BENEFITS PLAN OVERVIEW 2016-2017

WELCOME

It is time for Open Enrollment. The following pages offer a highlight of National Community Reinvestment Coalition (NCRC) 2016 benefit programs. We are excited to announce these programs which will continue to provide you and your family access to high-quality healthcare and an array of additional benefits. It is important that you take the time to review all of the plan options available to you. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet your and your family's needs throughout the year.

The benefit plans described in this brochure will be in place October 1, 2016 through September 30, 2017.

NCRC encourages you to take the time to read and understand the full array of benefits offered so that you may take full advantage of all of these programs.

Pre-Tax Benefit Contributions

Some benefit deductions may be made on a pre-tax basis. This means that you do not pay state, federal, and social security taxes on eligible premiums paid using a payroll deduction. Bottom-line, this means more money in your pocket. Your payroll deductions for medical, vision, dental, flexible spending accounts (FSA), parking, transit and 401(k) benefits will be made on a pre-tax basis where applicable. Please contact Human Resources if you do not wish to pay your premiums with pre-tax income.

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About this Guide

This guide describes the benefit plans available to you as an employee of National Community Reinvestment Coalition (NCRC). The details of these plans are contained in the official plan documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in your summary plan description (as described by the Employees Retirement Income Security Act).

If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the plan documents, the formal wording in the plan documents will govern.

Please note that the benefits described in this guide may be changed at any time and do not represent a contractual obligation.

Benefits 101

Before you begin, here are a few key items to understand to help you through the enrollment process. Once you elect your benefits, your elections remain in effect for the entire policy year (Oct 1 - Sept 30). You may only change coverage due to a qualified life event and must do so within 30 days of the event. We advise you to review all your benefits and make your selections wisely.

Initial Enrollment Eligibility/ Benefits Begin

You are eligible for the insurance benefits outlined in this guide if you are an active full-time and work at least 30 hours per week. Benefits will begin the first of the month following 30 days from your date of employment. You must apply for benefits within 30 days of your date of employment.

Benefits Termination

Your medical, dental and vision coverage ends on the last day of the month in which your employment terminates. Your life and disability coverage ends on your last day of employment. Please see HR about your options to convert your life insurance to an individual policy should termination occur.

Dependent Coverage

Your legal spouse and children are eligible dependents for medical, dental, vision and voluntary life insurance coverage. Your dependent's coverage will terminate at the end of the month following his or her 26th birthday.

Qualifying Events

You can make changes to your current coverage if you have a legally qualifying life event change. These events are:

- Marriage, divorce, legal separation or annulment
- Birth, adoption or placement for adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects benefits eligibility
- Significant change in your or your spouse's health coverage attributable to your spouse's employment
- Change in your child's eligibility for benefits
- Becoming eligible for Medicare or Medicaid during the year
- Receiving a Qualified Medical Child Support Order (QMCSO)

Depending on the type of change, you may need to provide proof of the change (for example, a marriage license or birth certificate). If you do not notify Human Resources within 30 days you will have to wait until the next annual open enrollment period to make benefit changes.

Medical & Rx Benefits

NCRC offers employees a choice of two medical plans through GBS utilizing the Cigna network. The medical options cover a broad range of healthcare services and supplies, including prescriptions, office visits and hospitalizations.

The Enhanced EPO Plan

The Enhanced EPO plan offers you access to a national network. You do need to select a primary care physician and you do not need referrals to see a specialists. Care received from non network providers will not be covered.

The PPO Plan

The PPO plan offers you access to a national network. You do not need to choose a primary care physician and you do not need referrals to see specialists. You can see non participating providers but you may incur higher out of network costs including charges over the "usual, reasonable and customary charges, know as UCR".

Below is a summary. If you want more detail about your coverage and costs, you can get the complete terms in the summary plan description at www.gbsio.net or by calling (800) 337-4973. Please refer to the summary below for specific details on each medical plan option.

Benefits Description	Enhanced EPO	PPO	
	In-Network	*In-Network*	*Out-Of-Network*
Deductible :October 1– September 30 Individual / Family	None	$300 / $600	$1,000 / $2,000
Out-Of-Pocket Maximum Individual / Family	$1,300 / $2,600	$2,300 / $4,600	$5,000 / $10,000
Preventive Office Visit	No Charge	No Charge	10% after Deductible
Primary Office Visit	$20 Copay	No Charge	10% after deductible then $50 copay
Specialist Services	$30 Copay	$30	10% after deductible then $50 copay
Urgent Care	$30 Copay	$50	10% after $50 copay
Emergency Room	$200 Copay	$200 copay	$200 copay
Inpatient Hospital Services	$300/visit	Deductible + $300 per visit	10% after deductible then $500 copay
Outpatient Surgery	$30 Copay	Deductible	10% after deductible then $50 copay
X-Ray and Lab & Pathology Services	$20 / $30	No Charge	10% after Deductible
Imaging Services MRI/MRA, CT, PET Scans	$30Copay	No Charge	10% after Deductible
Prescription Drug Out of Pocket Maximum (Individual / Family) Generic Brand Formulary Self Administered Injectables Mail Order (90 day Supply)	$5,300 /$10,600 $5 Copay $35 Copay $60 Copay 50% up to $100 2 X Retail Copay	$4,300 / $8,600 $5 Copay $35 Copay $60 Copay 50% up to $100 $2 X retail Copay	Not Covered

Note[i] *Single deductible and out-of-network maximum apply when an individual is enrolled without dependents. Family deductible and out-of-pocket maximum apply when an individual and one or more dependents are enrolled.*

Per Pay Check (Bi-Weekly)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Spouse + Child(ren)
EPO	$0	$322.71	$264.64	$388.18
PPO	$27.58	$464.35	$377.65	$559.74

Using the GBS Online Benefit Plan Manager Website

NCRC and Group Benefit Services (GBS) are pleased to provide the GBS Online Benefit Plan Manager website that includes an online inquiry system. GBS administers our Medical Claims beginning October 1, 2014.

You can access the GBS **Online Benefit Plan Manager** by typing in the address:
https://lin.g-b-s.com/ncrcwelcome.htm

Once you enter the Plan Manager site, you will be welcomed with a menu of options from which to choose; these options are:

- **Enrollment Inquiry *requires logon**
- **Claims Inquiry *requires logon**
- **Document Library *requires logon**
- **Provider Choice Rewards *requires logon**
- **Provider Directory**
- **Health & Wellness Center**
- **Contact Listing**
- **Request for Service**

Your username is your Member Id Number, with no hyphens. The first time you access the Online Benefits and Claims Inquiry option, you will need to enter your Member ID Number in the Username field. After pressing Login, you will be asked to verify a few pieces of your personal information. Complete the required fields and click Next. You will then need to create a unique password and hint for your online access. We suggest that you use the "Account Manager" feature to set up your email address once you have logged on in the event that you need the password hint emailed to you.

Benefits At A Glance

You can view your current benefit plans in which you and/or your dependents are enrolled by selecting the **Benefits at a Glance** folder on the left. The system lists any dependents (if applicable) covered in each plan.

Claims Inquiry

The **Claims Inquiry** link will take you to the Online Benefits & Claims Inquiry section that is specific to your personal information for the benefits you have through GBS, and you will need to log on with a Username and Password.

Document Library

The Document Library offers a wealth of information at your fingertips. It provides you an electronic copy of the most important information about your plans. You can find a copy of your Summary Plan Description, COBRA documentation, and much more. The Document Library also includes many standard forms (claim forms, enrollment forms, etc.) that you can print and use for your convenience.

Provider Choice Rewards

Provider Choice Rewards helps you save money on healthcare services by selecting high value providers at the best price, quickly and easily!

Provider Directory

This link on the Online Benefit Plan Manager welcome screen provides you with a list of the Provider Directories associated with your health and prescription drug plan. This screen provides direct links to the Provider websites to allow you to search and find Preferred Plan Providers to ensure maximum benefit payments for these plans. Through the **Provider Directory** link, you can also find a link to Catamaran RX Prescriptions. You can view your prescription drug history and mail order status, learn more about your current and prospective medications, compare drugs, and even refill your Mail Order prescriptions online.

Health & Wellness Center

The **Health & Wellness Center** link on the Online Benefit Plan Manager welcome screen offers valuable health information to help you better manage your health and become an educated healthcare consumer. This feature provides you with direct website links to interesting sites such as MedScape, HealthierUS.gov, and various specialty Medical Associations.

Contact Listing

Through this link on the Online Benefit Plan Manager welcome screen, you can find answers to important questions via the GBS **Contact Listing**. This feature provides you with a list of important organization names, Member Service phone numbers, and their website address.

Request for Service

Through this link on the Online Benefit Plan Manager welcome screen, you can request an ID Card, request an address change, or request a customer service representative contact you. **For assistance with this website, please contact Group Benefit Services, Inc. at toll-free at 800.337.4973.**

Dental

Good dental health is important to your overall well being. NCRC offers dental coverage through United Concordia. The United Concordia PPO network has access to a national network of providers through Alliance. With this insurance, you can go to any dentist you choose, but you will save money when you use in-network dentists. In addition, network dentists will file claims for you. If you use an out-of-network dentist, the benefit is subject to reasonable and customary reimbursement. That means you may be balance billed additional charges.

Remember, you need to have 6 months in between dental exams and cleanings. If you are having extensive dental work done, we suggest you have your dentist requests a pre-treatment estimate. A rule of thumb is, requesting a pre-treatment estimate for charges over $300.

The dental Plan provides three main types of dental benefits:

- Preventive care (routine exams and cleanings, fluoride treatments, sealants, X-rays)
- Basic treatment (root canals, extractions, fillings, periodontics)
- Major treatment (bridges, crowns, dentures)

The table below provides a brief benefit description. To locate an in-network preferred provider near you, go to www.unitedconcordia.com and search the provider directory or call Humana's customer service at 800-332-0366

Dental Benefits Description	Concordia Preferred	
	In-Network	*Out-of-Network*
Deductible: October 1– September 30 Individual / Family	$50 / $150	$50 / $150
Preventive Services[1] Oral Exams, Full Mouth X-Rays, Fluoride Treatments, Sealants, Teeth Cleaning[1], Periodontal Maintenance	No Charge	No Charge
Basic Services Fillings, Endodontics-Root Canal, Periodontics, Oral Surgery, General Anesthesia, Pulp Capping	Deductible + 10%	Deductible + 20%
Major Services Inlays & Onlays, Crowns, Dentures, Bridges	Deductible + 40%	Deductible + 50%
Orthodontic Services	Not Covered	Not Covered
Annual Maximum	$1,500/*Per Member Per Year*	

Per Month Cost	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Spouse + Child(ren)
Concordia Preferred	$30.28	$61.43	$55.65	$93.14

UNITED CONCORDIA® DENTAL

Vision

NCRC offers Vision insurance through National Vision Administrators (NVA). Services include both in-network and out-of-network benefits. Annual vision benefits include one vision exam, frames and discounted lenses. To locate a participating provider visit www.e-nva.com or call 866-672-7723.

Vision Benefits Description	NVA	
	In-Network	*Reimbursement Amounts*
Examination Once every 12 months	Covered 100% after $10 copay	Up to $35
Lenses Once every 12 months	Standard Glass or Plastic Covered at 100%	Single Vision up to $25 Bifocal up to $45 Trifocal up to $75 Lenticular up to $75
Frame Once every 12 months	Covered up to $100 Retail Allowance (20% discount of remaining balance over $100 allowance)	Up to $45
Contact Lenses Once every 12 months (in Lieu of Lenses/Frames		
Elective	Covered to $100 Retail Allowance (15% discount (conventional) or 10% discount (disposable) off remaining balance over $100	Up to $100
Medically Necessary	Covered at 100%	$210
Evaluation & Fitting	Covered at 100% After $20 daily wear / $30 extended wear copay	Daily Wear: $20 Extended Wear: $30

Per Month Cost	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Spouse + Child(ren)
NVA Vision	$5.91	$11.49	$11.49	$16.99

Flexible Spending Accounts *(FSA)*

You have the opportunity to save money in taxes by participating in the health care and/or dependent care FSA. Keep in mind that you don't need to elect medical, dental and vision coverage in order to participate in the FSA.

New employees are eligible to participate the first of the month following date of employment. *Please refer to your benefits summary for more detailed information.*

How the Health Care FSA Works

You can set aside pre-tax dollars up to $2,550 in the health care FSA to pay for eligible expenses you incur during the plan year to include the following:

- Co-pays
- Out of pocket medical costs, such as deductibles and copayments
- Over the counter medications (prescription required)
- Prescription drug copayments
- Dental, vision and hearing care expenses

How the Dependent Care FSA Works

You can set aside pre-tax dollars up to $5,000 in the dependent care FSA to pay dependent day care expenses that allow your and/or your spouse to work, look for work or attend school full time. Eligible expenses include the following:

- Preschool or nursery school expenses
- Babysitter in your home
- Day care center
- Summer day camp
- After-school care
- Adult day care center or in-home care for an adult dependent

Care can be for your dependent children through age 12 and/or any dependent who is physically or mentally unable to care for himself or herself who spends at least eight hours a day in your home and whom you claim as a dependent on your federal income tax return.

It is important that you carefully estimate the expenses that you intend to pay from your FSA. If you do not use all of the money in your accounts by the end of the plan year, Federal law requires you to forfeit any unused balances. You may rollover up to $500. You have up to three months after the plan year ends to submit qualified expenses for reimbursement incurred during the prior year.

Employee account reports are available on-line: www.wealthcareadmin.com.

Using your HealthCare FSA Card

Per IRS regulations, your debit card is restricted for use at health care providers (merchants that have a merchant category code that indicates they are a health care provider). These merchants include hospitals, doctors, dentists, chiropractors, etc. You may also use your debit card at merchants that have an inventory information approval system such as pharmacies.

Transit and Parking

Transit and Parking reimbursement provides some relief from the burdens of transportation expenses experienced by employees, such as parking a vehicle in a parking facility, or transit passes for mass transportation. You have the opportunity to save money in taxes by participating in the transit and or parking benefit.

Maximum monthly contribution allowed for Parking is $255
Maximum monthly contribution allowed for Transit is $255

Disability Benefits

While you never expect to become hurt or sick and unable to work, it's good to be prepared in the event this happens even if only for a short time. NCRC provides Short-Term Disability (STD) and Long-Term Disability (LTD) insurance benefits to all eligible employees at no cost to you**.** Coverage is provided through The Hartford. Please note: some states such as CA, HI, NJ, NY, PR and RI require state-mandated STD benefits. This means the state plan will pay a portion of the benefit and The Hartford will pay the difference up to the benefit amount listed below. In some cases, you are responsible for paying the state mandated STD premium through payroll taxes.

Short-Term Disability (STD):

Your STD benefit equals 60% of your weekly base earnings to a maximum benefit of $500 per week. This benefit takes effect after a 14-day waiting period that begins at the start of an absence due to an accident or illness. The benefit duration is 11 weeks.

Please note: some states such as CA, HI, NJ, NY, PR and RI require state-mandated STD benefits. This means the state plan will pay a portion of the benefit and Mutual of Omaha will pay the difference up to the benefit amount listed below. In some cases, you are responsible for paying the state mandated STD premium through payroll taxes.

Long-Term Disability (LTD):

Your LTD benefit equals 60% of your monthly base earnings to a maximum benefit of $4,000 per month. This benefit takes effect when your STD coverage ends and continues for as long as you remain disabled or until you reach your Social Security normal retirement age.

Basic Life and Accidental Death & Dismemberment Insurance

Life insurance is an important part of your financial security, especially if others depend on you for support. Even if you are single, your beneficiary can use your life insurance to pay off your debts - like credit cards, mortgages and other final expenses. AD&D insurance is designed to provide a benefit in the event of an accidental death or dismemberment.

Basic Life and AD&D insurance is provided to you at no cost through The Hartford. NCRC provides you with a benefit of 2 times your basic annual earnings to a maximum of $200,000. Benefits will be reduced at 35% at ages 65, 70, 75 and by 25% at ages 80, 85, 90 and 95.

Employee Assistance Program

Sometimes balancing work and family creates stress that's hard to handle on your own. Through Ability Assist, you have the option of utilizing the EAP plan. This plan provides a CONFIDENTIAL service, free of charge to you and your family, designed to help with personal, financial, legal, and family and job concerns. You and your immediate household members have access to:

- Counseling and referral services on a wide range of personal and work-related issues
- On-line access to resources, referrals
- Telephonic counseling sessions
- 24-hour access to counselors over the telephone

Referral services available for child care and elder care facilities ach caller is connected to a BHS Care Coordinator, a Masters level clinician who will conduct a brief, professional assessment of the problem, connect the caller to a licensed BHS counselor in his/her local area for a face-to-face counseling, and guide the caller through the EAP process. As EAP services are designed for short-term problem resolution, counseling beyond the available 3 sessions is obtained through health insurance. For more information, call 800-964-3577 or visit the web site, www.guidanceresources.com. You will need create your own confidential user name and password. The Company/Organization field use **HLF902** and the Company Name Field type **ABILI**.

Travel Assistance Program

This plan is offered at no cost to you. The program ensures access to appropriate health care, and management of medical emergencies to employees and dependents traveling 100 or more miles from home, or in a foreign country. Should you become ill or have an accident, you can access care anywhere in the world. Services are provided by AXA Assistance USA.

A range of services to eligible members to help with issues related to: emergency medical assistance, pre-trip information, emergency personal services, and identity theft assistance. All it takes is one call to the toll free number of 800-243-6108 US (from outside US call collect: 202-828-5885) ID# GLD-09012

Medical Plan Definitions

Annual Out-of-Pocket Limit - Once this amount is satisfied, the plan will pay 100% of covered services up to the plan allowance.

Co-pay - The amount you pay at the time of service for each office visit or trip to the pharmacy.

Coinsurance - After you satisfy any applicable deductible, you share the cost of coverage (coinsurance) with the insurance company, until you reach your Annual Out-of-Pocket Limit.

Deductible - A fixed dollar amount during the benefit period that you must pay before the insurer begins to make payments for covered medical services.

High Deductible Health Plan - a health insurance policy that has a higher deductible and lower premium than traditional plans.

PCP (Primary Care Physician) - A health care professional who is responsible for monitoring and providing your overall health care needs.

In-Network - Typically refers to physicians, hospitals, or other health care providers who contract with an insurance plan to provide services to members. Coverage for services is typically greater when received from in-network providers.

Out-of-Network - Typically refers to physicians, hospitals or other health care providers who do not contract with the insurance plan to provide services to its members. Coverage for services is typically less than it would be for in-network providers, or not covered at all.

UCR (Usual, Customary & Reasonable) - When services are provided out of network, the amount payable to the provider by the insurance company is limited to the provider allowance amount, or the industry standard, for the charges in that providers given geographic region. Out-of-network providers may balance bill you for charges in excess of the allowable charges that are not payable by your insurance. To avoid this, consider using in-network providers.

COMPLIANCE NOTICES

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision 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 and/or 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/vision 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/vision coverage.

Non-Medical

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or CHIP.

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

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 your plan administrator at 202-464-2704.

Important Notice from NCRC 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 NCRC 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. NCRC has determined that the prescription drug coverage offered by Aetna 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 **NCRC** coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current **NCRC** coverage, be aware that you and your dependents may 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 **NCRC** 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 **NCRC** changes. You also may request a copy of this notice at any time.

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:	**October 1, 2016**
Name of Entity/Sender:	**National Community Reinvestment Coalition**
Contact--Position/Office:	**Frances Breedlove, Director Human Resources**
Address:	**727 15th Street, NW, Suite 900**
Phone Number:	**202-464-2704**

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO – Medicaid

Medicaid Website: https://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid

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

GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

INDIANA – Medicaid

Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/id
Click on Health Care, then Medical Assistance
Phone: 800-657-3629

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

Website: http://hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: http://www.health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2015, 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)

Contact Information

Benefit	Provider	Plan Number	Contact Info
Claims Customer Service	GBS	116	800-337-4973
Medical	GBS	116	(800) 337-4973 www.gbsio.net
Vision	National Vision Administrators (NVA)	8739000001	800-672-7723 www.e-nva.com
Dental	United Concordia	A05415000	(800) 332-0366 www.ucci.com
Disability	The Hartford	688450	800-538-8439 www.thehartford.com
Life/AD&D	The Hartford	688450	888-563-1124 www.thehartford.com
Flexible Spending Accounts	GBS	N/A	800-337-4973 www.wealthcareadmin.com
Employee Assistance Program	Ability Assist	Company/Organization: HLF902 Company Name Field: ABILI	800-964-3577 www.guidanceresources.com
Travel Assistance Program and ID Theft Protection	The Hartford	GLD-09012	800-243-6108, Collect from other locations: 202-828-5885 www.thehartford.com/employeebenefits
COBRA	GBS		800-9374973

HR Contact

NCRC
OPENING DOORS TO ECONOMIC OPPORTUNITY

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