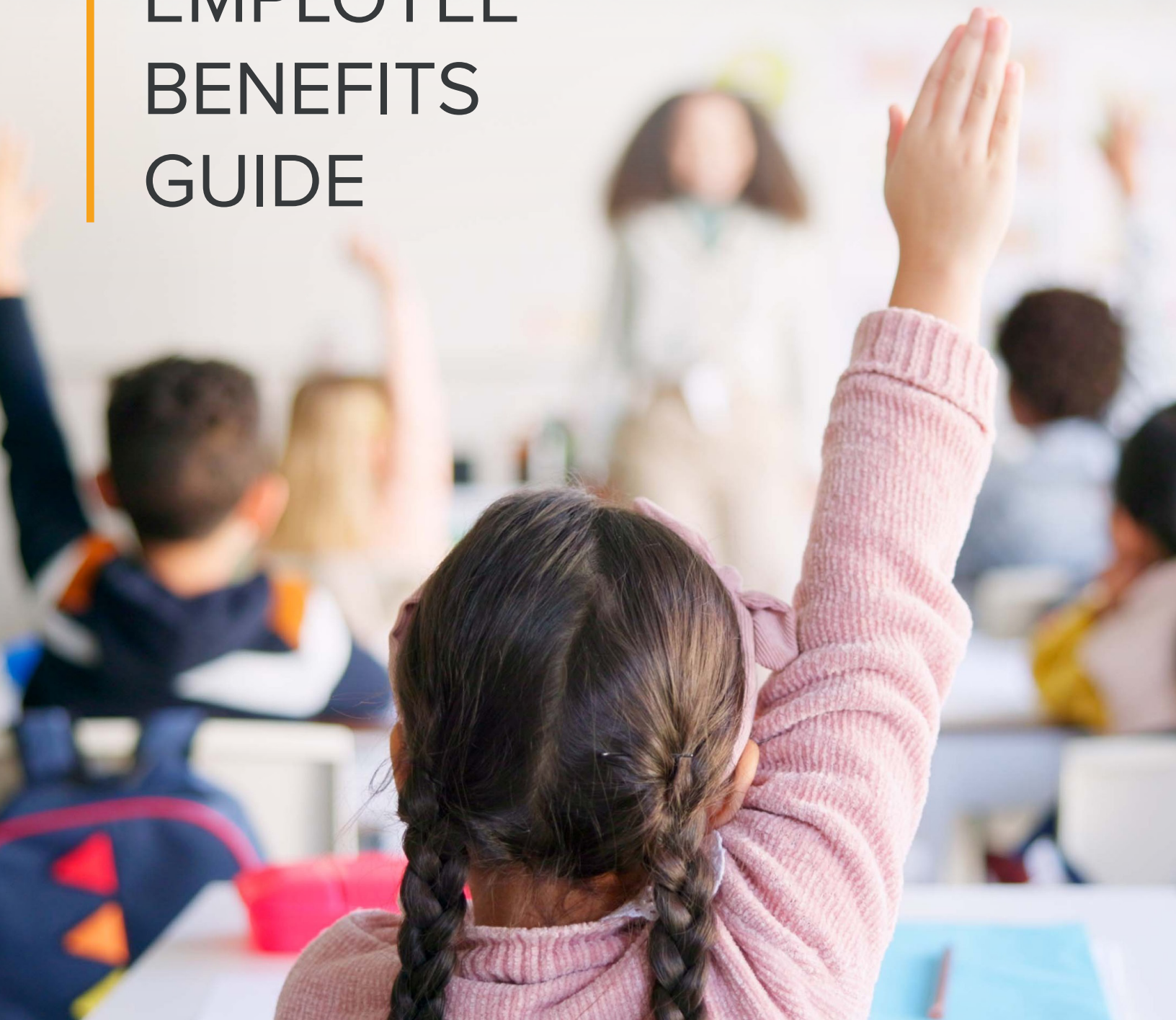


2026–27



**EMPLOYEE
BENEFITS
GUIDE**



For Benefits Effective:
JULY 1, 2026 – JUNE 30, 2027



Welcome!



At LEAP Academy Charter Schools, Inc., (LEAP) we are committed to providing our employees with a comprehensive, valuable benefits package and the resources you need to understand all the options available to you.

As an employer, we recognize that our team members are our most valuable asset. The health and well-being of our team members and that of your families is important to us as is the overall health and well-being of the organization. This is why we are committed to sustaining the high value benefit plans we make available.

We encourage you to carefully review this guide to familiarize yourself with our 2025-2026 benefit offerings and ensure that you are making the best benefits decisions for you and your eligible family members.

The benefits outlined in this guide will be effective through June 30, 2026.

Questions?

If you have any questions on any of the benefits available to you, you may contact Jameelah Surgeon at **856.614.5785** anytime between 8 am and 4 pm.

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Eligibility & Enrollment Information

Who is eligible to elect benefits?

Full-time employees, who work a regular schedule of 35 hours or more per week, are eligible to enroll in the benefits described in this Guide.

Please remember that only eligible dependents can be enrolled. **Eligible dependents include all of the following:** Legal spouse/civil union partner, Biological child(ren), Legally adopted child(ren), Foster child(ren), Stepchild(ren) as long as natural parent remains married to the employee and resides in the employee's household, Child(ren) for whom you are responsible for under a court-order, Grandchild(ren) for whom you are responsible for under a court-order, Child(ren) up to age 26 for medical and prescription drug benefits, and Child(ren) to age 19 or, if a full-time student, to age 23 for dental coverage.

If you are enrolling a dependent(s) for the first time, you will need to provide proof of your dependent's eligibility (i.e. birth certificate, marriage certificate, proof of full-time status, etc.).

Your dependent(s) under 31 can be covered by electing to continue coverage for young adults after age 26. DU31 is a New Jersey law that allows children older than the child-dependent age in a parents' coverage to elect to remain covered for medical and prescription coverage only until age 31, if certain other eligibility standards are met. Go to www.state.nj.us/dobi/division_consumers/du31.html for more information regarding dependent coverage to age 31.

How often can I change plan elections?

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next Open Enrollment period.

Qualified changes in status include: marriage, civil union partnership status change, divorce, birth or adoption of a child, change in child's dependent status, death of a spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse/civil union partner, commencement or termination of adoption proceedings, or change in spouse's/civil union partner'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.

You must notify the Payroll and Benefits Administrator within 60 days of experiencing a qualified status change. For birth of a child or adoption, please notify the business office within 60 days.



Now, take a look at your benefit options and

LET'S FIND THE COVERAGE THAT FITS!

Employee Resources

Benefits Member Advocacy Center

Conner Strong & Buckelew

Employee benefits can be complex, making it difficult to fully understand your coverage and use it properly. The Benefits Member Advocacy Center (Benefits MAC) allows you to speak to a specially trained Member Advocate who can answer your questions and help you get the most out of your benefits.

Contact the Benefits MAC if you:

- Believe your claim was not paid properly
- Need clarification on information from the insurance company
- Have a question regarding a bill from a doctor, lab, or hospital
- Are unclear on how your benefits work
- Need information about adding or deleting a dependent
- Need help to resolve a problem you've been working on

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

How To Contact Member Advocacy?

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**



BenePortal:

Online Benefits Information

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

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

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

Logging in to the BenePortal is easy! Simply visit **www.leapbenefits.com**.

Medical Plans

Aetna



Through the SHIF, LEAP Academy offers the following medical plan options to their staff, administered by Aetna.

- Employees hired on/after 7/1/2020 may only elect either the NJEHP or GSP for medical coverage and must be enrolled in the corresponding NJEHP or GSP prescription plan, administered by Express Scripts.
- All other employees may elect any district offered plan design.

NOTE: Dependents are eligible for benefits until the end of the calendar year that he/she turns 26.

	NJEHP	GSP*
IN-NETWORK MEDICAL BENEFITS		
Deductible (per calendar year)		
Individual	None	None
Family	None	None
Out-of-Pocket Maximum (per calendar year)		
Individual	\$500	\$500
Family	\$1,000	\$1,000
Preventive Care Services	Plan pays 100%	Plan pays 100%
PCP Office Visits	\$10 copay	\$10 copay
Specialist Office Visit	\$15 copay	\$15 copay
Inpatient Hospital	Plan pays 100%	Plan pays 100%
Outpatient Surgery	Plan pays 100%	Plan pays 100%
Diagnostic Lab & X-Ray	Lab: Plan pays 100% X-Ray: Plan pays 100%	Lab: Plan pays 100% X-Ray: Plan pays 100%
Emergency Room	\$125 copay	\$125 copay
Durable Medical Equipment	Plan pays 90%	Plan pays 90%
Vision Exam	\$15 copay**	\$15 copay**
OUT-OF-NETWORK MEDICAL BENEFITS		
Deductible (per calendar year)		
Individual	\$350	\$350
Family	\$700	\$700
Out-of-Pocket Maximum (per calendar year)		
Individual	\$2,000	\$2,000
Family	\$5,000	\$5,000
Coinsurance	Plan pays 70%***	Plan pays 70%***
Vision Exam	Not Covered	Not Covered

* GSP is a network of NJ providers only. Out of state services will not be covered unless it is a true medical emergency.

** Once routine exam every calendar year.

*** After deductible

The above is an overview of your medical plan option and does not contain all of the benefits or limitations that may apply to the plan. Please see the plan document from the carrier for greater detail.

Medical Plans

Aetna



Through the SHIF, LEAP Academy offers the following medical plan options to their staff, administered by Aetna.

- Employees hired on/after 7/1/2020 may only elect either the NJEHP or GSP for medical coverage and must be enrolled in the corresponding NJEHP or GSP prescription plan, administered by Express Scripts.
- All other employees may elect any district offered plan design.

NOTE: Dependents are eligible for benefits until the end of the calendar year that he/she turns 26.

	PATRIOT X	PATRIOT XV LOW	PATRIOT XV HIGH
IN-NETWORK MEDICAL BENEFITS			
Deductible (per calendar year) Individual/Family	None/None	None/None	None/None
Out-of-Pocket Maximum (per calendar year) Individual/Family	\$6,350/\$12,700	\$1,500/\$3,000	\$6,350/\$12,700
Preventive Care Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
PCP Office Visits	\$15 copay	\$10 copay	\$10 copay
Specialist Office Visit	\$30 copay	\$15 copay	\$30 copay
Inpatient Hospital	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient Surgery	\$30 copay	\$15 copay	\$30 copay
Diagnostic Lab & X-Ray	Lab: Plan pays 100% X-Ray: \$30 copay	Lab: Plan pays 100% X-Ray: \$15 copay	Plan pays 100%
Emergency Room	\$150 copay	\$150 copay	\$150 copay
Durable Medical Equipment	Plan pays 100%	Plan pays 50%	Plan pays 100%
Vision Exam Exam Materials	\$30 copay* \$70 max/24 months**	Plan pays 100%* \$35 max/24 months**	Plan pays 100%* \$100 max/24 months**
OUT-OF-NETWORK MEDICAL BENEFITS			
Deductible (per calendar year) Individual/Family	\$300/\$600	\$5,000/\$15,000	\$3,000/\$6,000
Out-of-Pocket Maximum (per calendar year) Individual/Family	\$400/\$1,200	\$10,000/\$30,000	\$2,500/\$5,000
Coinurance	Plan pays 70%***	Plan pays 50%***	Plan pays 60%***
Vision Exam	Plan pays 70%*	Plan pays 50%*	Plan pays 60%*

* One routine exam every 24 months. (Combined In/Out-of-Network).

** Vision Materials Maximum is combined for In/Out-of-Network

*** After deductible

The above is an overview of your medical plan options and does not contain all of the benefits or limitations that may apply to the plan. Please see the plan document from the carrier for greater detail.

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.

Locate an In-Network Provider

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 bloodwork.

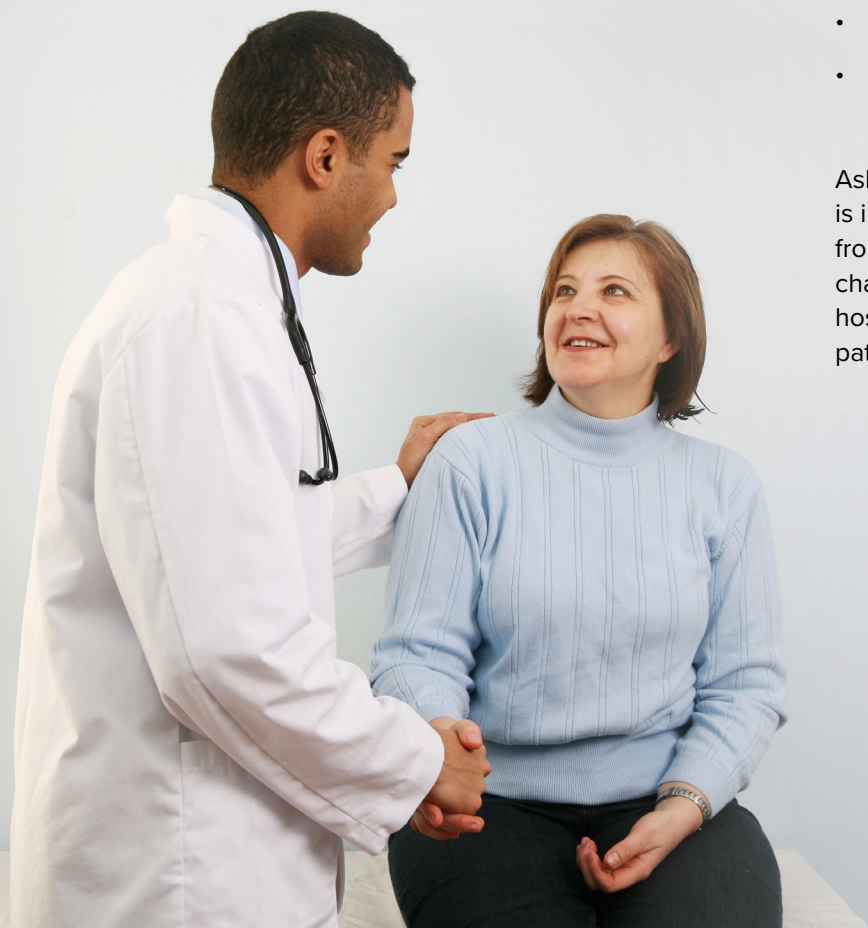
In-Patient or Observation

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



How to Find In-Network Providers

Aetna

- STEP 1:** Visit Aetna’s website at www.aetna.com
- STEP 2:** At the middle of the webpage on the right, click on **“Find a Doctor”**
- STEP 3:** On the right side of the page under Guest, select **“Plan from an employer”** (1st choice on the list)
- STEP 4:** Under **Continue as a Guest**, enter your zip code, city, state or county
- STEP 5:** You will be asked to **“Select a Plan”**. Use the key below to help you make the correct selection:

IF YOU'RE ENROLLING IN...	DOCFIND PLAN SELECTION IS...
NJEHP	Category Heading = <u>Aetna Open Access Plans</u> Plan Name = Aetna Choice POS II (Open Access)
Aetna Garden State Plan	Category Heading = <u>Aetna Standard Plans</u> Plan Name = QPOS
Patriot Plans	Category Heading = <u>Aetna Standard Plans</u> Plan Name = QPOS



CVS Health Virtual Care

For Aetna-covered members

Your care. Your Way.

*Convenient and affordable virtual care
wherever you need it.*

From your therapy appointments to quick care, CVS Health Virtual Care has got you covered. You can use CVS Health Virtual Care in addition to your traditional network of providers.

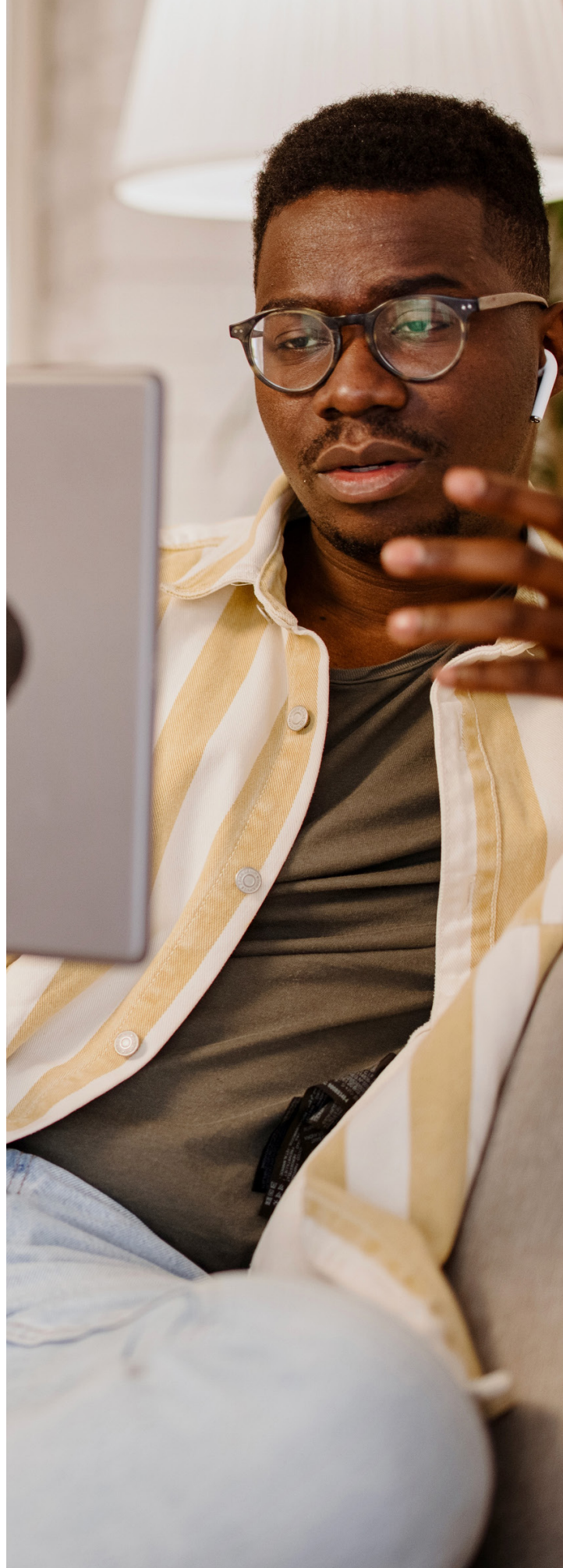
Access is included as part of your medical plan from Aetna, a CVS Health company because healthier happens together.

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

Get started today with CVS Health Virtual Care!

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

Scan the QR Code to
activate your virtual care
benefit!



Know Where to Get Care

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.

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

How to Access Telemedicine 24/7

\$0 COST TELEMEDICINE VS. VIRTUAL VISITS

Please note that Telemedicine services are different from virtual/telephonic office visits with your participating provider. Most SHIF Health Plans have a \$0 copay for the Telemedicine services (CVS Virtual Care) listed below.

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.

Contact CVS Virtual Care

- Via phone: **877.993.4321**
- Via the web: **www.cvs.com/virtual-care**



Guardian Nurses

Struggling With a Healthcare Issue? Call Guardian Nurses Healthcare Advocates

If you or a dependent is ill with a serious and/or catastrophic condition, chances are you could use some help. Our Mobile Care Coordinator RNs, backed by a team of registered nurses, are ready to respond whenever you are struggling with a healthcare issue. They 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** to get you seen as quickly as possible.
- **GO WITH YOU TO SEE DOCTORS**, ask questions and get answers.
- **IDENTIFY PROVIDERS** for all care needs and second opinions.
- **PROVIDE DECISION SUPPORT** when you are thinking about treatments or surgery.
- **EXPLAIN A NEW DIAGNOSIS** to help you make informed decisions.
- **GET THINGS YOU NEED** such as healthcare equipment.

Who is Eligible?

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 included through your coverage with the Schools Health Insurance Fund (SHIF).**



*To request help from our Mobile
Care Coordinators or the team
at Guardian Nurses, call
215-836-0260 or toll free at
888-836-0260.*

CVS Minute Clinics & Health Hubs*

CVS Minute Clinics offer a broad range of services to keep you and your family healthy. In addition to diagnosing and treating illnesses, injuries and skin conditions, they provide wellness services including vaccinations, physicals, screenings and monitoring for chronic conditions.

- Located in select CVS pharmacies and Target stores nationwide
- No appointments necessary
- Visits usually last less than 30 minutes
- A record of your visit can be sent to your family doctor
- Open seven days a week with convenient evening hours

CVS Minute Clinic Practitioners Can:

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



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](https://www.cvs.com/HealthHUB).

Health Hubs Offer the Following Services:

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

HealthHUB[®]

* 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.

Employee Assistance Program (EAP)

Aetna

The Employee Assistance Program (EAP), through Aetna, is available to all LEAP active employees and their household members, including adult children up to age 26 — even if they are not living at home.

The following confidential services through Aetna are available to all LEAP employees at NO ADDITIONAL COST!

Counseling & Relationship Support

Unlimited telephonic consultations with referrals and referral services plus up to 10 face-to-face counseling sessions per issue per year, for an unlimited number of issues.

myStrength

A unique online emotional wellness portal that can assist you with mild or moderate depression and anxiety. The program offers practical ways to improve emotional and overall well-being through eLearning programs, simple tools, trusted resources, and daily motivation.

Legal Services

Members have unlimited telephonic consultations with legal professionals or an initial 30-minute face-to-face consultations with in-state legal professionals. If the member retains the legal professional, an additional 25% discount is provided.

Financial Services

Members may access financial forms and templates online, as well as unlimited telephonic consultations with financial professionals.



How to contact your EAP for 24/7 support:

- By phone at **888.238.6232** **OR** online at **www.resourcesforliving.com**
- Username: **LEAP**
- Password: **EAP**

Prescription Drug Plan

Express Scripts

Through the SHIF, LEAP Academy offers the following prescription plan options to their staff, administered by Express Scripts.

- Employees hired on/after 7/1/2020 may only elect either the NJEHP or GSP for prescription coverage and must be enrolled in the corresponding NJEHP or GSP medical plan, administered by Aetna.
- All other employees may elect any district offered plan design.

NOTE: Dependents are eligible for benefits until the end of the calendar year that he/she turns 26.

NJEHP / GSP RX		RX \$3/\$10/\$15
RETAIL PHARMACY (UP TO A 30 DAY SUPPLY)		
Generic	\$5 copay	\$3 copay
Brand Without Generic Alternative	\$10 copay	\$10 copay
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic and Brand Drug	\$15 copay
MAIL ORDER (UP TO A 90 DAY SUPPLY)		
Generic	\$10 copay	\$3 copay
Brand Without Generic Alternative	\$20 copay	\$10 copay
Brand With Generic Alternative	Member Pays Brand Copay Plus Difference in Cost Between Generic and Brand Drug	\$15 copay

Mandatory Mail Order Program

Employees must use the mail order program through Express Scripts for maintenance medications. Once the initial prescription and two refills are filled at the retail pharmacy, the mail order program is mandatory for coverage of the ongoing prescriptions. This means you are required to transition to mail order or pay the full cost of the medication.

Please Note:

- The prescription drug plan has dispensing limits when you receive your medication from a retail pharmacy. You may receive up to a 30 day supply at a retail pharmacy.
- Prior authorizations, clinical reviews and step therapy may apply to certain medications. Please refer to the Express Scripts formulary listing for more information or contact Express Scripts directly at **800.467.2006**.



Additional Prescription Information

Express Scripts

The following additional features will apply to prescription drug coverage under the NJEHP or GSP.

Mandatory Generics

Pharmacists must dispense the generic equivalent medication when available. If a member fills the brand name drug instead, they will be responsible for the brand drug copay plus the difference in cost between the brand and generic medication.

Step Therapy

Requires a trial with a lower cost medication before the member is given approval for a higher cost medication, when clinically appropriate. If a member purchases the higher cost medication without prior approval, then the medication will not be covered.

Formulary List

A guide for selecting clinically and therapeutically appropriate medications. This list includes a majority of brand and generic medications, and also lists certain medications which will not be covered. The formulary updates throughout the year, and brand name drugs may move to non-formulary status if a generic version becomes available during the year. For the most up to date version, please visit the Express Scripts website using the following link: www.express-scripts.com.



Digital ID Card

Express Scripts

Your prescription ID card is now digital. 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 instance access to your prescription ID card. You can view your card online or even on the app, download it to your digital wallet, or even print a card from the Express Scripts website.

A digital profile also helps you connect to:

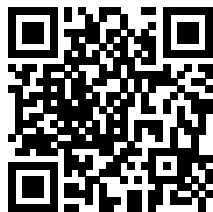
- Lower-cost medical options
- Nearby, in-network pharmacies
- More ways to manage your medications

Don't wait until you are at the pharmacy. Connect to your ID card today.

Visit www.express-scripts.com or download the Express Scripts mobile app to create your profile in a few easy steps.

You can also text **JOIN** to **69717** for a link to the Express Scripts registration page.

Scan the QR code to download the mobile app from the App Store or Google Play.



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 member's date of birth



Temporary Prescription ID Card

RxBin: 003858

RxPCN: A4

RxGRP: K8CA



Temporary Prescription ID Card

RxBin: 003858

RxPCN: A4

RxGRP: K8CA

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

Understanding Your Prescription Plan

Express Scripts

How to get started with Express Scripts Home Delivery

Contact Express Scripts

- For transfers from a retail pharmacy, sign in at www.express-scripts.com, or

Speak with 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.



Save Money Using Mail Order

Express Scripts

HOW MUCH CAN YOU SAVE WHEN USING MAIL ORDER

Compare for Yourself...

NJHP / GSP		
RETAIL PHARMACY	MAIL ORDER	ANNUAL SAVINGS
Generic Copay \$5	Generic Copay \$10	\$20
Annual Cost (\$5 per month x 12 fills) \$60	Annual Cost (\$10 per order x 4 fills per year) \$40	
Preferred Brand Copay \$10	Preferred Brand Copay \$20	\$40
Annual Cost (\$10 per month x 12 fills) \$120	Annual Cost (\$20 per order x 4 fills per year) \$80	



Dental Plans

Delta Dental

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

NOTE: Dependents are eligible for benefits until age 19 if they are not a full-time student, and until the age of 23 if they are a full-time student. Student transcripts showing at least 12 credits must be submitted every semester to your Human Resources Office in order to show proof of student status.

	PPO	DeltaCare USA NJ11A
SERVICES	IN-NETWORK	IN-NETWORK ONLY
Primary Care Dentist Selection	Not Required	<u>Required</u>
Calendar Year Deductible Individual/Family	\$50/\$150	None
Calendar Year Maximum (per patient)	\$1,000	None
Preventive Services Exams, Cleanings, Bitewing X-rays, Sealants (permanent molars only), Fluoride Treatment	Plan pays 100% NO deductible	Copay varies from \$0 to \$45. Please refer to benefit summary for further details.
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Osseous Surgery	Plan pays 80% after deductible	Copays vary. Please refer to benefit summary for further details.
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	Plan pays 50% after deductible	Copays vary. Please refer to benefit summary for further details.
Orthodontia Benefits (child only) Appliance must be placed prior to age 20	Not Covered	Copays vary. Please refer to benefit summary for further details.
Orthodontia Lifetime Maximum (per patient)	Not Covered	24 months of comprehensive orthodontic treatment plus 24 months of retention. Various copays apply. Please refer to benefit summary for further details.

Find a Dental Provider

PPO Plan

Visit www.deltadentalnj.com. You may sign into your account or continue as a guest. Choose a plan to start (i.e. Delta Dental Premier Plan).

DeltaCare Plan

Go to www1.deltadentalins.com; bottom lefthand corner, click on **Find a Dentist**; enter your zip code and select the **DeltaCare USA** network



Chapter 78 Percentage of Premium Schedule

Pursuant to P.L. Chapter 78, all LEAP employees have a contribution arrangement for health benefits that is consistent with NJ State statute. Eligible employees and their eligible dependents share in the cost of healthcare premiums in accordance with the following schedule. The schedule is based upon employees' annual wages and coverage tier (Employee, Employee & Spouse/Child or Family coverage) and represents Year 4 of P.L. Chapter 78 contributions.

Please Note: Employees enrolled in the NJEHP or GSP for medical and prescription benefits will follow a new salary-based contribution schedule. Please refer to the specific NJEHP & GSP Ch. 44 Contribution Schedules for information regarding this contribution schedule.

SALARY RANGE (ANNUAL)	EMPLOYEE ONLY	SALARY RANGE (ANNUAL)	EMPLOYEE & SPOUSE OR EMPLOYEE & CHILD(REN)	SALARY RANGE (ANNUAL)	EMPLOYEE & FAMILY
<\$20,000	4.5%	<\$25,000	3.5%	<\$25,000	3%
20,000–24,999.99	5.5%	25,000–29,999.99	4.5%	25,000–29,999.99	4%
25,000–29,999.99	7.5%	30,000–34,999.99	6%	30,000–34,999.99	5%
30,000–34,999.99	10%	35,000–39,999.99	7%	35,000–39,999.99	6%
35,000–39,999.99	11%	40,000–44,999.99	8%	40,000–44,999.99	7%
40,000–44,999.99	12%	45,000–49,999.99	10%	45,000–49,999.99	9%
45,000–49,999.99	14%	50,000–54,999.99	15%	50,000–54,999.99	12%
50,000–54,999.99	20%	55,000–59,999.99	17%	55,000–59,999.99	14%
55,000–59,999.99	23%	60,000–64,999.99	21%	60,000–64,999.99	17%
60,000–64,999.99	27%	65,000–69,999.99	23%	65,000–69,999.99	19%
65,000–69,999.99	29%	70,000–74,999.99	26%	70,000–74,999.99	22%
70,000–74,999.99	32%	75,000–79,999.99	27%	75,000–79,999.99	23%
75,000–79,999.99	33%	80,000–84,999.99	28%	80,000–84,999.99	24%
80,000–94,999.99	34%	85,000–99,999.99	30%	85,000–89,999.99	26%
95,000 and over	35%	100,000 and over	35%	90,000–94,999.99	28%
				95,000–99,999.99	29%
				100,000–109,999.99	32%
				110,000 and over	35%

Chapter 44 Salary-Based Contributions

NJ Educator's Health Plan (NJEHP)

The Chapter 44 NJ Educators' Health Plan is tied to a new salary based employee contribution schedule, that applies only to medical and prescription benefits. It does not apply to any other coverage that may be offered by the district, such as dental coverage. **For questions regarding employee contributions, please speak with your Human Resources office.**

NJEHP SALARY BASED CONTRIBUTION	SINGLE	PARENT + CHILD	EMPLOYEE + SPOUSE	FAMILY
\$0.00 - \$40,000	1.7%	2.2%	2.8%	3.3%
\$40,001 - \$50,000	1.9%	2.5%	3.3%	3.9%
\$50,001 - \$60,000	2.2%	2.8%	3.9%	4.4%
\$60,001 - \$70,000	2.5%	3.0%	4.4%	5.0%
\$70,001 - \$80,000	2.8%	3.3%	5.0%	5.5%
\$80,001 - \$90,000	3.0%	3.6%	5.5%	6.0%
\$90,001 - \$100,000	3.3%	3.9%	6.0%	6.6%
\$100,001 - \$125,000*	3.6%	4.4%	6.6%	7.2%

Please Note:

- Employees with salaries above \$125,000 shall pay at the \$125,000 rate.
- This is for the medical and prescription benefits **ONLY** under the NJEHP, and **DOES NOT** apply to any other benefits you may be enrolled in with the district.
- For additional assistance regarding your employee contributions, please refer to your Human Resources Office.



Chapter 44 Salary-Based Contributions

Garden State Plan (GSP)

The Chapter 44 Garden State Plan is tied to a new salary based employee contribution schedule, that applies only to medical and prescription benefits. It does not apply to any other coverage that may be offered by the district, such as dental coverage. **For questions regarding employee contributions, please speak with your Human Resources office.**

GSP SALARY BASED CONTRIBUTION	SINGLE	PARENT + CHILD	EMPLOYEE + SPOUSE	FAMILY
\$0.00 - \$40,000	1.50%	1.50%	1.50%	1.65%
\$40,001 - \$50,000	1.50%	1.50%	1.65%	1.95%
\$50,001 - \$60,000	1.50%	1.50%	1.95%	2.20%
\$60,001 - \$70,000	1.50%	1.50%	2.20%	2.50%
\$70,001 - \$80,000	1.50%	1.65%	2.50%	2.75%
\$80,001 - \$90,000	1.50%	1.80%	2.75%	3.00%
\$90,001 - \$100,000	1.65%	1.95%	3.00%	3.30%
\$100,001 - \$125,000*	1.80%	2.20%	3.30%	3.60%

Please Note:

- Employees with salaries above \$125,000 shall pay at the \$125,000 rate.
- This is for the medical and prescription benefits **ONLY** under the GSP, and **DOES NOT** apply to any other benefits you may be enrolled in with the district.
- For additional assistance regarding your employee contributions, please refer to your Human Resources Office.



Value-Added Services

Conner Strong & Buckelew

Benefit Perks

This feature provides a broad array of services, discounts and special deals on consumer services, travel services, recreational services and much more. Simply access the site and register and you can begin using it now.

Learn more at:

<https://connerstrong.corestream.com>

HUSK Marketplace

Achieving optimal health and wellness doesn't have to be complicated or expensive. Access exclusive best-in-class pricing with some of the biggest brands in fitness, nutrition, and wellness with HUSK Marketplace (formerly GlobalFit).

Learn more visiting:

<https://marketplace.huskwellness.com/connerstrong>

GoodRX

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

Learn more at: www.goodrx.com

HealthyLearn

This resource covers over a thousand health and wellness topics in a simple, straight-forward manner. The HealthyLearn On-Demand Library features all the health information you need to be well and stay well.

Learn more at:

<https://healthylearn.com/connerstrong>



Hospital Safety Grade

Leapfrog

Know where to get care!

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

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

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

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

Getting started

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



Benefit Contacts

LINE OF COVERAGE	COMPANY	WEBSITE	PHONE
Medical	Aetna	www.aetna.com	800-370-4526
Nurse Case Management	Guardian Nurses	www.guardiannurses.com	215-836-0260 or toll free at 888-836-0260
Employee Assistance Program (EAP)	Aetna Resources for Living	www.resourcesforliving.com Username: LEAP Password: EAP	888-238-6232
Prescription Drug	Express Scripts	www.express-scripts.com	800-467-2006
Dental	Delta Dental	PPO Plan: www.deltadentalnj.com DeltaCare USA Plan: www.deltadentalins.com	DeltaCare USA: 800-422-4234 PPO: 800-452-9310
Member Advocacy	Conner Strong & Buckelew	www.connerstrong.com/member-advocacy	800-563-9929



Legal Notices & Disclosures

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 or any longer period that applies under the plan 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. Coverage will be effective the first of the month following your request for enrollment.

Loss of coverage 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 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 a state children's health insurance program (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 or any longer period that applies under the plan 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.

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, contact Human Resources.

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.insure-kidsnow.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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid
Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center:

1-800-221-3943/State Relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, Press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program

All other Medicaid

Website: <https://www.in.gov/medicaid/>

<http://www.in.gov/fssa/dfr/>

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

Iowa Medicaid | Health & Human Services

Medicaid Phone: 1-800-338-8366

Hawki Website: <https://hhs.iowa.gov/medicaid/plans-programs/hawki>

Hawki Phone: 1-800-257-8563

HIPP Website: <https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program>

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Louisiana Medicaid Website:

<https://www.ldh.la.gov/healthy-louisiana>

Medicaid Customer Service Line: 1-888-342-6207

Louisiana Medicaid email: healthy@la.gov

Louisiana Health Insurance Premium Program (LaHIPP) Website:

<https://www.ldh.la.gov/lahipp>

LaHIPP phone: 1-877-697-6703

LaHIPP email: La.HIPP@la.gov

LaHIPP fax: 1-888-716-9787

LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

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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/>

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-MyWVHIP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 1-800-251-1269

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

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Insurance Marketplace Notice

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax

credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Jameelah Surgeon, HR Director, 856-614-5785. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

3. Employer Name LEAP Academy University Charter School		4. Employer Identification Number (EIN) 22-349-4324
5. Employer Address 130 N. Broadway		6. Employer phone number 856-614-5785
7. City Camden	8. State NJ	9. Zip Code 08102
10. Who can we contact about employee health coverage at this job? Jameelah Surgeon, HR Director		
11. Phone number (if different from above) 856-614-5785	12. Email address jsurgeon@leap.rutgers.edu	

PART B: Information about Health Coverage Offered by Your Employer

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

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - Some employees. Eligible employees are: Full-time employees, who work a regular schedule of 35 hours or more per week, are eligible to enroll in benefits.
- With respect to dependents:
 - We do offer coverage. Eligible dependents are: Legal spouse/civil union partner, Biological child(ren), Legally adopted child(ren), Foster child(ren), Stepchild(ren) as long as natural parent remains married to the employee and resides in the employee’s household, Child(ren) for whom you are responsible for under a court-order, Grandchild(ren) for whom you are responsible for under a court-order.
- This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary week to week (perhaps you are an hourly employee or you work on a commission bases), if you are newly employed mid-year, or if you have other income losses, you may still qualify for the premium discount.**

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.



LEAP Academy 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.