Bridgewater-Raritan Regional School District

Important Notice to Employees Eligible for or Enrolled in District Health Benefit Plans

Benefits Open Enrollment May 11 → May 29

Open Enrollment 2026 for our health plans is here! If you wish to make changes to your health plans, *now is the time to:*

- Switch to an alternative benefit plan as eligible
- Add / remove dependents from your plans
- Enroll yourself for new coverage
- Enroll / re-enroll in the benefits opt-out

Switch to an alternative benefit plan as eligible

If you are interested in changing benefit plans, review the plan materials at our *Benefits Online* website (click here or visit the HR page of the District website and click "Health Benefits") to see if a switch works for you.

Per your existing Collective Bargaining Agreement, if you wish to enroll in the Horizon BCBSNJ Direct Access 10 plan, you can do so by paying the Chapter 78 contribution on the Direct Access 15 plan and 100% of the premium cost differential between the Direct Access 10 and Direct Access 15 plans. See the attached form for information and instructions.

Note: if your start date was on or after July 1, 2020, you must be enrolled in the New Jersey Educators Health Plan (NJEHP) or Garden State Plan (GSP) for your medical and prescription coverage.

Add / remove dependents from your plans

During Open Enrollment, you can newly enroll an eligible dependent if you failed to do so within the initial enrollment window. For instance, you can enroll a new spouse or your dependent child who is eligible for coverage under the District plan (e.g., your child under age 26 without health coverage).

Likewise, if your dependent child no longer needs District health coverage or has 'aged out' of the plan, or you need to disenroll a spouse from whom you are now divorced, now is the time. While you should notify Lisandra Florek in Human Resources at the time when such events occur, you can do so now during Open Enrollment.

Note the following about your dependents:

- Your dependent child is eligible for District dental coverage until their 19th birthday (or 23rd birthday if attending an accredited school, college, or university full-time).
- If enrolling a new dependent(s) to your plans, you must provide copies of applicable eligibility documentation:
  - Spouse: marriage / civil union certificate
  - Natural child: birth certificate showing employee name
  - Stepchild: birth certificate showing name of spouse/partner **and** marriage/civil union certificate with employee/spouse name
  - Adopted child: final court orders with presiding judge's signature and seal

Enroll yourself for new coverage

Employees who are eligible for District coverage but are not currently enrolled can join now.

Enroll / re-enroll in the benefits opt-out

If you have access to benefits elsewhere (e.g., your spouse's employer plan), you may be eligible to waive District plans in return for incentive payments. **Note, if currently waiving coverage and wish to continue your opt-out into the coming year, you MUST re-enroll now.**

If enrolling or re-enrolling in the waiver option, complete the form and return to Lisandra Florek in Human Resources by **May 29, 2026.**

Next Steps:

- Review your plan options at *Benefits Online* (click here or visit the HR page of the District website and click "Health Benefits").
- Paperwork to adjust your plans or waive benefits is due to Lisandra Florek in Human Resources on or before **May 29, 2026**.
- ***If none of the above applies to you, no action is needed; you will retain your current plan status.***
- Any adjustments you make take effect **July 1, 2026**.

Questions? Please contact Lisandra Florek in Human Resources.

Bridgewater-Raritan Board of Education

Simplified Horizon BCBSNJ Medical & Prescription Plan Benefits Comparison with July 1, 2026 Rates

	Horizon Direct 10		Horizon Direct 15		Horizon Direct 15/25		Horizon Direct 20/20		Horizon Direct 20/35		New Jersey Educators Health Plan (NJEHP)		Garden State Plan (GSP) New Jersey Providers Only	
Medical:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Referral Required	No		No		No		No		No		No		No	
Individual Deductible	None	$100	None	$100	None	$100	None	$200	$200	$800	None	$350	None	$350
Family Deductible	None	$250	None	$250	None	$250	None	$500	$400	$1,600	None	$700	None	$700
Coinsurance	10% (select serv)	20%	10% (select serv)	30%	10% (select serv)	30%	10% (select serv)	30%	20% after ded.	40%	10% (select serv)	30%	10% (select serv)	30%
Max. Coinsurance Single	$400	$2,000	$400	$2,000	$400	$2,000	$800	$5,000	$2,000	$5,000	$500	$2,000	$500	$2,000
Max. Coinsurance Family	$800	$5,000	$800	$5,000	$800	$5,000	$1,600	$12,500	$4,000	$12,500	$1,000	$5,000	$1,000	$5,000
Max. Out of Pocket Single	$400	$2,000	$400	$2,000	$400	$2,000	$800	$5,000	$2,000	$5,000	$500	$2,000	$500	$2,000
Max. Out of Pocket Family	$800	$5,000	$800	$5,000	$800	$5,000	$1,600	$12,500	$4,000	$12,500	$1,000	$5,000	$1,000	$5,000
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Office Copay	$10	80% after ded.	$15	70% after ded.	$15	70% after ded.	$20	70% after ded.	$20	60% after ded.	$10	70% after ded.	$10	70% after ded.
Specialist Office Copay	$10	80% after ded.	$15	70% after ded.	$25	70% after ded.	$20	70% after ded.	$35	60% after ded.	$15	70% after ded.	$15	70% after ded.
Inpatient Hospital Copay	100%	80% after ded.	100%	70% after ded.	100%	70% after ded. & $200 copay	100%	70% after ded. & $500 copay	80% after ded.	60% after ded. & $500 copay	100%	70% after ded.	100%	70% after ded.
Emergency Room Copay	100% after $25 copay		100% after $50 copay		100% after $75 copay		100% after $100 copay		80% after $100 copay		100% after $125 copay		100% after $125 copay	
Medical Monthly Premium Rates:														
Single	$1,441.49		$1,372.26		$1,331.83		$1,251.64		$1,076.47		$1,206.35		$1,155.68	
Parent/Child(ren)	$2,522.63		$2,401.48		$2,330.71		$2,190.37		$1,883.79		$2,111.13		$2,022.46	
2-Party	$2,883.04		$2,744.56		$2,617.12		$2,503.31		$2,152.88		$2,412.75		$2,311.42	
Family	$3,964.11		$3,773.75		$3,598.58		$3,442.04		$2,960.25		$3,317.49		$3,178.15	
Prescription:														
Retail Generic Copay	$10		$10		$10		$10		$10		Preferred Generic: $5		Preferred Generic: $5	
											Preferred Brand: $10		Preferred Brand: $10	
Retail Brand Copay	$20		$20		$20		$20		$20		Non-Preferred: $10		Non-Preferred: $10	
Mail Order Generic Copay	$10		$10		$10		$10		$10		Preferred Generic: $10		Preferred Generic: $10	
											Preferred Brand: $20		Preferred Brand: $20	
Mail Order Brand Copay	$20		$20		$20		$20		$20		Non-Preferred: $20		Non-Preferred: $20	
Prescription Drug Monthly Premium Rates:														
Single	$313.87		$313.87		$313.87		$313.87		$313.87		$257.61		$257.61	
Parent/Child(ren)	$499.43		$499.43		$499.43		$499.43		$499.43		$409.89		$409.89	
2-Party	$621.62		$621.62		$621.62		$621.62		$621.62		$510.20		$510.20	
Family	$840.02		$840.02		$840.02		$840.02		$840.02		$689.44		$689.44	
Medical & Rx Annual Premium														
Single	Single	$21,064.32	Single	$20,233.56	Single	$19,748.40	Single	$18,786.12	Single	$16,684.08	Single	$17,567.52	Single	$16,959.48
Parent/Child(ren)	P/C	$36,264.72	P/C	$34,810.92	P/C	$33,961.68	P/C	$32,277.60	P/C	$28,598.64	P/C	$30,252.24	P/C	$29,188.20
2-Party	2A	$42,055.92	2A	$40,394.16	2A	$38,864.88	2A	$37,499.16	2A	$33,294.00	2A	$35,075.40	2A	$33,859.44
Family	Family	$57,649.56	Family	$55,365.24	Family	$53,263.20	Family	$51,384.72	Family	$45,603.24	Family	$48,083.16	Family	$46,411.08

Bridgewater-Raritan Board of Education

Simplified Horizon BCBSNJ Medical & Prescription Plan Benefits Comparison with July 1, 2026 Rates

	POS 10		POS 15/25		POS 20/20		POS 20/35		OMNIA 10	
Medical:	In-Network		In-Network		In-Network		In-Network		Tier 1	Tier 2
Referral Required	YES		YES		YES		YES		No	
Individual Deductible	$500		$500		$500		$500		None	$1,500
Family Deductible	$1,000		$1,000		$1,000		$1,000		None	$3,000
Coinsurance	N/A		N/A		N/A		20%		N/A	N/A
Max. Coinsurance Single	N/A		N/A		N/A		$2,000		$400	$2,000
Max. Coinsurance Family	N/A		N/A		N/A		$4,000		$800	$4,000
Max. Out of Pocket Single	$4,000		$4,000		$4,000		$2,000		$400	$2,000
Max. Out of Pocket Family	$8,000		$8,000		$8,000		$4,000		$800	$4,000
Lifetime Benefit Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	Unlimited
PCP Office Copay	$10		$15		$20		$20		$5	$10
Specialist Office Copay	$10		$25		$20		$35		$5	$10
Inpatient Hospital Copay	100%		100%		100%		80%		100%	70% after ded.
Emergency Room Copay	100% after $35 copay		100% after $75 copay		100% after $100		80% after $100 copay		100% after $25 copay	
Medical Monthly Premium Rates:										
Single	$1,308.57		$1,208.34		$1,136.22		$977.18		$1,096.73	
Parent/Child(ren)	$2,289.98		$2,114.61		$1,988.44		$1,710.04		$1,907.09	
2-Party	$2,617.12		$2,416.64		$2,272.42		$1,954.32		$2,193.49	
Family	$3,598.58		$3,324.13		$3,124.67		$2,687.24		$3,016.04	
Prescription:										
Retail Generic Copay	$10		$10		$10		$10		$10	
Retail Brand Copay	$20		$20		$20		$20		$20	
Mail Order Generic Copay	$10		$10		$10		$10		$10	
Mail Order Brand Copay	$20		$20		$20		$20		$20	
Prescription Drug Monthly Premium Rates:										
Single	$313.87		$313.87		$313.87		$313.87		$313.87	
Parent/Child(ren)	$499.43		$499.43		$499.43		$499.43		$499.43	
2-Party	$621.62		$621.62		$621.62		$621.62		$621.62	
Family	$840.02		$840.02		$840.02		$840.02		$840.02	
Medical & Rx Annual Premium										
Single	Single	$19,469.28	Single	$18,266.52	Single	$17,401.08	Single	$15,492.60	Single	$16,927.20
Parent/Child(ren)	P/C	$33,472.92	P/C	$31,368.48	P/C	$29,854.44	P/C	$26,513.64	P/C	$28,878.24
2-Party	2A	$38,864.88	2A	$36,459.12	2A	$34,728.48	2A	$30,911.28	2A	$33,781.32
Family	Family	$53,263.20	Family	$49,969.80	Family	$47,576.28	Family	$42,327.12	Family	$46,272.72

2026-27 Bridgewater-Raritan Regional Board of Education Medical Coverage Form
For Employees Wishing to Enroll in Horizon Direct Access 10

If you wish to enroll in the Horizon Direct Access 10 plan, per the collective bargaining agreement, you can do so by paying the Chapter 78 contribution on the Horizon Direct Access 15 plan *and* 100% of the premium cost differential between the Horizon Direct Access 10 and the Horizon Direct Access 15. Those per paycheck premium differences are listed below. Remember this cost is *in addition* to the Chapter 78 contribution on the Horizon Direct Access 15 plan. These medical rates are from July 1, 2026 to June 30, 2027 and do not include the contributions for the prescription plan. These are strictly medical contributions.

Per Paycheck Differential Between Horizon Direct Access 10 and Horizon Direct Access 15

Single - $41.54 (10 months), $34.62 (12 months)	*Parent/Child – $72.69 (10 months), $60.58 (12 months)*
Two Adult - $83.09 (10 months), $69.24 (12 months)	*Family - $114.22 (10 months), $95.18 (12 months)*

By signing the below, you are telling us you wish to enroll in the Horizon Direct Access 10 and are aware that you will be paying the above amount (based on enrolled category) *in addition* to the Chapter 78 contribution on the Horizon Direct Access 15 .

I, _____(Print Name), wish to enroll in the Horizon Direct Access 10 plan.

_____ (Employee signature) **_____(Date)**

FORMS MUST BE SIGNED AND RETURNED ALONG WITH YOUR HORIZON ENROLLMENT APPLICATION

Health/Dental Benefits
Opt-Out Election Form
July 1, 2026 - June 30, 2027

BRRSD Employee Name: _____ Location: _____

The Bridgewater-Raritan Board of Education is offering benefits "Opt-Out" compensation to eligible employees who choose to waive the Board's health insurance coverages. Under this provision, an employee may elect to waive medical, prescription and dental benefits in return for a waiver incentive. Employees who elect to waive all or some of their coverage options shall receive an incentive which reflects 25% of the Board's savings, not to exceed $5,000. Acceptance of this waiver involves important factors that should be considered:

1. If elected, the benefit waiver for all employees will be paid in 20 equal installments (September through June).
2. The payment will be treated as taxable income.
3. Once waived, you will be ineligible to receive benefits until open enrollment for the following contract year ***unless*** you experience a qualifying life event (loss of job, loss of benefits, divorce, etc.). ***It is the employee's responsibility to notify the Human Resources Department if benefits are lost for any reason and to complete an enrollment application.***
4. You can elect to waive medical insurance alone and enroll in dental insurance and/or prescription coverage. However, if you do elect prescription coverage, you will be required to pay the greater of 1.5% of your annual salary or a percentage of the premium based on the State Chapter 78 contribution chart. You will not be charged a premium if you elect to enroll in the dental plan.

I elect to waive the following insurance coverage being offered by the Bridgewater-Raritan Board of Education for myself (and my dependents), effective July 1, 2026 through June 30, 2027 (check all that apply):

☐ Medical ☐ Prescription ☐ Dental*

Note: The waiver of dental insurance does not include payment of a waiver incentive.

Level of coverage waived (check one):

Single ☐ Parent/Child ☐ Member/Spouse ☐ Family ☐

I certify that all of my dependents and I have health benefits coverage under:

Name: _____ Relationship: _____ Health Plan: _____

I have read, understood, and agree to the provisions outlined above.

Employee Signature: _____ Date: _____

Return this form to the Human Resources Department by May 29, 2026.
Proof of coverage (Photocopy of health benefits ID card) must be attached.

Follow *Steps 1-3* to figure your annual mandated Chapter 78 contribution amount

Bridgewater-Raritan Regional Board of Education
Annual Health Plan Employee Contribution Comparison
Combined Horizon BCBSNJ Medical and Prescription Plans
Single Coverage Year 4: July 2026 through June 2027

Estimated Chapter 78 Annual Single Contribution

Step 1: Find your Salary Range; go to ***Step 2***

[This is your Year 4 contribution percentage]

Step 2: Identify the below contribution amount in your Salary Range that matches your selected medical/prescription plan.

Go to *Step 3* to figure your approximate annual contribution amount per paycheck

Salary Range	Year 4	Horizon BCBSNJ Direct Access 15	Horizon BCBSNJ Direct Access 15/25	Horizon BCBSNJ Direct Access 20/20	Horizon BCBSNJ Direct Access 20/35
less than 20,000	**4.50%**	$910.51	$888.68	$845.38	$750.78
20,000-24,999	**5.50%**	$1,112.85	$1,086.16	$1,033.24	$917.62
25,000-29,999	**7.50%**	$1,517.52	$1,481.13	$1,408.96	$1,251.31
30,000-34,999	**10.00%**	$2,023.36	$1,974.84	$1,878.61	$1,668.41
35,000-39,999	**11.00%**	$2,225.69	$2,172.32	$2,066.47	$1,835.25
40,000-44,999	**12.00%**	$2,428.03	$2,369.81	$2,254.33	$2,002.09
45,000-49,999	**14.00%**	$2,832.70	$2,764.78	$2,630.06	$2,335.77
50,000-54,999	**20.00%**	$4,046.71	$3,949.68	$3,757.22	$3,336.82
55,000-59,999	**23.00%**	$4,653.72	$4,542.13	$4,320.81	$3,837.34
60,000-64,999	**27.00%**	$5,463.06	$5,332.07	$5,072.25	$4,504.70
65,000-69,999	**29.00%**	$5,867.73	$5,727.04	$5,447.97	$4,838.38
70,000-74,999	**32.00%**	$6,474.74	$6,319.49	$6,011.56	$5,338.91
75,000-79,999	**33.00%**	$6,677.07	$6,516.97	$6,199.42	$5,505.75
80,000-94,999	**34.00%**	$6,879.41	$6,714.46	$6,387.28	$5,672.59
95,000 and over	**35.00%**	$7,081.75	$6,911.94	$6,575.14	$5,839.43
Monthly Single Premium (Med+RX)		$1,686.13	$1,645.70	$1,565.51	$1,390.34

Step 3:

To calculate your approximate contribution amount per paycheck:

1) if you are a 10-month employee, divide the shown contribution amount matching your salary range by 20.
2) if you are a 12-month employee, divide the shown contribution amount matching your salary range by 24.

[Note: Employee must contribute 1.5% of salary or the above contribution amount, whichever is greater.]

Follow ***Steps 1-3*** to figure your annual mandated Chapter 78 contribution amount

Bridgewater-Raritan Regional Board of Education
Annual Health Plan Employee Contribution Comparison
Combined Horizon BCBSNJ Medical and Prescription Plans
Parent-Child Coverage Year 4: July 2026 through June 2027

Step 1: Find your Salary Range; go to ***Step 2***

[This is your Year 4 contribution percentage]

Step 2: Identify the below contribution amount in your Salary Range that matches your selected medical/prescription plan.

Go to ***Step 3*** to figure your approximate annual contribution amount per paycheck

		Estimated Chapter 78 Annual Parent-Child Contribution			
Salary Range	Year 4	**Horizon BCBSNJ Direct Access 15**	**Horizon BCBSNJ Direct Access 15/25**	**Horizon BCBSNJ Direct Access 20/20**	**Horizon BCBSNJ Direct Access 20/35**
less than 25,000	**3.50%**	$1,218.38	$1,188.66	$1,129.72	$1,000.95
25,000-29,999	**4.50%**	$1,566.49	$1,528.28	$1,452.49	$1,286.94
30,000-34,999	**6.00%**	$2,088.66	$2,037.70	$1,936.66	$1,715.92
35,000-39,999	**7.00%**	$2,436.76	$2,377.32	$2,259.43	$2,001.90
40,000-44,999	**8.00%**	$2,784.87	$2,716.93	$2,582.21	$2,287.89
45,000-49,999	**10.00%**	$3,481.09	$3,396.17	$3,227.76	$2,859.86
50,000-54,999	**15.00%**	$5,221.64	$5,094.25	$4,841.64	$4,289.80
55,000-59,999	**17.00%**	$5,917.86	$5,773.49	$5,487.19	$4,861.77
60,000-64,999	**21.00%**	$7,310.29	$7,131.95	$6,778.30	$6,005.71
65,000-69,999	**23.00%**	$8,006.51	$7,811.19	$7,423.85	$6,577.69
70,000-74,999	**26.00%**	$9,050.84	$8,830.04	$8,392.18	$7,435.65
75,000-79,999	**27.00%**	$9,398.95	$9,169.65	$8,714.95	$7,721.63
80,000-84,999	**28.00%**	$9,747.06	$9,509.27	$9,037.73	$8,007.62
85,000-99,999	**30.00%**	$10,443.28	$10,188.50	$9,683.28	$8,579.59
100,000 and over	**35.00%**	$12,183.82	$11,886.59	$11,297.16	$10,009.52
Monthly P-C Premium (Med+RX)		$2,900.91	$2,830.14	$2,689.80	$2,383.22

Step 3:

To calculate your approximate contribution amount per paycheck:

1) if you are a 10-month employee, divide the shown contribution amount matching your salary range by 20.
2) if you are a 12-month employee, divide the shown contribution amount matching your salary range by 24.

[Note: Employee must contribute 1.5% of salary or the above contribution amount, whichever is greater.]

Follow *Steps 1-3* to figure your annual mandated Chapter 78 contribution amount

Bridgewater-Raritan Regional Board of Education
Annual Health Plan Employee Contribution Comparison
Combined Horizon BCBSNJ Medical and Prescription Plans
2Adult Coverage Year 4: July 2026 through June 2027

Estimated Chapter 78 Annual 2Adult Contribution

Step 1: Find your Salary Range; go to ***Step 2***

[This is your Year 4 contribution percentage]

Step 2: Identify the below contribution amount in your Salary Range that matches your selected medical/prescription plan.

Go to *Step 3* to figure your approximate annual contribution amount per paycheck

Salary Range	Year 4	Horizon BCBSNJ Direct Access 15	Horizon BCBSNJ Direct Access 15/25	Horizon BCBSNJ Direct Access 20/20	Horizon BCBSNJ Direct Access 20/35
less than 25,000	**3.50%**	$1,413.80	$1,360.27	$1,312.47	$1,165.29
25,000-29,999	**4.50%**	$1,817.74	$1,748.92	$1,687.46	$1,498.23
30,000-34,999	**6.00%**	$2,423.65	$2,331.89	$2,249.95	$1,997.64
35,000-39,999	**7.00%**	$2,827.59	$2,720.54	$2,624.94	$2,330.58
40,000-44,999	**8.00%**	$3,231.53	$3,109.19	$2,999.93	$2,663.52
45,000-49,999	**10.00%**	$4,039.42	$3,886.49	$3,749.92	$3,329.40
50,000-54,999	**15.00%**	$6,059.12	$5,829.73	$5,624.87	$4,994.10
55,000-59,999	**17.00%**	$6,867.01	$6,607.03	$6,374.86	$5,659.98
60,000-64,999	**21.00%**	$8,482.77	$8,161.62	$7,874.82	$6,991.74
65,000-69,999	**23.00%**	$9,290.66	$8,938.92	$8,624.81	$7,657.62
70,000-74,999	**26.00%**	$10,502.48	$10,104.87	$9,749.78	$8,656.44
75,000-79,999	**27.00%**	$10,906.42	$10,493.52	$10,124.77	$8,989.38
80,000-84,999	**28.00%**	$11,310.36	$10,882.17	$10,499.76	$9,322.32
85,000-99,999	**30.00%**	$12,118.25	$11,659.46	$11,249.75	$9,988.20
100,000 and over	**35.00%**	$14,137.96	$13,602.71	$13,124.71	$11,652.90
Monthly 2A Premium (Med+RX)		$3,366.18	$3,238.74	$3,124.93	$2,774.50

Step 3:

To calculate your approximate contribution amount per paycheck:

1) if you are a 10-month employee, divide the shown contribution amount matching your salary range by 20.

2) if you are a 12-month employee, divide the shown contribution amount matching your salary range by 24.

[Note: Employee must contribute 1.5% of salary or the above contribution amount, whichever is greater.]

Follow *Steps 1-3* to figure your annual mandated Chapter 78 contribution amount

Bridgewater-Raritan Regional Board of Education
Annual Health Plan Employee Contribution Comparison
Combined Horizon BCBSNJ Medical and Prescription Plans
Family Coverage Year 4: July 2026 through June 2027

Estimated Chapter 78 Annual Family Contribution

Step 1: Find your Salary Range; go to ***Step 2***

[This is your Year 4 contribution percentage]

Step 2: Identify the below contribution amount in your Salary Range that matches your selected medical/prescription plan.

Go to *Step 3* to figure your approximate annual contribution amount per paycheck

Salary Range	Year 4	Horizon BCBSNJ Direct Access 15	Horizon BCBSNJ Direct Access 15/25	Horizon BCBSNJ Direct Access 20/20	Horizon BCBSNJ Direct Access 20/35
less than 25,000	**3.00%**	$1,660.96	$1,597.90	$1,541.54	$1,368.10
25,000-29,999	**4.00%**	$2,214.61	$2,130.53	$2,055.39	$1,824.13
30,000-34,999	**5.00%**	$2,768.26	$2,663.16	$2,569.24	$2,280.16
35,000-39,999	**6.00%**	$3,321.91	$3,195.79	$3,083.08	$2,736.19
40,000-44,999	**7.00%**	$3,875.57	$3,728.42	$3,596.93	$3,192.23
45,000-49,999	**9.00%**	$4,982.87	$4,793.69	$4,624.62	$4,104.29
50,000-54,999	**12.00%**	$6,643.83	$6,391.58	$6,166.17	$5,472.39
55,000-59,999	**14.00%**	$7,751.13	$7,456.85	$7,193.86	$6,384.45
60,000-64,999	**17.00%**	$9,412.09	$9,054.74	$8,735.40	$7,752.55
65,000-69,999	**19.00%**	$10,519.40	$10,120.01	$9,763.10	$8,664.62
70,000-74,999	**22.00%**	$12,180.35	$11,717.90	$11,304.64	$10,032.71
75,000-79,999	**23.00%**	$12,734.01	$12,250.54	$11,818.49	$10,488.75
80,000-84,999	**24.00%**	$13,287.66	$12,783.17	$12,332.33	$10,944.78
85,000-89,999	**26.00%**	$14,394.96	$13,848.43	$13,360.03	$11,856.84
90,000-94,999	**28.00%**	$15,502.27	$14,913.70	$14,387.72	$12,768.91
95,000-99,999	**29.00%**	$16,055.92	$15,446.33	$14,901.57	$13,224.94
100,000-109,999	**32.00%**	$17,716.88	$17,044.22	$16,443.11	$14,593.04
110,000 and over	**35.00%**	$19,377.83	$18,642.12	$17,984.65	$15,961.13
Monthly Family Premium (Med+RX)		$4,613.77	$4,438.60	$4,282.06	$3,800.27

Step 3:

To calculate your approximate contribution amount per paycheck:

1) if you are a 10-month employee, divide the shown contribution amount matching your salary range by 20.

2) if you are a 12-month employee, divide the shown contribution amount matching your salary range by 24.

[Note: Employee must contribute 1.5% of salary or the above contribution amount, whichever is greater.]

Follow ***Steps 1-3*** to figure your annual mandated Chapter 78 contribution amount

Bridgewater-Raritan Regional Board of Education
Annual Health Plan Employee Contribution Comparison
Combined Horizon BCBSNJ Medical and Prescription Plans
Single Coverage Year 4: July 2026 through June 2027

Step 1: Find your Salary Range; go to ***Step 2***

[This is your Year 4 contribution percentage]

Step 2: Identify the below contribution amount in your Salary Range that matches your selected medical/prescription plan.

Go to ***Step 3*** to figure your approximate annual contribution amount per paycheck

		Estimated Chapter 78 Annual Single Contribution				
Salary Range	Year 4	**Horizon BCBSNJ POS 10**	**Horizon BCBSNJ POS 15/25**	**Horizon BCBSNJ POS 20/20**	**Horizon BCBSNJ POS 20/35**	**OMNIA**
less than 20,000	**4.50%**	$876.12	$821.99	$783.05	$697.17	$761.72
20,000-24,999	**5.50%**	$1,070.81	$1,004.66	$957.06	$852.09	$931.00
25,000-29,999	**7.50%**	$1,460.20	$1,369.99	$1,305.08	$1,161.95	$1,269.54
30,000-34,999	**10.00%**	$1,946.93	$1,826.65	$1,740.11	$1,549.26	$1,692.72
35,000-39,999	**11.00%**	$2,141.62	$2,009.32	$1,914.12	$1,704.19	$1,861.99
40,000-44,999	**12.00%**	$2,336.31	$2,191.98	$2,088.13	$1,859.11	$2,031.26
45,000-49,999	**14.00%**	$2,725.70	$2,557.31	$2,436.15	$2,168.96	$2,369.81
50,000-54,999	**20.00%**	$3,893.86	$3,653.30	$3,480.22	$3,098.52	$3,385.44
55,000-59,999	**23.00%**	$4,477.93	$4,201.30	$4,002.25	$3,563.30	$3,893.26
60,000-64,999	**27.00%**	$5,256.71	$4,931.96	$4,698.29	$4,183.00	$4,570.34
65,000-69,999	**29.00%**	$5,646.09	$5,297.29	$5,046.31	$4,492.85	$4,908.89
70,000-74,999	**32.00%**	$6,230.17	$5,845.29	$5,568.35	$4,957.63	$5,416.70
75,000-79,999	**33.00%**	$6,424.86	$6,027.95	$5,742.36	$5,112.56	$5,585.98
80,000-94,999	**34.00%**	$6,619.56	$6,210.62	$5,916.37	$5,267.48	$5,755.25
95,000 and over	**35.00%**	$6,814.25	$6,393.28	$6,090.38	$5,422.41	$5,924.52
Monthly Single Premium (Med+RX)		$1,622.44	$1,522.21	$1,450.09	$1,291.05	$1,410.60

Step 3:

To calculate your approximate contribution amount per paycheck:

1) if you are a 10-month employee, divide the shown contribution amount matching your salary range by 20.
2) if you are a 12-month employee, divide the shown contribution amount matching your salary range by 24.

[Note: Employee must contribute 1.5% of salary or the above contribution amount, whichever is greater.]

Follow *Steps 1-3* to figure your annual mandated Chapter 78 contribution amount

Bridgewater-Raritan Regional Board of Education
Annual Health Plan Employee Contribution Comparison
Combined Horizon BCBSNJ Medical and Prescription Plans
Parent-Child Coverage Year 4: July 2026 through June 2027

Estimated Chapter 78 Annual Parent-Child Contribution

Step 1: Find your Salary Range; go to ***Step 2***

[This is your Year 4 contribution percentage]

Step 2: Identify the below contribution amount in your Salary Range that matches your selected medical/prescription plan.

Go to *Step 3* to figure your approximate annual contribution amount per paycheck

Salary Range	Year 4	Horizon BCBSNJ POS 10	Horizon BCBSNJ POS 15/25	Horizon BCBSNJ POS 20/20	Horizon BCBSNJ POS 20/35	OMNIA
less than 25,000	**3.50%**	$1,171.55	$1,097.90	$1,044.91	$927.98	$1,010.74
25,000-29,999	**4.50%**	$1,506.28	$1,411.58	$1,343.45	$1,193.11	$1,299.52
30,000-34,999	**6.00%**	$2,008.38	$1,882.11	$1,791.27	$1,590.82	$1,732.69
35,000-39,999	**7.00%**	$2,343.10	$2,195.79	$2,089.81	$1,855.95	$2,021.48
40,000-44,999	**8.00%**	$2,677.83	$2,509.48	$2,388.36	$2,121.09	$2,310.26
45,000-49,999	**10.00%**	$3,347.29	$3,136.85	$2,985.44	$2,651.36	$2,887.82
50,000-54,999	**15.00%**	$5,020.94	$4,705.27	$4,478.17	$3,977.05	$4,331.74
55,000-59,999	**17.00%**	$5,690.40	$5,332.64	$5,075.25	$4,507.32	$4,909.30
60,000-64,999	**21.00%**	$7,029.31	$6,587.38	$6,269.43	$5,567.86	$6,064.43
65,000-69,999	**23.00%**	$7,698.77	$7,214.75	$6,866.52	$6,098.14	$6,642.00
70,000-74,999	**26.00%**	$8,702.96	$8,155.80	$7,762.15	$6,893.55	$7,508.34
75,000-79,999	**27.00%**	$9,037.69	$8,469.49	$8,060.70	$7,158.68	$7,797.12
80,000-84,999	**28.00%**	$9,372.42	$8,783.17	$8,359.24	$7,423.82	$8,085.91
85,000-99,999	**30.00%**	$10,041.88	$9,410.54	$8,956.33	$7,954.09	$8,663.47
100,000 and over	**35.00%**	$11,715.52	$10,978.97	$10,449.05	$9,279.77	$10,107.38
Monthly P-C Premium (Med+RX)		$2,789.41	$2,614.04	$2,487.87	$2,209.47	$2,406.52

Step 3:

To calculate your approximate contribution amount per paycheck:

1) if you are a 10-month employee, divide the shown contribution amount matching your salary range by 20.

2) if you are a 12-month employee, divide the shown contribution amount matching your salary range by 24.

[Note: Employee must contribute 1.5% of salary or the above contribution amount, whichever is greater.]

Follow *Steps 1-3* to figure your annual mandated Chapter 78 contribution amount

Bridgewater-Raritan Regional Board of Education
Annual Health Plan Employee Contribution Comparison
Combined Horizon BCBSNJ Medical and Prescription Plans
2Adult Coverage Year 4: July 2026 through June 2027

Estimated Chapter 78 Annual 2Adult Contribution

Step 1: Find your Salary Range; go to ***Step 2***

[This is your Year 4 contribution percentage]

Step 2: Identify the below contribution amount in your Salary Range that matches your selected medical/prescription plan.

Go to *Step 3* to figure your approximate annual contribution amount per paycheck

Salary Range	Year 4	Horizon BCBSNJ POS 10	Horizon BCBSNJ POS 15/25	Horizon BCBSNJ POS 20/20	Horizon BCBSNJ POS 20/35	OMNIA
less than 25,000	**3.50%**	$1,360.27	$1,276.07	$1,215.50	$1,081.89	$1,182.35
25,000-29,999	**4.50%**	$1,748.92	$1,640.66	$1,562.78	$1,391.01	$1,520.16
30,000-34,999	**6.00%**	$2,331.89	$2,187.55	$2,083.71	$1,854.68	$2,026.88
35,000-39,999	**7.00%**	$2,720.54	$2,552.14	$2,430.99	$2,163.79	$2,364.69
40,000-44,999	**8.00%**	$3,109.19	$2,916.73	$2,778.28	$2,472.90	$2,702.51
45,000-49,999	**10.00%**	$3,886.49	$3,645.91	$3,472.85	$3,091.13	$3,378.13
50,000-54,999	**15.00%**	$5,829.73	$5,468.87	$5,209.27	$4,636.69	$5,067.20
55,000-59,999	**17.00%**	$6,607.03	$6,198.05	$5,903.84	$5,254.92	$5,742.82
60,000-64,999	**21.00%**	$8,161.62	$7,656.42	$7,292.98	$6,491.37	$7,094.08
65,000-69,999	**23.00%**	$8,938.92	$8,385.60	$7,987.55	$7,109.59	$7,769.70
70,000-74,999	**26.00%**	$10,104.87	$9,479.37	$9,029.40	$8,036.93	$8,783.14
75,000-79,999	**27.00%**	$10,493.52	$9,843.96	$9,376.69	$8,346.05	$9,120.96
80,000-84,999	**28.00%**	$10,882.17	$10,208.55	$9,723.97	$8,655.16	$9,458.77
85,000-99,999	**30.00%**	$11,659.46	$10,937.74	$10,418.54	$9,273.38	$10,134.40
100,000 and over	**35.00%**	$13,602.71	$12,760.69	$12,154.97	$10,818.95	$11,823.46
Monthly 2AD Premium (Med+RX)		$3,238.74	$3,038.26	$2,894.04	$2,575.94	$2,815.11

Step 3:

To calculate your approximate contribution amount per paycheck:

1) if you are a 10-month employee, divide the shown contribution amount matching your salary range by 20.

2) if you are a 12-month employee, divide the shown contribution amount matching your salary range by 24.

[Note: Employee must contribute 1.5% of salary or the above contribution amount, whichever is greater.]

Follow *Steps 1-3* to figure your annual mandated Chapter 78 contribution amount

Bridgewater-Raritan Regional Board of Education
Annual Health Plan Employee Contribution Comparison
Combined Horizon BCBSNJ Medical and Prescription Plans
Family Coverage Year 4: July 2026 through June 2027

Estimated Chapter 78 Annual Family Contribution

Step 1: Find your Salary Range; go to ***Step 2***

[This is your Year 4 contribution percentage]

Step 2: Identify the below contribution amount in your Salary Range that matches your selected medical/prescription plan.

Go to *Step 3* to figure your approximate annual contribution amount per paycheck

Salary Range	Year 4	Horizon BCBSNJ POS 10	Horizon BCBSNJ POS 15/25	Horizon BCBSNJ POS 20/20	Horizon BCBSNJ POS 20/35	OMNIA
less than 25,000	**3.00%**	$1,597.90	$1,499.09	$1,427.29	$1,269.81	$1,388.18
25,000-29,999	**4.00%**	$2,130.53	$1,998.79	$1,903.05	$1,693.08	$1,850.91
30,000-34,999	**5.00%**	$2,663.16	$2,498.49	$2,378.81	$2,116.36	$2,313.64
35,000-39,999	**6.00%**	$3,195.79	$2,998.19	$2,854.58	$2,539.63	$2,776.36
40,000-44,999	**7.00%**	$3,728.42	$3,497.89	$3,330.34	$2,962.90	$3,239.09
45,000-49,999	**9.00%**	$4,793.69	$4,497.28	$4,281.87	$3,809.44	$4,164.54
50,000-54,999	**12.00%**	$6,391.58	$5,996.38	$5,709.15	$5,079.25	$5,552.73
55,000-59,999	**14.00%**	$7,456.85	$6,995.77	$6,660.68	$5,925.80	$6,478.18
60,000-64,999	**17.00%**	$9,054.74	$8,494.87	$8,087.97	$7,195.61	$7,866.36
65,000-69,999	**19.00%**	$10,120.01	$9,494.26	$9,039.49	$8,042.15	$8,791.82
70,000-74,999	**22.00%**	$11,717.90	$10,993.36	$10,466.78	$9,311.97	$10,180.00
75,000-79,999	**23.00%**	$12,250.54	$11,493.05	$10,942.54	$9,735.24	$10,642.73
80,000-84,999	**24.00%**	$12,783.17	$11,992.75	$11,418.31	$10,158.51	$11,105.45
85,000-89,999	**26.00%**	$13,848.43	$12,992.15	$12,369.83	$11,005.05	$12,030.91
90,000-94,999	**28.00%**	$14,913.70	$13,991.54	$13,321.36	$11,851.59	$12,956.36
95,000-99,999	**29.00%**	$15,446.33	$14,491.24	$13,797.12	$12,274.86	$13,419.09
100,000-109,999	**32.00%**	$17,044.22	$15,990.34	$15,224.41	$13,544.68	$14,807.27
110,000 and over	**35.00%**	$18,642.12	$17,489.43	$16,651.70	$14,814.49	$16,195.45
Monthly Family Premium (Med+RX)		$4,438.60	$4,164.15	$3,964.69	$3,527.26	$3,856.06

Step 3:

To calculate your approximate contribution amount per paycheck:

1) if you are a 10-month employee, divide the shown contribution amount matching your salary range by 20.

2) if you are a 12-month employee, divide the shown contribution amount matching your salary range by 24.

[Note: Employee must contribute 1.5% of salary or the above contribution amount, whichever is greater.]

NJ EDUCATORS HEALTH PLAN

		NJEHP
IN-NETWORK	NETWORK: National network - NOT limited to NJ doctors and facilities	
	Deductible (Single/Family)	None
	In-Network Coinsurance	10%
	Primary Care Physician Copayment	$10
	Specialist Copayment	$15
	Emergency Room Copayment	$125
	Total In-Network Coinsurance and Copayment Out-of-Pocket Maximum (Single/Family)	$500/$1,000
	Inpatient Hospitalization	No charge
OUT-OF-NETWORK	Deductible (Single/Family)	$350/$700
	Out-of-Network Coinsurance	30%
	Total Out-of-Network, Out-of-Pocket Maximum (Single/Family)	$2,000/$5,000
	Inpatient Hospitalization	No charge
	Maximum Provider Reimbursement (Reasonable and Customary)	200% of Medicare*
PRESCRIPTION DRUG	Retail – Generic	$5
	Retail – Brand w/ No Generic Available	$10
	Retail – Brand w/ Generic Available	Member pays the difference**
	Mail – Generic	$10
	Mail – Brand w/ No Generic Available	$20
	Mail – Brand w/ Generic Equivalent	Member pays the difference**

* Chiropractic: $35/visit or 75% of the in-network cost per visit, whichever is less. Acupuncture $60/visit or 75% of the in-network cost per visit, whichever is less. Physical therapy: in-network cost per visit. Currently $52.

** For brand-name drugs with generic equivalents available, the plan will pay the cost of the generic equivalent. Members who choose to fill the prescription with the brand-name drug will be responsible for the difference in the cost of the prescription. A medical appeal process is available.

CONTRIBUTION SCHEDULE[1]

BASE SALARY OR PENSION[2] AMOUN ▮	LEVEL OF COVERAGE/PERCENTAGE OF SALARY			
	Single	Parent/child(ren)	Two Adults	Family
Up to - $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]	3.6%	4.4%	6.6%	7.2%

[1] This contribution cannot exceed the previous Ch. 78 contribution. In every case, the lower contribution applies.

[2] Only applicable to retirees required to contribute under Ch. 78. Retirees currently receiving or eligible to receive premium-free health benefits will continue to do so.

[3] For any employee earning a base salary above $125,000, the maximum contribution will be based on a salary of $125,000.

GARDEN STATE HEALTH PLAN

		GSP
IN-NETWORK	NETWORK: New Jersey network ONLY - limited to NJ doctors and facilities	
	Deductible (Single/Family)	None
	In-Network Coinsurance	10%
	Primary Care Physician Copayment	$10
	Specialist Copayment	$15
	Emergency Room Copayment	$125
	Total In-Network Coinsurance and Copayment Out-of-Pocket Maximum (Single/Family)	$500/$1,000
	Inpatient Hospitalization	No charge
OUT-OF-NETWORK	Deductible (Single/Family)	$350/$700
	Out-of-Network Coinsurance	30%
	Total Out-of-Network, Out-of-Pocket Maximum (Single/Family)	$2,000/$5,000
	Inpatient Hospitalization	No charge
	Maximum Provider Reimbursement (Reasonable and Customary)	200% of Medicare*
PRESCRIPTION DRUG	Retail – Generic	$5
	Retail – Brand w/ No Generic Available	$10
	Retail – Brand w/ Generic Available	Member pays the difference**
	Mail – Generic	$10
	Mail – Brand w/ No Generic Available	$20
	Mail – Brand w/ Generic Equivalent	Member pays the difference**

* Chiropractic: $35/visit or 75% of the in-network cost per visit, whichever is less. Acupuncture $60/visit or 75% of the in-network cost per visit, whichever is less. Physical therapy: in-network cost per visit. Currently $52.

** For brand-name drugs with generic equivalents available, the plan will pay the cost of the generic equivalent. Members who choose to fill the prescription with the brand-name drug will be responsible for the difference in the cost of the prescription. A medical appeal process is available.

CONTRIBUTION SCHEDULE

BASE SALARY	LEVEL OF COVERAGE/PERCENTAGE OF SALARY			
	Single	Parent/child(ren)	Two Adults	Family
Up to - $40,000	1.5%	1.5%	1.5%	1.65%
$40,001 - $50,000	1.5%	1.5%	1.65%	1.95%
$50,001 - $60,000	1.5%	1.5%	1.95%	2.2%
$60,001 - $70,000	1.5%	1.5%	2.2%	2.5%
$70,001 - $80,000	1.5%	1.65%	2.5%	2.75%
$80,001 - $90,000	1.5%	1.8%	2.75%	3.0%
$90,001 - $100,000	1.65%	1.95%	3.0%	3.3%
$100,001 - $125,000	1.8%	2.2%	3.3%	3.6%

1. This contribution cannot exceed the previous Ch. 78 contribution. In every case, the lower contribution applies.
2. For any employee earning a base salary above $125,000, the maximum contribution will be based on a salary of $125,000.

IF ENROLLING IN THE GARDEN STATE PLAN THE BELOW MUST BE SIGNED AND RETURNED

Garden State Plan

In the Garden State Plan, providers outside of the State of New Jersey will not be covered; not for in-network or out-of-network claims. The only time an out of state provider/claim will be considered is if it is for an accidental emergency or medical emergency.

- An Accidental Emergency is **a traumatic** bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a person's health or result in loss of life.
- A Medical Emergency is **a sudden** condition and, at the time, unexpected onset of a health condition that requires immediate medical treatment and could reasonably be expected to seriously jeopardize a person's health or result in loss of life.

The prescription plan is the same as the NJEHP prescription plan. It includes Mandatory Generic, Step Therapy and a Formulary that excludes certain medications both Brand Name and Generic.

I have read and understand the above and wish to enroll in the Garden State Plan:

_____

Print Name Sign Name Date

Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Fax (973) 274-2297
www.HorizonBlue.com

Group Information – to be completed by Employer.

Group Name: _____ Group Number: _____
Sub Group Number: _____
Date of Hire: _____/_____/_____ Effective Date/Date of Event: _____/_____/_____
Reason: _____

A. Type of Activity – to be completed by Employer.

Refer to instructions before completing this form. Print clearly.

☐ ADD ☐ REMOVE ☐ OTHER CHANGE	Effective Date/Date of Event	Reason for Change
☐ Subscriber	_____/_____/_____	_____
☐ Spouse	_____/_____/_____	_____
☐ Civil Union Partner (CUP)/Domestic Partner (DP)	_____/_____/_____	_____
☐ Dependent Child	_____/_____/_____	_____
☐ Over-Age Child as a Dependent Under 30 *(and complete Coverage Continuation and section B)*	_____/_____/_____	_____
☐ Name Change	_____/_____/_____	_____
☐ Change Plan	_____/_____/_____	_____
☐ Other	_____/_____/_____	_____
☐ Add/Change Office ID Numbers	_____/_____/_____	_____
☐ Primary Care Provider	_____/_____/_____	_____

COVERAGE CONTINUATION

☐ **For Employee**

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

☐ Total Disability* ☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29
**Attach proof of disability*

☐ **For Spouse/Civil Union Partner*/Domestic Partner**

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36
**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ **For Dependent or Over-aged Child**

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36
☐ Dependent Under 30 Billing: ☒ Home Home Address: _____

Date of Loss of Coverage _____/_____/_____ Qualifying Event #** _____ Date of Qualifying Event _____/_____/_____

Group # _____ Subgroup # _____ ***Qualifying event #s: see list in Instructions.*

B. Additional Information for Dependent Under 30 Continuation Elections.

Provide information below about children listed in Section F for whom a Dependent Under 30 continuation election is being made.

This Continuation Election is being made:

☐ During an Open Enrollment period for the Over-Age Child based on his/her age-out anniversary
☐ Within 30 days prior to the attainment of the limiting age (when the Dependent will become an Over-Age Child)
☐ Within 30 days after the Over-Age Child has established eligibility for a Chapter 375 Continuation Election

C. Employee Information – to be completed by Employee.

☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

If a name change, indicate prior name: _____

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____/_____/_____ Sex _____

Home Address _____ Apt. _____ City _____ State _____ Zip Code _____

Home Phone _____ E-Mail Address _____

Employer Name _____ Employment Date ____/____/____

Employer Address _____ City _____ State _____ Zip Code _____

Hours Worked Per Week _____ Work Phone _____ E-Mail Address _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

Submit a copy of the Certificate of Creditable Coverage

D. Race/Ethnicity – to be completed by the Employee, at his/her option.

NOTE: Your response is appreciated but NOT required! *Choose a category that most closely describes you:*

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin
☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

E. Plan Option – Your selection must be offered by your employer.

Medical ***Check One:***

S	F	2 Adults	PC
☐	☐	☐	☐

☐ NJEHP ☐ Garden State ☐ Direct Access _____

☐ Horizon Traditional
☐ Horizon HMO
☐ Horizon POS
☐ Horizon PPO
☐ Horizon PPO (HRA)
☐ Horizon PPO (HSA)
☐ Horizon Direct Access (HRA)
☐ Horizon Direct Access (HSA)
☐ Horizon EPO
☐ Horizon Dental Option Plan
☐ Horizon Dental PPO Plan
☐ Horizon Dental Access PPO Plan

Prescription ***Check One:***

S	F	2 Adults	PC
☐	☐	☐	☐

S = Single; F = Family; 2 Adults = Husband/Wife, Civil Union Partners or Domestic Partners; P/C = Parent/Child(ren)

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

F. Other Individuals Covered – to be completed by Employee.

Identify individuals other than yourself for whom you are adding/changing/removing/ continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof if full-time post-secondary student. Attach proof of disability.

SPOUSE/CUP/DP ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUE SPOUSE (COBRA/NJSGC)** ☐ **CONTINUE CU PARTNER (NJSGC)** ☐ **CONTINUE DP (COBRA/NJSGC)**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

Employed? ☐ Yes ☐ No *If Yes, Complete Section G1*

Home or billing address same as Employee? ☐ Yes ☐ No *If No, Complete Section G2*

Submit a copy of the Certificate of Creditable Coverage

1. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section H*

Submit a copy of the Certificate of Creditable Coverage

2. Child ☐ **ADD** ☐ **REMOVE** ☐ **CONTINUATION** ☐ **OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security# _____ Date of Birth _____/_____/_____ Sex _____

Primary Care Provider Name _____ Current Patient ☐ Yes ☐ No

NPI # _____ Loc Code _____

Other Health Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Previous Coverage ☐ Yes ☐ No, If Yes, Payer Name _____

Policy # _____ Effective Date ____/____/____ Termination Date ____/____/____

If last name is different from Employee's, please explain: _____

Living with Employee? ☐ Yes ☐ No *If No, Complete Section H*

Submit a copy of the Certificate of Creditable Coverage

G. Additional Spouse/CUP/DP Information – to be completed by Employee.

If not applicable mark as N/A.

1. Employer Name _____ Employer Phone _____

Employer Address _____

City _____ State _____ Zip Code _____

2a. Home Address _____

City _____ State _____ Zip Code _____

2b. Please explain why the address is different: _____

H. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section F, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Reason: _____

I. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: ___/___/___

J. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 30 Continuation Election is true and complete.

I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make premium payments required from me for the Dependent Under 30 Continuation Election.

Signature: _____ Date: ___/___/___

K. Employer Verification

The requested activity is believed eligible and is approved by the Employer: ☐ Yes ☐ No

Employer Representative: _____ Date: ___/__/___

Representative's Title: _____

Bridgewater-Raritan Board of Education
Group # 07668
Delta Dental PPO Plus Premier™/Advantage Program

Preventive & Diagnostic	100%
* Exams, Cleanings & Bitewing X-rays (each subject to frequency limitations)	
* Fluoride Treatment (subject to frequency limitations, children to age 19)	
Remaining Basic	70%
* Fillings, Extractions	
* Endodontics (root canal)	
* Periodontics, Oral Surgery	
* Sealants	
Crowns	70%
* Crowns, Gold Restorations (over natural teeth)	
Prosthodontics	50%
* Bridgework	
* Full & Partial Dentures	
Calendar Year Maximum (per patient)	$2,000
Orthodontic Benefits (Dependent children only)	50%
* Lifetime Maximum (per patient)	$1,500

Over 300,000 participating dental offices nationwide participate with the national Delta Dental system, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member. **Maximum benefit may be derived by utilizing the services of a participating dentist.**

Where the eligible patient is treated by a Delta Dental PPO dentist, the fee for the covered service(s) will not exceed the Delta Dental PPO maximum allowable charge(s). Where the eligible patient is treated by a Delta Dental Premier® dentist who does not participate in Delta Dental PPO or by a *Participating Specialist*, the dentist has agreed not to charge eligible patients more than the dentist's filed fee or Delta Dental's established maximum plan allowance, and Delta Dental will pay such dentists based on the least of the actual fee, the filed fee, or Delta Dental's established maximum plan allowance for the procedure(s). Claims for services provided by dentists who are neither Delta Dental Premier, Delta Dental PPO dentists, or *Participating Specialists* are paid based on the lesser of the dentist's actual charge or the prevailing fee.

Advantage Program is based upon a sub-network of over 8,000 dental offices in New Jersey ***only***, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member.

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

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Member ID number.

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

DENTAL ENROLLMENT FORM

Eight Digit Group Number

Name of Employer	Effective Date of Coverage	☐ Delta Dental Premier®/Advantage Program/Delta PPO 07668 - _____
Bridgewater-Raritan Regional Board of Education		

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last) (First) (Middle)	Date of Birth	Social Security Number
	____/____/____	___-___-____

Street Address	City, State, Zip	County

Date of Employment	Type of Coverage	Marital Status	Home Telephone
____/____/____	☐ Single ☐ Parent/Child ☐ Husband/Wife ☐ Parent/Children ☐ Family	☐Single ☐Married ☐Divorced/Separated	( )

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		___-___-___	/ /	
Spouse*		___-___-___	/ /	
Dependent		___-___-___	/ /	☐ Yes ☐ No
Dependent		___-___-___	/ /	☐Yes ☐No
Dependent		___-___-___	/ /	☐Yes ☐No
Dependent		___-___-___	/ /	☐Yes ☐No

* If spouse has other dental coverage, please list name and address of employer and other carrier:

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

_____ _____
Subscriber Signature Date

Delta Use Only

_____
Entered

_____
Operator #

Know Your Benefits

2026 Open Enrollment Tips

Making wise decisions about your benefits requires planning. By selecting benefits that provide the best care and coverage, you can optimize their value and minimize the impact to your budget.

Many people get tripped up when asked to select benefits for themselves and their families because these decisions can be complicated, and it is often easier to elect the same coverage that you had during the previous plan year. However, last year's coverage may not suit you again, and there may be other plans that better meet your needs. Follow these tips to make the best benefit decisions for you and your family.

- **Assess** your health and the health of your family members before making any selections. For instance, plans with higher monthly contributions and lower copays and deductibles are best for those who will use a lot of health care services over the course of the year. Yet, healthy individuals and families may save a great deal by selecting a plan with low contributions and a high deductible.
- **Know** your options. Health care needs change over time, so don't be afraid to review a plan that might be different from the plan you chose last year. Review all plan materials that explain your benefit offerings. These are helpful for learning the ins and outs of your plan options.
- **Verify** that your doctor and hospital of choice are part of the network of health care providers that are covered before selecting / moving to a new a plan. If they are not included, you will pay significantly more for their services.
- **Participate** in wellness and disease management programs to not only become healthier, but also to enjoy potential discounts on health-related products and services.
- **Watch** for open enrollment announcements for tax-free benefits such as flexible spending accounts (FSAs). These savings vehicles can provide tremendous tax advantages, as contributions are made with before-tax income. Reimbursements from these accounts are also tax-free. They can be used to pay for prescriptions, deductibles, and health-related costs that are not covered by your insurance (braces, eyewear, etc.).

The best rule of thumb is to make a list of your benefit priorities to determine which plan will serve you best. Then, let the selection process begin.

Provided by Integrity Consulting Group
104 Interchange Plaza, Suite 202, Monroe Township, NJ 08831
Toll-Free: 888 737 4313
Fax: 609 737 4314
Email: customerservice@integritycg.com

INTEGRITY CONSULTING GROUP
Employee Benefits Specialists