependents.

BenePortal Features Include

- Secure online access - with NO login required!
- Mobile-optimized site
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!

Accessing BenePortal is Easy!

Simply go to **www.eveshamtownshipbenefits.com** to access your benefits information today!

Carrier Contacts

Benefit	Carrier	Phone Number	Website
Medical	AmeriHealth Administrators	800-841-5328	www.myahabenefits.com
Prescription	Express Scripts	800-467-2006	www.express-scripts.com
Dental	Delta Dental	PPO: 800-452-9310	www.deltadentalnj.com
Vision	Superior Vision	800-507-3800	www.superiorvision.com
Flexible Spending Accounts, Health Savings Accounts, Dependent Care Accounts, Health Reimbursement Accounts, and Voluntary Benefits	American Fidelity	800-662-1113	www.americanfidelity.com

Legal Notices

Newborns' and Mothers' Health Protection Act Notice
Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, based on your plan, deductibles and coinsurance could apply. If you would like more information on WHCRA benefits, please contact your Plan Administrator.

Special Enrollment Notice
Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, please contact your employer.

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

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

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

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

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

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

Legal Notices

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

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

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

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

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

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

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

Keep your Plan informed of address changes.
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Please contact your employer's Human Resources or Benefits Department for further information regarding the Plan and COBRA continuation coverage.

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

Legal Notices

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, 2025. 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: Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

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

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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

LOUISIANA – Medicaid
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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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

Legal Notices

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

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

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

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

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

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

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

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

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

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

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

Notes

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