Benefit Overview

December 1, 2016 - November 30, 2017

Our company offers a variety of benefits in addition to regular compensation. This is called your **total compensation package.** The benefit program is provided to enhance your personal and professional life. You are encouraged to review and understand the options that are available to you. Human Resources will assist you in understanding these programs.

For new employees: Coverage for medical benefits becomes effective the first day of the month following 30 days of employment (Example: If your start date is March 9, your coverage becomes effective on May 1). Certain benefits also have specific eligibility conditions or waiting periods, which you need to satisfy in order to be enrolled or to receive that individual benefit. This information for other benefits can be found in your handbook or throughout this overview.

Please keep in mind that unless otherwise stated in the Employee Handbook, insurance benefits and other benefits offered by our company are extended only to regular full-time (minimum of 30 hours/week) employees who are actively employed. Your continuous service with our company is important for establishing eligibility for benefits and other privileges of employment. Your continuous service date will be the length of time you have continuously been employed by our company. If your employment is terminated for any reason, this will break your service.

The Internal Revenue Service *(IRS)* states that the eligible employees may only make elections to the plan at time of hire and once a year at open enrollment. Your benefit choices are binding through November 30, 2017. The following circumstances are the ONLY reasons you may change your benefits during the year:

Marriage	*Death of a Spouse*
Divorce	*Death of a Dependent*
Birth & Adoption	*Loss of Dependent Status*
Loss of Spouse's job where coverage is maintained through a spouse's plan *Marketplace Annual/Special Enrollment*	

These special circumstances, often referred to as life event changes, will allow you to make plan changes at any time during the year in which they occur. For any allowable changes, you must inform the Employee Benefits Center within 30 days of the event to avoid lapse in coverage. All other changes are deferred to open enrollment.

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Human Resources Contact Information
JoAnn Musser
(877) 856-6267, Ext. 261

Medical Coverage—Highmark

For the 2016-2017 plan year, we offer medical coverage through Highmark. You have the option to choose between two Highmark PPO Blue plans. The Highmark PPO Blue plans provide you with enhanced benefits and services at a reasonable cost. The Highmark PPO Blue is a Preferred Provider Organization (PPO) plan. The Highmark PPO Blue plan provides you with direct access to in- and out-of-network providers without a referral, and you do not need to choose a Primary Care Physician (PCP). However, if you choose to see a non-network provider, your out-of-pocket cost will be higher. You also have the option to use hospitals and visit specialists outside of the network but you will receive a lower level of benefits for most services and you may be responsible for paying any differences between the program's payments and the provider's actual charges.

Medical Benefits Description

	12/1/2016 Highmark Blue Shield	12/1/2016 Highmark Blue Shield
In-Network	**PPO Blue Healthy Savings $2,000Q RX D**	**PPO Blue Sharing $1,500 RX A**
Selection of PCP Required?	No	No
Referrals Required?	No	No
Deductible	$2,000 / $4,000	$1,500 / $3,000
Annual Out-of-Pocket Maximum	$2,000 / $4,000	$6,850 / $13,700
Preventive Care Services	Covered 100% (DEDUCTIBLE WAIVED)	Covered 100% (DEDUCTIBLE WAIVED)
Mammograms - Annual Routine Medically Necessary	100% (DEDUCTIBLE WAIVED) 100% (AFTER DEDUCTIBLE)	100% (DEDUCTIBLE WAIVED)
Primary Care Copay	$0 Copay (AFTER DEDUCTIBLE)	$10 Copay (DEDUCTIBLE WAIVED)
Specialty Copay	$0 Copay (AFTER DEDUCTIBLE)	$25 Copay (DEDUCTIBLE WAIVED)
Lab/Pathology	Covered 100% (AFTER DEDUCTIBLE)	Covered 100% (AFTER DEDUCTIBLE)
Routine Radiology	Covered 100% (AFTER DEDUCTIBLE)	Covered 100% (AFTER DEDUCTIBLE)
MRI/MRA, CT & PET Scans	Covered 100% (AFTER DEDUCTIBLE)	Covered 100% (AFTER DEDUCTIBLE)
ER Copay	$0 Copay (AFTER DEDUCTIBLE)	$100 Copay (DEDUCTIBLE WAIVED) (COPAY WAIVED IF ADMITTED)
Urgent Care	$0 Copay (AFTER DEDUCTIBLE)	$50 Copay (DEDUCTIBLE WAIVED)
Inpatient Hospital	Covered 100% (AFTER DEDUCTIBLE)	Covered 100% (AFTER DEDUCTIBLE)
Outpatient Surgery	Covered 100% (AFTER DEDUCTIBLE)	Covered 100% (AFTER DEDUCTIBLE)
Durable Medical Equipment	Covered 100% (AFTER DEDUCTIBLE)	Covered 100% (AFTER DEDUCTIBLE)
Prescription Drug	$0 Copay (AFTER DEDUCTIBLE)	$8/$35/$50 w/orals (DEDUCTIBLE WAIVED)
Prescription Drug Mail-Order	$0 Copay/ 90 Day Supply (AFTER DEDUCTIBLE)	$20/$90/$125/ 90 Day Supply (DEDUCTIBLE WAIVED)
Out-of-Network		
Deductible	$4,000 / $8,000	$3,000 / $6,000
Co-insurance	Covered 80%	Covered 80%
Annual Out-of-Pocket Maximum	$5,500 / $11,000	$8,000 / $16,000
Lifetime Maximum	Unlimited	Unlimited

This spreadsheet is for highlight purposes only. See certificate of coverage for details and limitations.

Medical Plan Contributions

PAYROLL DEDUCTIONS PER PAY PERIOD		
	PPO Healthy Savings $2,000Q RX D	**PPO Blue Sharing $1,500 RX A**
Employee	$39.00	$44.00
Employee/Spouse	$243.00	$301.00
Employee/Child(ren)	$224.00	$278.00
Family	$320.00	$395.00

Highmark Website

To help you locate a provider before you enroll, go to www.highmarkblueshield.com and click on "Find a doctor, hospital or other medical provider." When selecting your health plan, choose: "BCBS PPO." Enter the zip code and type of doctor you are looking for and click on "Search Now." You can also do advance searches by following the instructions on the site.

Once you become a member, you can create a login and have access to view your benefit information, as well as request replacement identification cards. You can also view and track your health care costs/claims.

Dependent Eligibility

You may enroll your eligible dependents when you enroll yourself. Dependents who are eligible for benefit coverage include:

- Your legally married spouse
- Your dependent child(ren)
    - ♦ Your natural born child(ren), legally adopted child(ren), stepchild(ren) or court-ordered dependent child(ren) for whom you are the court-appointed legal guardian.
    - ♦ Your dependent child(ren) up to age 26, whether they are a full-time student or not, are covered for medical, voluntary dental and voluntary vision. Coverage ends at the end of the month following the date they turn 26.
    - ♦ For Voluntary Life dependent child(ren) are covered to age 19 (23 if a full-time student). Coverage ends on the earlier of the date your dependent reaches the maximum age or ceases to be a full-time student.
    - ♦ Your continuously disabled dependent child(ren) [if disabled prior to age 26] who are incapable of self-sustaining employment and dependent upon your for support, regardless of age.

Cutting Health Care Costs

Ask Your Doctor Questions

Amazingly, many patients do not ask their doctor basic questions. “How much will my treatment cost?” “Can I be treated another way that is equally effective but less costly?” “What are the risks?” “What are the side effects?”

Patients often blindly accept their doctors’ advice without truly understanding what treatment alternatives are available, and what – if any – differences there are in cost and effectiveness among those alternatives. Many health plans still allow for great freedom in your choice of physicians. If you have such a plan, your doctor has little incentive to find the perfect balance between treatment effectiveness and cost effectiveness. That is, unless you ask.

Carefully check all medical bills

Insurance companies and hospitals are not exempt from making billing errors. Insurers often miscalculate the family deductible, so keep a careful tally of individual as well as total family payments to be sure you don’t pay too much. If you have a hospital stay, try to keep a log of all the services, medications and supplies you are given, so when you get a bill you can be sure you are not charged for procedures you didn’t have or items you didn’t use. Ask for an itemized bill.

Compare Prices

Shop around for the pharmacy that offers the best value for your needs. You may even need to get different medications from different pharmacies depending on which offers a better price.

Don’t skimp on preventive care

Be sure you and your dependents get routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, all individuals should get preventive screenings recommended for their age to detect health conditions early.

Prescription Drugs

When you enroll in a Berks Homes/Firefly Homes’ medical plan, you automatically receive prescription drug coverage through the Highmark Blue Shield Pharmacy Management Formulary Program. The Pharmacy Management Formulary Program provides a defined list of FDA-approved medications chosen for their medical effectiveness and value. The formulary list includes both generic and brand-name drugs. Your share of the cost will always be less for drugs that are on the formulary list; however, coverage is available for many non-formulary drugs.

PPO $1500 Plan:

There is a $8 co-pay for all generic formulary drugs, a $35 co-pay for brand formulary drugs and a $50 co-pay for non-formulary drugs, depending on the amount of drugs dispensed.

Healthy Savings $2000Q

Plan pays 100% after deductible is met.

Save Money - Use Mail Order!

The prescription plan also includes a Mail Order program, which allows you to purchase a 90-day supply of medications you take on an ongoing basis (known as maintenance drugs). When you order prescriptions through the mail, you pay two co-pays, rather than three, for a 90-day supply. To access the mail order program, call the customer service number on your Highmark Blue Shield card or access the Highmark Blue Shield web site at www.highmarkblueshield.com.

Voluntary Dental

Good dental health is important to your overall well being. At the same time, we all need different levels of dental treatment. Principal Financial Group provides affordable coverage based on the type of services obtained – **Preventive, Basic & Major** – whether or not you receive services from a network or non-network provider. Additionally, effective December 1, 2016, **Child Orthodontia** benefits will be included under the plan.

Under this voluntary dental plan, you seek covered services from any dentist. However, If an out-of-network dentist is used, your benefit is based upon Principal's Reasonable and Customary charge. Employees who use dentists or dental specialists that are part of the Principal Plan Dental Network *(participating Dental Provider)* will reduce or eliminate out-of-pocket expenses. Dependent children are covered up to age 26.

A complete provider directory can be accessed online at www.principal/dentist.com.

Principal PPO Plan Dental Benefits Description	*In-Network*	*Out-of-Network*
Deductible Individual Family	$50 $150	
Class I - Diagnostic/Preventive Services Oral Exams, X-Rays, Fluoride Treatments, Teeth Cleaning,	100%	100%
Class II - Basic Services Fillings, Endodontics - Root Canal, Periodontal Maintenance , Oral Surgery, General Anesthesia, Pulp Capping , Dentures	80%	80%
Class III - Major Services Implants	50%	50%
Orthodontic Services (dependent child age 19 and under)	50%	50%
Lifetime Orthodontic Maximum	$1500	
Annual Maximum per person	$1,000 per covered person	$1,000 per covered person

Bi-Weekly Rates	
EE	$11.90
EE & Spouse	$24.03
EE & Child(ren)	$34.78
EE & Family	$49.64

Voluntary Vision

Our Voluntary Vision Service Plan (VSP) allows participants to get an eye examination and lenses (or contact lenses in lieu of lenses and frames) every 12 months. Frames or contact lenses are available to members every 24 months.

Participants have the option of receiving care from an in-network or out-of-network provider; however, if you use an out-of-network provider, you will incur higher out-of-pocket expenses. Dependent children are covered up to age 26. A provider directory can be accessed at www.vsp.com.

VSP Choice Plan Benefits Description	In-Network	Out-of-Network
Examinations (once every 12 months)	$10 Copay	Up to $45
Material Copay (Includes Lens and Frames)	$10 Copay	N/A
Lenses *(once every 12 months)*	$10 Copay; $130 Allowance	$30 - $100
Frames (once every 24 months)	$130 Allowance	Up to $70
Contact Lenses (once every 12 months)	$10 Copay; $130 Allowance	In lieu of Frames Up to $105 if elective $210 if necessary

Bi-Weekly Rates	
EE	$3.22
EE & Plus 1	$5.16
EE & Child(ren)	$5.26
EE & Family	$8.48

Health Savings Account (HSA)

If you are enrolled in the Highmark HSA High Deductible option (which is the Health Savings $2,000Q plan), you may open an HSA as a tax-exempt savings vehicle set up with a qualified institution. Our company will only direct deposit your contributions to the preferred HSA Bank, Healthcare Bank. Money in your HSA is yours to keep even if you change plans or jobs. HSAs give you a tax-favored way to fund your own health care expenses. Unused HSA dollars can be rolled over to the next year for future qualified medical expenses.

Under this plan, you may contribute up to $3,400 in 2017 if you elect single coverage or up to $6,750 if you elect any level of employee and dependent or family coverage. Additionally, if you are 55 or older in 2017 you may also contribute an additional $1,000 into your HSA. These contributions are 100% tax deductible from gross income.

While the medical benefits plan year is 12/1/16 to 11/30/17, the HSA plan year is driven by the IRS and remains 1/1/17 to 12/31/17.

Note: Participants who are age 65 and older and enrolled in Medicare are not eligible to contribute to an HSA under federal tax rules.

Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) is an easy and convenient way to get more out of your paycheck. It allows you to set aside a predetermined amount of your pre-tax dollars to cover certain out-of-pocket expenses as they occur throughout the plan year. Two types of accounts are available—Health Care Spending Account and Dependent Care Spending Account.

FSA Plan Year is December 1, 2016 - November 30, 2017.

Health Care Flexible Spending Account:

A Health Care FSA can reimburse you for eligible medical dental and vision expenses, up to the amount you contribute for the plan year. Your Health Care Spending Account lets you pay for medical, dental and vision care expenses not covered by your insurance plan with pre-tax dollars. You can contribute up to $2,550 annually to the Health Care FSA. Some eligible Health Care FSA expenses include:

- Medical deductibles, copays and coinsurance
- Prescription Drug copays and prescribed over-the-counter medications
- Dental copays and coinsurance, amounts that exceed the annual allowed amount, and orthodontia treatments that are not strictly cosmetic
- Eyeglasses, laser surgery, prescription sunglasses, and contact lenses

Dependent Care Flexible Spending Account:

The Dependent Care FSA lets you use pretax dollars toward qualified dependent care. You can contribute up to $5,000 ($2,500 if married and file individual tax return) for the Dependent Care FSA for children under age 13 and for disabled adults in your care.

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

FSA FAQs

What expenses are eligible through flexible spending accounts?

- Medical and dental deductibles and co-payments (the portion you are responsible for)
- Physical examinations, chiropractic expenses, orthodontics
- Vision expenses not fully paid by any vision plan
- Prescription drugs and insulin not paid by the medical plan

What are some examples of expenses that are not covered?

- Expenditures that are merely beneficial to the general health of the person
- Amounts compensated for by insurance, government agency or workers' compensation
- Cosmetic surgery, other than that needed to improve congenital abnormality, personal injury or disfiguring disease

What happens if I do not use all of the money that I set aside each plan year? You must use all of your money for the year or it will be forfeited to the company to offset administrative costs. Be conservative in your election.

As you think about your FSA for the coming year, be sure to carefully estimate your expenses and the amount you want to contribute to your account. As you do, remember that, as a result of national healthcare reform, you may no longer use the Health Care FSA to pay for certain over-the-counter drugs and medicines without a doctor's prescription or letter of medical necessity. You are still able to purchase many items, such as contact lens solution and bandages, without a prescription. Please keep this in mind when calculating your FSA elections. You must re-enroll in the FSA plan(s) annually per IRS requirements.

The goal in estimating carefully is to use whatever you set aside so you don't lose it. That's because the Internal Revenue Service (IRS) has a "use it or lose it" rule, which means if you don't spend everything in your FSA by the end of the plan year, you'll forfeit whatever funds remain. You have up to 3 1/2 months after the plan year ends to submit qualified expenses for reimbursement incurred during the prior year.

Additionally, you have 2 1/2 months grace period after the plan year ends to continue to incur claims for expenses.

Once I make an election, can I change that amount during the plan year? Not unless you have a change of status during the year and the change in status must be consistent with the change in election you wish to make. Examples of status changes include marriage, divorce, change in the number of dependents, change in employment, etc.

Do I have to submit receipts with my reimbursement request? Yes, you must submit a statement from the provider describing the medical expenses and a receipt or insurance company explanation of benefits. Cancelled checks or credit card/debit card receipts are not acceptable proof of service.

Profit Sharing Plan/401k

To provide employees with additional income for retirement, our company provides a Profit Sharing Plan. It is 100% fully paid by the company. In order to be eligible for the plan, employees must complete one (1) year of service and will then be automatically enrolled during the next enrollment period (January 1st or July 1st). Vesting begins on the employee's hire date; employees become fully vested upon the sixth year of employment (as long as employee works at least 1000 hours per year). The vesting schedule is as follows:

Years of Service	Percent Vested
<2	0%
2	20%
3	40%
4	60%
5	80%
6	100%

Annual contributions to this plan are discretionary and are determined based on the profitability of the company.

Our company offers employees an easy and convenient way to save for retirement by offering a 401k plan, in which employees may elect to have a portion of their compensation contributed to the plan on a pre-tax basis (not taxed until withdrawn from the plan unless rolled over). Employees are eligible to begin making contributions after the completion 30 days of service if you are at least age 21. **New for 2017!** Our company is pleased to match a portion of employees' contributions. Although the company has the discretion to change the matching formula from time to time, beginning in 2017 the matching formula will be **50% of the first 5% deferred, per bi-weekly pay.** You may elect to change your contribution rate as of each payroll period. The annual (Jan-Dec) statutory limit for the employee contributions in 2017 is $18,000, plus another $6,000 if you're at least age 50 (called "catch-up" contributions). The matching contribution follows the above noted vesting schedule.

Life and AD&D Insurance

All full-time employees are eligible for life insurance in the amount of $10,000* the first day of the month after thirty (30) days of service through The Standard. Employees should reference the LIFE INSURANCE booklet for complete policy details located on the Company Drive under Employee Information.

Disability

Our company provides disability coverage to all active full-time employees who are eligible for coverage after completing 60 days of full-time service. Payments will begin after a one-week waiting period (five business days) and will be paid bi-weekly. Employees must use PTO as the one-week waiting period.

Length of Employment	Coverage
60 days - 10 years	50% of gross base wages for a maximum of 1 year per period of disability and a maximum of 2 years over an employee's lifetime
10+ years	100% of gross base wages for a maximum of 6 months over an employee's lifetime and 50% of gross base wages for 2 one-year periods over an employee's lifetime

Voluntary Life

Eligible employees may buy additional Voluntary Basic Life Insurance through The Standard. More information can be found on the Benefit Summary and at www.standard.com

Voluntary Employee Life - 100% Employee Paid:
Employee Amount = Increments of $10,000 to Max of $300,000 (not to exceed 5x salary)

Age Reduction = 35% at age 65; 50% at 70; 65% at 75

Guarantee Issue (for newly eligible employees only) = $50,000

Waiver of Premium, Portability and Conversion Included

Voluntary Spouse Life - 100% Employee Paid:
Spouse Amount = Increments of $5,000 to Max of $150,000—Up to 50% of the Employee's approved and enrolled voluntary life

Guarantee Issue (for newly eligible employees only) = $20,000

Spouse Monthly Rate Based on Employee's Age

Voluntary Child Life - 100% Employee Paid:
Child Amount = Birth to 19 years (24 if a full-time student) - increments of $1,000 to Max of $10,000

Guarantee Issue = Full Benefit

Enrollment Worksheet Tips

- ☐ Review all of the Open Enrollment materials provided. You may view the presentation any time under Company Folders/Company/Employee Information/Benefits/**2016 2017 Open Enrollment Presentation or request a copy from Human Resources.**
- ☐ Complete the Employee Election Form.

  Please Note: If you are waiving medical coverage, you must provide proof of coverage elsewhere.
- ☐ The Standard Enrollment Form ***only*** if you are enrolling or waiving voluntary life plan for the first time. If enrolling, Medical History form is required.

During this time of year, it is also good to revisit your beneficiaries you've designated on your Life Insurance and 401k/Profit Sharing Plan. If you'd like to make changes, please reach out to Human Resources to request a Beneficiary Form.

Return all forms to Human Resources no later than Thursday, November 17th.

Other Important Dates to Remember:

- **New benefit plan deductions begin with the pay of 12/23/16.**
- **New FSA and HSA deductions begin with the pay of 12/23/16.**

Summary of PPO Blue Healthy Savings $2,000Q ASD Rx D *Benefits*

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Employee Only Plan Family Plan	 $2,000 $4,000	 $4,000 $8,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period) Employee Only Plan Family Plan	 None None	 $1,500 $3,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Employee Only Plan Family Plan	 $2,000 $4,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after deductible	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after deductible	80% after deductible
Specialist Office Visits	100% after deductible	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after deductible	80% after deductible
Telemedicine Services (3)	100% after network deductible	Not Covered
Preventive Care (4)		
Routine Adult		
Physical exams	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% after deductible	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after network deductible	
Ambulance - Emergency	100% after network deductible	
Ambulance – Non-Emergency	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	100% after deductible	80% after deductible
Speech & Occupational Therapy	100% after deductible	80% after deductible
	Limit: 20 visits per therapy/benefit period	

Benefit	Network	Out-of-Network
Spinal Manipulations	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible
Outpatient - Includes Virtual Behavioral Health Visits	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis (5)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 90 visits/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Limit: 100 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements (7)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	Combined with medical Combined with medical	
Prescription Drug Program (8) *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Open Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** Plan pays 100% after deductible **Maintenance Drugs through Mail Order (90-day Supply)** Plan pays 100% after deductible	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed $6,550 for individual and $13,100 for two or more persons. In addition, new regulations for 2016 do not allow a member within a family plan to exceed $6,850 in cost sharing. If you are enrolled as an individual, the deductible, out-of-pocket maximum and Total Maximum Out-of-Pocket (TMOOP) for the "Employee Only" plan apply. If you are enrolled in a "Family" plan, the entire family deductible must be satisfied before any claim reimbursement begins. In addition the entire family out-of-pocket maximum must be satisfied for additional claim reimbursement. Once the entire family TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the family, regardless of whether the individual deductible, individual out-of-pocket maximum and individual TMOOP have been satisfied.(NE)

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance Abuse benefit.

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.

(5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

(7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

(8) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.

HIGHMARK | PPO Blue

Summary of PPO Blue Sharing $1,500 ASD Rx A *Benefits*

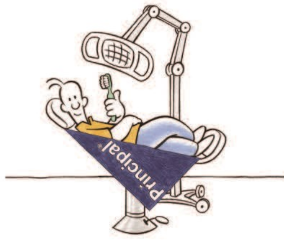
On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $1,500 $3,000	 $3,000 $6,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $5,000 $10,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only)(2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,850 $13,700	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $10 copayment	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $10 copayment	80% after deductible
Specialist Office & Virtual Visits	100% after $25 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $50 copayment	80% after deductible
Telemedicine Services (3)	100% after $5 copayment	Not Covered
Preventive Care(4)		
Routine Adult		
Physical exams	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copayment (waived if admitted)	
Ambulance - Emergency	100% after network deductible	
Ambulance – Non-Emergency	100% after deductible	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $25 copayment Limit: 20 visits/benefit period	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Speech & Occupational Therapy	100% after $25 copayment Limit: 20 visits per therapy/benefit period	80% after deductible
Spinal Manipulations	100% after $25 copayment Limit: 20 visits/benefit period	80% after deductible

Benefit	Network	Out-of-Network
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible
Outpatient - Includes Virtual Behavioral Health Visits	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(5)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diagnostic Services *Advanced Imaging* (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 90 visits/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment(6)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Limit: 100 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements(7)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 None None	
Prescription Drug Program(8) Soft Mandatory Generic *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** $8/$16/$24 generic copayment $35/$70/$105 formulary brand copayment $50/$100/$150 non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copayment $90 formulary brand copayment $125 non-formulary brand copayment	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed $6,850 for individual and $13,700 for two or more persons.
3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance Abuse benefit.
4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
8) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.



Policyholder: BERKS CONSTRUCTION CO

Voluntary Dental PPO Benefit Summary

Effective Date: 12/01/2016

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Principal Life Insurance Company. Principal Life will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	ALL MEMBERS

Benefits Payable				
Network	Dental Preferred Provider Organization (PPO)			
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 – Preventive	$0	$0	100%	100%
Unit 2 – Basic	$50	$50	80%	80%
Unit 3 – Major	$50	$50	50%	50%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined. Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are $1,000 per person. Non-network Calendar year maximums are $1,000 per person.			
Emergency Services	If a member requires treatment or service for an emergency dental condition and cannot reach a preferred dental provider without unreasonable delay, benefits for such treatment or service received from a non-preferred dental provider will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that identifies the situation as an emergency.			
Participating Provider Services	If a member requires treatment or service and cannot reasonably reach a preferred dental provider and the member receives such treatment or service from a non-preferred dental provider, benefits for such treatment or service received will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that informs Principal Life there was no participating provider reasonably available.			

Additional Benefits				
	Lifetime Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Unit 4 - Orthodontia • Child Lifetime Maximum: In-Network: $1,500 Non-Network: $1,500	$0	$0	50%	50%

How Are Dental Procedures Covered?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit	Procedures
Unit 1 – Preventive Procedures	• Routine exams - one per six months • Routine cleaning (prophylaxis) - one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Second Opinion Consultation • Fluoride – one treatment each calendar year (covered only for dependent children under age 14) • Sealants – on first and second permanent molars for dependent children under age 14; one each tooth each 36 months • X-rays - Bitewing (one set every calendar year), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral
Unit 2 – Basic Procedures	• Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; subject to Routine cleaning frequency limit (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Emergency exams – subject to Routine exam frequency limit • Space maintainers - covered only for dependent children under age 14; repairs not covered • Harmful Habit Appliance - covered only for dependent children under age 14 • Fillings and stainless steel crowns • Simple Oral Surgery • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Simple Endodontics (root canal therapy for anterior teeth)
Unit 3 – Major Procedures	• General Anesthesia (covered only for specific procedures)/IV Sedation • Complex Oral Surgical Procedures • Periodontal Surgical Procedures – one each quadrant each 36 months • Complex Endodontics (root canal therapy for molar teeth) • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 120 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup - each 120 months per tooth • Bridges - Initial placement / Replacement of bridges 120 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old
Unit 4 - Orthodontic Procedures	• X-rays and other diagnostic procedures, fixed and removable appliances

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Dental Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for dental coverage before it can be offered to your dependents. Eligible dependents include your spouse and children. Additional eligibility requirements may apply.

An annual enrollment applies. Members can enroll for dental coverage during the annual enrollment period and not be subject to the late entrant waiting period. Certain restrictions apply.

How Do I Find A Participating Provider?

Use the Provider Directory on www.principal.com to locate nearby dentists or see if your dentist participates in your network.

1	Visit www.principal.com/dentist.
2	Begin your search by picking the **state** where you would like to find a provider. Next, specify a **network**. Depending on the network chosen, you may be transferred to a partner site.
3	Enter the **name of the provider** you are looking for (if known). If you are looking for a nearby dentist, enter the **city and state and/or ZIP code**. Be sure to indicate **how far you are willing to travel**.
4	Select the **desired specialty** or use the No Specialty Preference default. Click **Continue**.
5	Select a **language** if your preference is other than English. Click **Continue**.

You may nominate your dentist for inclusion in our network. Please submit the dentist's name, address, phone and specialty by calling 1-800-832-4450, or submit through www.principal.com/refer-dental-provider.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Limitations & Exclusions	
Late Entrant Provision	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to policy guidelines.
Missing Tooth	Benefits for the initial placement of bridges, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Principal Life policy. When the policy replaces coverage under a prior plan, continuous coverage under the prior plan may be applied to the missing tooth provision requirement.
Orthodontia	If there is orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group coverage for ortho, there will be immediate coverage for treatment if proof is submitted that shows: 1) The lifetime maximum under any prior group coverage has not been exceeded, 2) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and 3) Ortho treatment has been continued while insured under this policy. Principal Life will credit payments made by the prior carrier toward the Principal Life lifetime ortho payment limit. You will not be covered if ortho treatment is in progress prior to the effective date with Principal Life and you are not covered under any prior group coverage for ortho.
Scheduled/MAC Design	Claim payments for both in-network and non-network services are based on the provider fee schedule amounts.
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

WE'LL GIVE YOU AN EDGE ®

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of dental coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

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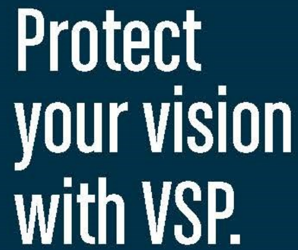

Get the best in eyecare and eyewear with Berks Homes and VSP® Vision Care.

Why enroll in VSP? We invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Register at vsp.com** Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.** To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

Enroll in VSP today.
You'll be glad you did.
Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

Berks Homes and VSP provide you with an affordable eyecare plan.

VSP Coverage Effective Date: 12/01/2016 **VSP Provider Network:** VSP Choice

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every 12 months
Prescription Glasses		$10	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
Your Bi-weekly Contribution	$3.22 Member only $5.16 Member + 1 $5.26 Member + children $8.48 Member + family		

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

Exam	up to $45	Lined Bifocal Lenses	up to $50	Progressive Lenses	up to $50
Frame	up to $70	Lined Trifocal Lenses	up to $65	Contacts	up to $105
Single Vision Lenses	up to $30				

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Contact us. **800.877.7195 | vsp.com**

[1]Brands/Promotion subject to change.

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Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by BERKS CONSTRUCTION COMPANY INC.

Eligibility

Definition of a Member	You are a member if you are an active L.L.C. Owner-employee or employee of BERKS CONSTRUCTION COMPANY INC and regularly working at least 30 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows or coincides with 30 consecutive days as a member.

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $10,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.
Age Reductions	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 65, to 50 percent at age 70 and to 35 percent at age 75.

Other Basic Life Features and Services

- Accelerated Benefit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag Benefit
- Coma Benefit
- Common Disaster Benefit
- Expanded AD&D Package
- Family Benefits Package
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by BERKS CONSTRUCTION COMPANY INC. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and BERKS CONSTRUCTION COMPANY INC may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279D-112431 (7/16)
4916245-44675

Standard Insurance Company
BERKS CONSTRUCTION COMPANY INC
Group Policy #112431

Group Additional Life Insurance

Help protect your loved ones from financial hardship.

This coverage is designed to help provide financial support and stability to your family should you pass away. You can also cover your eligible spouse and child(ren). Life insurance is an easy, responsible way to help protect your family from financial hardship during a difficult time — and into the future.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits if you become terminally ill or die

About This Coverage

If you take no action, you'll be covered under Basic Life insurance provided you meet the eligibility requirements. Consider whether that would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund your children's education. If not, you may want to apply for additional coverage now.

How Much Can I Apply For? The coverage amount for your spouse cannot exceed 100 percent of your combined Basic and Additional Life coverage. The coverage amount for your child(ren) cannot exceed 100 percent of your combined Basic and Additional Life coverage.	For You:	**$10,000 – $300,000** in increments of **$10,000**
	For Your Spouse:	**$5,000 – $150,000** in increments of **$5,000**
	For Your Child(ren):	**$1,000 – $10,000** in increments of **$1,000**
What is the Guarantee Issue Maximum? Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.	For You:	Up to **$50,000**
	For Your Spouse:	Up to **$20,000**

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Additional Feature

Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

How much Life insurance do you need?
After a death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Burial expenses
- Medical bills
- Your children's education
- Daily expenses

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/life/needs**.

How Much Your Coverage Costs

Your Basic Life insurance is paid for by BERKS CONSTRUCTION COMPANY INC. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

Use this formula to calculate your premium payment:

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your spouse's age and your spouse's rate.

If you buy Dependents Life coverage for your child(ren), your monthly rate is $0.20 per $1,000, no matter how many children you're covering.

Age (as of June 1)	Your Rate (Per $1,000 of Total Coverage)	Your Spouse's Rate (Per $1,000 of Total Coverage)
<35	$0.09	$0.09
35–39	$0.11	$0.11
40–44	$0.15	$0.15
45–49	$0.23	$0.23
50–54	$0.41	$0.41
55–59	$0.76	$0.76
60–64	$1.10	$1.10
65–69	$1.92	$1.92
70–74	$3.45	$3.45
75-79	$7.11	$7.11
80-84	$9.69	$9.69
85-89	$14.43	$14.43
90-94	$20.43	$20.43
95+	$23.25	$23.25

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Eligibility Requirements

To be eligible for basic and additional coverage, you must be:

- An active L.L.C. Owner-employee or employee of BERKS CONSTRUCTION COMPANY INC
- Regularly working at least 30 hours per week
- Insured for Basic Life insurance through The Standard to qualify for Additional Life insurance

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

If you buy Additional Life insurance for yourself, you may also buy additional coverage for your eligible children and/or spouse. This is called Dependents Life insurance. You can choose to cover your spouse, meaning a person to whom you are legally married. Child means your child from live birth through age 20 (through age 24 if a registered student in full-time attendance at an accredited educational institution). Your child cannot be insured by more than one employee. Your spouse or child(ren) must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

Medical Underwriting Approval

Required for:

- Coverage amounts higher than the guarantee issue maximum amount
- All late applications (applying 31 days after becoming eligible)
- Requests for coverage increases
- Reinstatements
- Eligible but not insured under the prior life insurance plan

Visit **www.standard.com/mhs** to submit a medical history statement online.

Coverage Effective Date

To become insured, you must

- Meet the eligibility requirements listed in the previous sections,
- Serve an eligibility waiting period*,
- Apply for coverage and agree to pay premium, and
- Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective.

If you are not actively at work on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee. Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your coverage.

*Defined as first of the month that follows or coincides with 30 consecutive days as a member

Life Insurance Age Reductions

Under this plan, your coverage amount reduces to 65 percent at age 65, to 50 percent at age 70 and to 35 percent at age 75. Your spouse's coverage amount reduces by your spouse's age as follows: to 65 percent at age 65, to 50 percent at age 70 and to 35 percent at age 75. If you or your spouse are age 65 or over, ask your human resources representative or plan administrator for the amount of coverage available.

Waiver of Premium

Your premiums may be waived if you:

- Become totally disabled while insured under this plan
- Are under age 60, and
- Complete a waiting period of 180 days

If these conditions are met, your Basic and Additional Life insurance coverage may continue without cost until age 65, provided you give us satisfactory proof that you remain totally disabled.

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage from The Standard.

Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

Exclusions

Subject to state variations, you and your dependents are not covered for death resulting from suicide or other intentionally self-inflicted injury, while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 12506D-AL-112431 (7/16)
4916245-44676

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy

In addition to the above requirements, your Dependents Life coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent.

For more details on when your insurance ends, contact your human resources representative or plan administrator.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP190-LIFE/S399, GP399-LIFE/TRUST, GP899-LIFE, GP190-LIFE/A997/S399, GP411-LIFE

Resource Directory

Plan	Phone Number	Additional Information
Highmark Blue Shield **PPO Blue Healthy Savings & PPO Blue Sharing** Medical & Rx Plan Telemedicine Services 24-Hour Access	Medical: (800) 877-7195 Rx: (800) 903-6228 (800) Teladoc (1-800-835-2362)	www.highmarkblueshield.com www.highmark.com/Teladoc
Principal Voluntary Dental	(800) 247-4695	www.principal.com
VSP Voluntary Vision	(800) 877-7195	www.vsp.com
The Standard Basic Life and AD&D Insurance Voluntary Life	(888) 937-4783	http://www.standard.com
CBIZ Flexible Spending Accounts & Health Savings Account	(800) 815-3023, Option 4.	www.myplans.cbiz.com
CBIZ COBRA	(800) 815-3023, Option 6	N/A

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent (s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself andor your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental coverage.

Women's Health and Cancer Rights Act Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call JoAnn Musser at 887-856-6267, Ext. 261.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers 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 vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the 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 insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

Important Notice from Berks Homes/Firefly Homes About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Berks Homes/Firefly Homes and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Berks Homes/Firefly Homes has determined that the prescription drug coverage offered by Highmark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Berks Homes/Firefly Homes coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Berks Homes/Firefly Homes coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Berks Homes/Firefly Homes and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Berks Homes/Firefly Homes changes. You also may request a copy of this notice at any time.

Important Notice from Berks Homes/Firefly Homes About Your Prescription Drug Coverage and Medicare (continued)

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
• Visit www.medicare.gov
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: November 10, 2016
Name of Entity/Sender: Berks Homes/Firefly Homes
Contact--Position/Office: JoAnn Musser/Human Resources
Address: 3335 Morgantown Road PO Box 7 Mohnton, PA 19540
Phone Number: 877-856-6267, Ext. 261

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

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 JoAnn Musser 877-856-6267 x261.

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.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Berks Homes/Firefly Homes		4. Employer Identification Number (EIN) 23-2022205
5. Employer address 3335 Morgantown Road PO Box 7		6. Employer phone number 877-856-6267 x261
7. City Mohnton	8. State PA	9. ZIP code 19540
10. Who can we contact about employee health coverage at this job? JoAnn Musser		
11. Phone number (if different from above)	12. Email address jmusser@berkshomes.com	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:
    Employees who work 30 or more hours/week
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    Spouse & Dependent Children/Stepchildren to Age 26
  - ☐ We do not offer coverage.

☑ If checked, 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 from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?____________________ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $______________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?____________
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $____________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	KENTUCKY – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ALASKA – Medicaid	**LOUISIANA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
ARKANSAS – Medicaid	**MAINE – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
COLORADO – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
FLORIDA – Medicaid	**MINNESOTA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739
GEORGIA – Medicaid	**MISSOURI – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
INDIANA – Medicaid	**MONTANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
IOWA – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Medicaid Website: http://www.coverva.org/ programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/ programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
OREGON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/ default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
RHODE ISLAND – Medicaid	**WYOMING – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
SOUTH CAROLINA – Medicaid	
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in the materials and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information.

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