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ENROLLMENT GUIDE

Benefits Enrollment Opportunities for Full Time and Part Time Employees

YOUR 2016-2017 BENEFITS GUIDE

Benefits that benefit you

● Medical/Prescription ● Dental ● Flex Accounts ● Voluntary

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About this Guide

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. If there is a conflict between the information in this guide and the formal language of the plan or the summary plan document (SPD), summary of benefits and coverage (SBC) or carrier plan documents, SBC, SPD and carrier plan documents will govern.

Please note benefits described in this guide may be modified or terminated at any time or for any reason by The Center. Employees are urged to consult tax advisors for any tax issues relating to the benefits described in these materials.

The intent of this booklet is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Page 22 for more details.

Enrollment Guidelines

Eligibility Guidelines for Coverage

Eligible Employees – The following are eligible for benefits:

- Employees scheduled as regular full-time (80 hours biweekly)
- Employees who are regular part-time (40 -79 hours biweekly)
- Employees who qualify for benefits under the Affordable Care Act by working an average of 30 hours or more per week during the past year

Eligible Dependents - Dependents eligible for medical/dental coverage are:

- The employee's spouse or qualified domestic partner may only enroll if they are not eligible for coverage through their own employer's plan. Any employee electing spouse or family coverage will be required to sign an affidavit stating there is no other employer coverage available.
- The employee's biological and or adopted children, stepchildren, or qualified children of a domestic partner through age 26 regardless of student status or financial dependency.

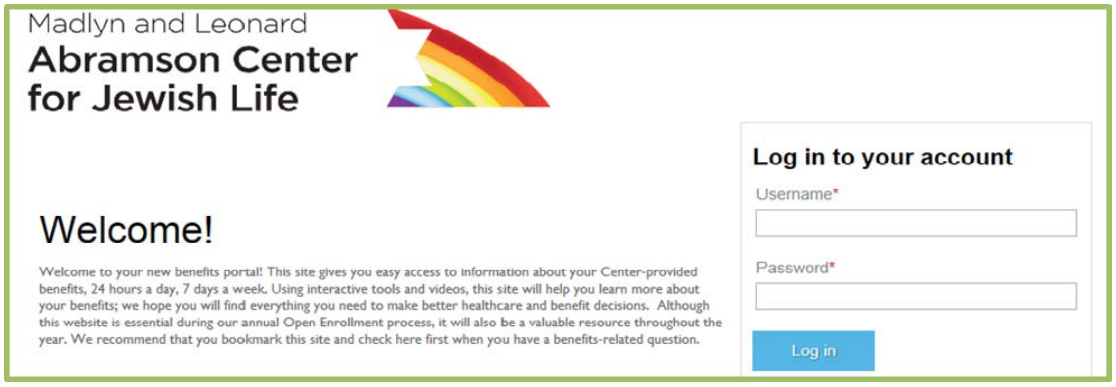
Points to Remember

- **Mid-year changes** – the IRS requires the elections you make during Open Enrollment to stay in effect for the entire year unless you experience an IRS-defined Life Event, such as marriage, birth, spouse's loss of other employer coverage, or dependent loss/gain of eligibility on another plan, etc. Changes have to be made within 30 days of the qualifying life event. After that time, the employee must wait until the next Open Enrollment.
- **Disabled child eligibility** - a fully disabled child may be eligible to continue coverage after reaching the plan age limit. You will be responsible for notifying Human Resources that a disabled child needs to remain on your benefits as a carrier form will need to be completed.
- **Newborn eligibility** – in most cases, a newborn is covered for the first 31 days, but in order to add the child to your benefits you must enroll the newborn within 31 days of the birth. After 31 days, you must wait until the next Open Enrollment.
- **Duty to notify of ineligibility –** the employee is responsible for notifying Human Resources in writing within 30 days of any change that affects the employee's dependent eligibility. A plan member ceases to be a covered dependent on the date the member no longer meets the definition of a dependent, regardless of when notice is given to Human Resources. Failure to provide timely notice can jeopardize COBRA benefits and result in additional costs to the employee.

How to Enroll

Employee Benefits Portal

Benefit enrollment is fast and easy through the Employee Benefits Portal website. It is truly as simple as point and click. Follow the steps below to make your benefit elections.



Prepare to Enroll

1. Go to the Employee Benefits Portal website at https://abramsoncenter.hrintouch.com.
2. Enter your Username.
   - Your user name is your full first name (up to 10 characters), the first initial of your last name, and the last four digits of your Social Security Number (SSN). Your initial password is your SSN without the dashes.
     - o Example: Christopher Smith, SSN 123-45-6789
       Login: ChristopheS6789 Password: 123456789
3. Click Log in.
   - When logging in for the first time you will need to:
     - o Select a new password
     - o Choose your Secret Question and type the answer in the box provided.
       - ➢ ***Please be sure to note your Username and Password for future use and then click Save.***
4. Click "Enroll Now!"
5. Make your Benefit Elections
6. Print your Confirmation Statement
   - Once you have completed your enrollment, a confirmation statement will appear. You should print or save a copy for your records.

Note: Once a benefit section is started, you must complete your selections for all plans contained within that section. If you are unable to finish, progress will not be saved. You may come back later, but will have to start from the beginning of the applicable section. When finished making all elections, print or save the confirmation page for your records.

When will Benefits Take Effect?

- For new employees, benefits will take effect on the first of the month following your date of hire.
- Life event changes take effect on the date of the event.

You only have 30 days from your eligibility date to make your elections - Don't miss your opportunity to enroll!!

Medical Plan Options for 2016-2017

Aetna Savings Plus

The two medical plan options offered through Aetna include an additional tier of in network benefits – Maximum Savings and Standard Savings.

- **Maximum Savings**
  - The following providers will fall within the Maximum Savings tier:
    - All primary care physicians (PCP) in the Philadelphia 5 county area and Southern NJ
    - Savings Plus designated specialists and facilities
    - All providers and hospitals in Delaware
  - The following services will always be paid at the Maximum Savings level when utilizing a participating Aetna provider within the Philadelphia 5 county area, Southern NJ, and Delaware.
    - Preventive care
    - Prescription drugs
    - Durable medical equipment
    - Physical & occupational therapy
    - Emergency room
    - Emergency ambulance
    - Outpatient lab/pathology
    - Mental health/Substance Abuse
    - Chiropractic Care
    - Transplants
- **Standard Savings**
  - The following providers will fall within the Standard Savings tier
    - Non-designated Savings Plus PA and NJ specialists, facilities, and hospitals
    - All Aetna providers outside the Philadelphia 5 county area, Southern New Jersey and Delaware
  - The following services will be paid at the Standard Savings level when utilizing an Aetna provider that is not designated as Maximum Savings:
    - All services not listed above
- **How to find a participating Aetna doctor or hospital:**
  - You can access Aetna's website to search for providers in the network by going to Doc Find at: www.aetna.com
  - "Select a Plan" – **Saving Plus of Southeast Pennsylvania Choice POSII or Saving Plus of Southeast Pennsylvania Aetna Select**
  - Best Results for Your Plan = Level 1 (Maximum Savings) - Savings Plus designated providers
  - All Other Results = Level 2 (Standard Savings) - Non-designated In-network providers

Aetna Choice Point of Service (POS) High Deductible Health Plan (HDHP)

This type of plan provides the greatest amount of freedom. You do not have to select a PCP (Primary Care Physician) or obtain referrals to visit a specialist. The plan is designed to lower your out-of-pocket costs when you see an in network provider for your care. You can see doctors who are not in-network, but your out-of-pocket costs will be higher.

Preventive care is covered at 100% if you see a provider who is in the Aetna network. You are required to meet the deductible before Aetna pays any benefits for all other medical services, including prescription drugs.

You will have access to a Health Reimbursement Arrangement (HRA) to help offset the In-Network deductible. The Center will contribute $1,000 for Single coverage and $2,000 for Family coverage to your HRA to help pay the first half of the In-Network Deductible.

How the HRA works

- Abramson Center owns the HRA; no payroll deductions can be contributed.
- Unused funds will not carry over into the next plan year.
- Tax-free benefit.

- When your HRA funds are exhausted, you will be responsible for paying 100% of the cost for in network medical and prescription expenses until you meet the full annual deductible. After that you are only responsible for prescription copays.

Receiving Reimbursement - Your debit card can be used to pay for eligible health care expenses. Using your debit card eliminates the need to pay cash up front and then wait for reimbursement. Listed below is how the reimbursement process works.

1. When you visit a provider, simply present your medical ID card. Typically you are not required to pay the provider at the time of service.
2. The provider will then submit a claim to Aetna for the service(s) you received.
3. Once Aetna processes the claim, they will send you an Explanation of Benefits (EOB) that lists the amount you need to pay the provider.
4. Around the same time, you should receive a bill from your provider. The dollar amount listed on the EOB and the provider's bill should match. If not, call the Benefit Hotline at 1-800-442-1413.
5. If the amounts match, you can pay the provider from your HRA fund. Simply write your HRA debit card number in the space provided on the invoice and return it to your provider.

Please Note: If your provider does not accept credit cards, you will need to submit the EOB to Eflex (TASC) for reimbursement. TASC will direct deposit the funds needed to pay your provider into your checking account (if you provide your routing information). You can then write a check for the outstanding balance.

Save All Receipts!
Each time you use your debit card [Exception – prescription at pharmacy], Eflex (TASC) will request an Explanation of Benefits (EOB) to substantiate the transaction. Do not ignore these requests or your debit card will be turned off.
If payment is required at the time of service, maintain all documentation and receipts in the event repayment is required because you paid the provider more than the Aetna discounted amount.

Aetna Select

This type of plan generally has lower costs to the member and a large network of providers. PCP (Primary Care Physician) selection is required for each family member. All services must be provided or referred by the PCP. Except for emergencies, there is no coverage for services without a PCP referral. There are no benefits with this plan for Out of Network services.

How to Find a Primary Care Physician

- Go to Aetna Doc Find at www.aetna.com or log into Aetna Navigator at www.aetna.com/navigator
- Search by Provider Name and/or zip code
- Select a Plan – Click on the **Saving Plus of Southeast Pennsylvania Aetna Select** listed under the "Savings Plus Plans" group

****It is important to note network providers, on rare occasions, may refer patients to a Standard Savings level or Out-of-Network provider. Such a referral does not mean the services will be paid at the preferred benefit level. It is always the patient's responsibility to verify the network status of a referral provider by using the Aetna website directory or by calling the number on the back of your member ID card. ****

Prescription

The prescription benefit is divided into three different tiers: Generic, Brand Formulary, and Non-Formulary Brand. Up to a 30 day supply may be obtained at a retail pharmacy. If you take maintenance medication, you may use the mail order program and obtain up to a 90 day supply for two times the retail copay.

Please Note: *if enrolled in the Choice POS HDHP, copays will not apply until the deductible is met. Before this occurs you are responsible for the full discounted amount of the prescription cost whether utilizing a retail pharmacy or mail order.*

Additional Information

- **Why register for Aetna Navigator?**

As a member you will have access to a personalized, secure website to help manage your health and benefits. The site allows you to:

- Access benefit information
- View processed claims and print Explanation of Benefits statements
- Find a doctor
- Download forms
- Print an ID Card

Register at www.aetna.com

- **Aetna Discount & Wellness Programs**

Your Aetna Medical Plans include Wellness Programs. Take advantage of everything your membership offers to reach and maintain your wellness goals. Aetna will provide you with motivation and discounts for healthy living. Save on what matters most to you! Aetna offers savings on:

- Acupuncture, chiropractic, and massage therapy
- Dental products
- Eye care products and services
- Gym memberships and home fitness and nutrition products
- Hearing aids and exams
- Over-the-counter vitamins and supplements
- Weight-loss programs
- And more!

For more information on these programs call the number on your member ID or log in to your Aetna Navigator member website.

- **Dependents Out of the Area**

Both Aetna medical plans utilize national networks. If you have dependents living outside your home (i.e. college student) he/she may still access care at one of the in network benefit levels as long as they use a participating provider.

- Aetna Select HMO
  - If the dependent resides outside of the Philadelphia 5 county area, Southern New Jersey, or Delaware, he/she must select a PCP in the Aetna Select network, but all care received will fall within the Standard Savings (Level 2) tier of benefits. They may change their PCP selection to a local provider if they return to your home and have access to the Maximum Savings (Level 1) tier until they leave. If a non-participating provider is used, there will be no coverage for services.

- Aetna Choice POS HDHP
  - The dependent may use any provider that participates in the Choice POS II network (whether they are home or away). Since this plan is open access, a PCP designation is not required. However, if they reside outside of the Philadelphia 5 county area, Southern New Jersey, or Delaware, all care received will fall within the Standard Savings (Level 2) tier of benefits. If the dependent returns home, they may access the Maximum Savings (Level 1) tier until they leave. If a non-participating provider is used, services will be processed as Out of Network (Level 3).

Aetna Medical ID Cards

- Medical ID cards will only be sent to new plan participants. Subsequent Aetna ID cards will be exclusively available online for participants requesting an extra card (whether for new or existing members). This includes instances of lost ID cards. Access is available via Aetna Navigator or the Aetna Mobile App. Once an Aetna member number is issued, it does NOT change when individuals change plans within the same employer.

Medical Plan Benefit Summary

Benefits	Aetna Choice POS HDHP			Aetna Select HMO	
	In-Network		Out Of Network [3]	In Network Only	
Network	Maximum Savings	Standard Savings		Maximum Savings	Standard Savings
Referral Required?	No	No	N/A	Yes	Yes
Benefit Period	Plan Year			Plan Year	
Deductible	$2,000 / $4,000[1, 2]	$3,000 / $6,000[1, 2]	$5,000 / $10,000[2]	None	$500/$1,000[2]
Coinsurance/ Copay Max	$5,600/$11,200[2]	$6,450/$12,900[2]	$10,000/$20,000[2]	$1,500/$3,000	$2,500/$5,000
PCP Visits	100% after ded.	20% after ded.	50% after ded.	$20 Copay	$30 Copay after ded.
Specialist OV	100% after ded.	20% after ded.	50% after ded.	$40 Copay	$50 Copay after ded.
OP Surgery	100% after ded.	20% after ded.	50% after ded.	$250 Copay	$250 Copay & 20% after ded.
Hospitalization	100% after ded.	20% after ded.	50% after ded.	$500 Copay/adm.	$500 Copay & 20% after ded.
Emergency Room	100% after Maximum Savings deductible			$200 Copay (waived if admitted)	
Outpatient Lab	100% after ded.	20% after ded.	50% after ded.	100%	20% after ded.
Routine X-Ray				$20 Copay	
Complex Radiology				$40 Copay	
Chiropractic	100% after ded. 20 visits/ year	20% after ded. 20 visits/ year	50% after ded.; 20 visits/ year	$40 copay 20 visits/year	$50 Copay after ded. 20 visits/year
Speech, Physical & Occupational Therapy	100% after ded. 30 visits/ year	80% after ded. 30 visits/ year	50% after ded.; 30 visits/ year	$40 Copay; 30 visits/year	$50 Copay after ded. 30 visits/year
Durable Medical Equip.	100% after ded.	20% after ded.	50% after ded.	100%	80% after ded.
Mental Health & Substance Abuse					
Inpatient	100% after ded.	20% after ded.	50% after ded.	$500 Copay/adm.	$500 Copay & 20% after ded.
Outpatient	100% after ded.	20% after ded.	50% after ded.	$40 Copay/visit	$50 Copay after ded.
Preventive Care:					
Routine Physical	100% no ded.[4]		50%; after ded.[4]	100% no ded.[4]	
Pap smear	100% no ded.[4]		50%; after ded.[4]	100% no ded.[4]	
Mammogram	100% no ded.[4]		50%; after ded.[4]	100% no ded.[4]	
Prescription:					
Retail (Up to 30 day supply)	$5/$20/$40 Copay after ded.		Not Covered	$10/$40/$60 Copay	
Mail Order (90 day supply)	2X retail copay; after ded.		Not Covered	2x's Copay for 90 day supply	
Specialty Rx	$20 Preferred/$40 Non-preferred		Not Covered	$40 Preferred/$60 Non-preferred	
Vision:					
Eye Exam	100%; no deductible/2 yrs.		50% after ded.	100%; no deductible/2 yrs.	
Lenses/Frames	$100 Reimbursement every 24 months				

[1] The Center will fund a Health Reimbursement Arrangement (HRA) to cover the first $1,000 of the Individual In-Network Deductible and $2,000 of the Family In-Network Deductible.

[2] If more than one person is covered, the family level (higher amount) applies. No single individual within the family will be subject to more than the individual deductible or out of pocket maximum.

[3] When utilizing an out of network provider, there are certain procedures which require pre-certification by the member. For a list of these services, please refer to your member handbook.

[4] Please refer to age and timing restrictions.

This information is a summary of benefits only and should not be considered a contract or a complete statement of benefits. All benefits are subject to the terms and provisions as explained in the Plan Document, including exclusions from and limitations on covered expenses. In the event the benefits outlined in this summary differ from those in the Plan Document, the Plan Document language will prevail.

Which Medical Plan is the Best?

Employees often ask this question. Choosing a medical plan is a personal decision and should be based on the unique medical needs and preferences of each employee. Each type of medical plan has features that may be considered advantageous by some employees or limited by others. No one can tell you which plan to select, but below are some factors you will want to consider.

- **Covered Services**

Both plans cover preventive services with no in-network deductible. These services include mammograms, childhood immunizations, annual physicals, and most other commonly recommended screening tests.
Both plans cover a comprehensive eye exam and $100 reimbursement for lenses/frames once every 24 months.
The copays and deductibles are listed in the Medical Plan Benefit Summary table listed on page 10 of this booklet. More details are provided in the benefits summaries available in the Aetna enrollment packets.

- **Cost**

What is the total cost of each medical plan you are considering? The total cost includes contributions you will pay out of your paycheck and what you will pay when you receive services (out-of-pocket expenses).
What tier of coverage do you require (i.e. Single, Family, etc)? Note: Any employee electing spouse or family coverage will be required to sign an affidavit stating their spouse/domestic partner does not have other employer coverage available.

- **Convenience and Flexibility**

Does the plan require referrals for Specialist care?
Is your family doctor in the Aetna network? Maximum Savings or Standard Savings tier?
Do you have specialists out of the network but you would like to continue to visit? If so, you may want to select a plan with out-of-network coverage.
Do you prefer less paperwork for yourself? Generally, the Select plan involves less paperwork due to all in-network coverage.

- **Comparison of the medical plans offered:**

	Choice POS HDHP w/HRA (Maximum Savings/Standard Savings)	**Select HMO (Maximum Savings/Standard Savings)**
PCP Selection Required	No/No	Yes/Yes
Referrals Required	No/No	Yes/Yes
In Network Deductible	Yes/Yes	No/Yes
Out of Network Benefits	Yes	No
Funding of Deductible & Copays	1st half of ded. - Center HRA; then FSA* or employee funds	FSA* or employee funds
Cost out of your paycheck	Lower	Higher

*Refer to section on Flexible Spending Accounts (FSA) for additional information.

- **Health Advocate can break it down for you. By calling 866-799-2728 an expert will:**
  - Explain your plan options and how they work.
  - Answer questions about what each plan covers including medications, preventive care and more.
  - Tell you if your current provider is in network.
  - Help you find an in-network provider and schedule the appointment.
  - Review costs, including the out-of-pocket maximum, premiums, deductibles, copays, and co-insurance.
  - Advise you about how to save money with generic drug equivalents or enrolling in the plan's mail-order prescription service.
  - Explain how to use your HRA or FSA.

Dental Plan Options for 2016-2017

Aetna Dental Plan Options

- DMO Plan
  - This plan offers In Network coverage only and includes Preventive, Basic, Major and Orthodontia services.
- Low Option PPO Plan
  - This plan offers coverage for Preventive and Basic services only.
- High Option PPO Plan
  - This plan offers coverage for Preventive, Basic, and Major Services.

It is recommended you review the benefits carefully to determine which option would best suit your dental needs.

Plan Highlights

The Dental Maintenance Organization (DMO) plan requires you designate a primary care dentist. You also have access to in network benefits only. The DMO generally has a higher level of benefits, but a smaller network of providers. This plan includes Orthodontia coverage.

- The DMO Option plan does not have an annual maximum benefit limit.

Both the Low Option and the High Option dental plans are PPO plans (Preferred Provider Organization). They are also both passive model PPO plans. This means the benefit percentages are the same whether you utilize an in or out of network dentist.
Employees may receive dental care from any licensed dentist. However, you will receive a higher level of benefits when covered services are obtained from an Aetna PPO dental provider, since these dentists have agreed to charge a reduced, negotiated fee for their services.

- The Low Option plan has a $1,000 per covered member calendar year annual benefit limit.
- The High Option plan has a $1,500 per covered member calendar year annual benefit limit.

Balance billing can occur when a non-participating provider charges over and above Aetna's Usual & Customary Rate (UCR) for a service. When this happens, the provider can charge the member the difference between their fee and Aetna's payment.

Children are covered to age 26 regardless of student status on all dental plan options.

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Dental Plan Features

Aetna Dental - Dual Option					
	DMO Option	**Low Option**		**High Option**	
	In-Network (only)	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible*					
Individual	N/A	$50		$50	
Family	N/A	$150		$150	
Calendar Year Maximum	N/A	$1,000		$1,500	
Diagnostic & Preventive					
Exams & Cleanings	100%	100%	100%	100%	100%
Fluoride	100%	100%	100%	100%	100%
X-rays	100%	100%	100%	100%	100%
Sealants	100%	100%	100%	100%	100%
Basic Services					
Amalgam Fillings	100%	100%	100%	80%	80%
Composite Fillings	100%	100%	100%	80%	80%
Root Canal (Molars)	60%	100%	100%	80%	80%
Root Canal (Anterior/ Bicuspid)	100%	100%	100%	80%	80%
Periodontics (Scaling)	100%	100%	100%	80%	80%
Denture Repair	60%	100%	100%	80%	80%
Stainless Steel Crowns	100%	100%	100%	80%	80%
Simple Extractions	100%	100%	100%	80%	80%
Dentures	60%	100%	100%	80%	80%
Major Services					
Onlays, Inlays, Crowns	60%	Not Covered	Not Covered	50%	50%
Implants	Not Covered	Not Covered	Not Covered	50%	50%
Orthodontia	$1,500 Copay	Not Covered	Not Covered	Not Covered	Not Covered

***Deductible is waived for Preventive Services.**

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How to find an in network dentist:

You can access Aetna's website to search for providers in the network by going to Doc Find at: www.aetna.com or logging into Aetna Navigator at www.aetna.com/navigator.

Flexible Spending Accounts

Flexible Spending Account (FSA)

Plan Highlights
FSA's provide you with an important tax advantage that can help you pay healthcare and dependent care expenses on a pre-tax basis. You may set aside part of your income in advance to pay for certain medical expenses or dependent care expenses. The contributions you make to a FSA are not subject to federal and state income or FICA taxes. By anticipating your family's healthcare and dependent care costs for the year, you can actually lower your taxable income.

If you enroll in an FSA account and the HDHP medical plan you may use FSA funds to pay out of pocket expenses not covered by the HRA.

The TASC Debit Card provides easy access to your FSA funds.
It can be used at:

- Health care provider's office
- Hospital
- Pharmacy

Health Care FSA - $500 Rollover

- Carryover of up to $500 of your unused FSA funds to the new plan year
- "Use it or lose it" rule still applies for balances over $500
- Cannot rollover unused Dependent Care funds
- Rollover amount will be applied to your account after the claims run out period

Plan Features

	Health Care FSA	Dependent Care FSA
Annual Contribution Limits	Maximum of $1,500 (excludes any funds that may be rolled over)	Max of $5,000 ($2,500 if married, filing separately)
Expenses Covered	Out of pocket expenses, such as: • Deductibles and copays • Prescription copays • Qualified over the counter expenses* • Dental/orthodontia fees • Vision/Eyecare expenses • Certain expenses not covered by an insurance plan	Day care or home care for a child under age 13 or elder adult, such as: • Day care • Nursery school or preschool • Summer day camp
When Eligible Expenses Must be Incurred	July 1, 2016- June 30, 2017	July 1, 2016- June 30, 2017
Claims Submission	During plan year, but no later than 90 days from June 30, 2017	During plan year, but no later than 90 days from June 30, 2017

**Important Note – Claims for over the counter medications require a prescription from your physician in order to qualify as an eligible expense for the Healthcare FSA.*

Resources

Benefit Hotline

You have direct access to a Benefit Specialist Monday through Friday 9:00 am to 5:00 pm who can assist you with any questions or concerns you may have related to your Center medical, dental, life, disability, and FSA benefits. It is as simple as picking up the phone and dialing (800) 442-1413 for any of the following reasons:

- Claim Issues
- Eligibility Questions
- Coverage Questions
- Plan Design Information
- General Questions

CBIZ Model Consulting

Health Advocate

The Center offers an important resource, Health Advocate, which is available to all benefit eligible employees, and their families. Health Advocate is designed to help handle healthcare and insurance related issues by cutting through the red tape and barriers that so often cause frustration and problems. There is no cost to the employee and it is easy to use. Simply call 866-799-2728 for:

- Help finding best doctors, hospitals and specialists
- Help scheduling timely appointments
- Help when faced with a serious illness or injury
- Help with insurance claims and billing issues and much more

HealthAdvocate
Always at your side

Employee Assistance Program (EAP)

The Center provides an Employee Assistance and Work Life Program at no cost to all benefit eligible employees. From time to time, we all face problems and challenges in our personal and work lives. Usually, we can deal with them ourselves, but every now and then, we could use help. You can call the EAP, which is an integrated counseling and referral service. This strictly confidential benefit is a resource to help employees and their dependents successfully manage temporary setbacks in life.

- Up to three (3) face-to-face counseling sessions per person per problem area (relationship issues, family/parenting, anxiety, stress, grief, adolescent issues, drug and alcohol issues, etc.)
- Available 24 hrs. a day/7 days a week – by phone - 866-799-2728 or online – www.healthadvocate.com
- Work Life services providing information on child care, elder care, etc.
- Half hour free consultation with a Financial Advisor and/or Legal Advisor

Employee Contributions for 2016-2017

The employee's contribution is deducted from each paycheck on a pre-tax basis. Listed below are the deduction amounts on a per pay basis (bi-weekly).

Full Time Bi-Weekly (per pay) rates:

Plan	Employee Only	Employee Plus Child(ren)	Employee Plus Spouse*	Family*
Choice POS HDHP	$ 23.73	$ 82.65	$276.91	$399.91
Select HMO	$ 87.15	$194.61	$393.00	$524.61
Dental DMO	$ 1.92	$ 10.77	$ 12.44	$ 23.33
Dental Low	$ 3.84	$ 17.94	$ 19.57	$ 34.15
Dental High	$ 10.01	$ 30.24	$ 31.95	$ 50.82

Part Time Bi-Weekly (per pay) Rates:

Hours Per Pay	Plan	Employee Only	Employee / Child(ren)	Employee / Spouse*	Family*
72 Hours	Choice POS HDHP	$ 44.41	$111.60	$292.15	$417.22
	Select HMO	$151.29	$260.11	$464.08	$606.42
	Dental DMO	$ 3.35	$ 11.84	$ 13.40	$ 24.88
	Dental Low	$ 5.73	$20.22	$ 21.70	$ 36.14
	Dental High	$ 12.11	$32.89	$ 31.97	$ 50.84
64 Hours	Choice POS HDHP	$ 44.41	$111.60	$292.15	$417.22
	Select HMO	$151.29	$260.11	$464.08	$606.42
	Dental DMO	$ 3.83	$ 12.92	$ 14.35	$ 25.81
	Dental Low	$ 7.08	$ 21.57	$ 22.41	$ 36.84
	Dental High	$ 13.44	$ 34.25	$ 31.98	$ 50.85
60 Hours	Choice POS HDHP	$ 44.41	$111.60	$292.15	$417.22
	Select HMO	$151.29	$260.11	$464.08	$606.42
	Dental DMO	N/A	N/A	N/A	N/A
	Dental Low	N/A	N/A	N/A	N/A
	Dental High	N/A	N/A	N/A	N/A
56 Hours	Choice POS HDHP	$104.68	$217.33	$342.03	$462.57
	Select HMO	$215.67	$378.35	$648.24	$798.94
	Dental DMO	$ 4.31	$ 14.00	$ 15.31	$ 26.75
	Dental Low	$ 8.43	$ 22.91	$ 23.11	$ 37.55
	Dental High	$ 14.79	$ 34.70	$ 31.99	$ 50.86
48 Hours	Choice POS HDHP	$104.68	$217.33	$342.03	$462.57
	Select HMO	$215.67	$378.35	$648.24	$798.94
	Dental DMO	$ 4.79	$ 15.07	$ 16.27	$ 27.68
	Dental Low	$ 9.78	$ 24.26	$ 23.75	$ 37.81
	Dental High	$ 15.96	$ 34.98	$ 32.00	$ 50.87
40 Hours	Choice POS HDHP	$104.68	$217.33	$342.03	$462.57
	Select HMO	$215.67	$378.35	$648.24	$798.94
	Dental DMO	$ 5.27	$ 16.15	$ 17.22	$ 28.62
	Dental Low	$ 11.13	$ 25.61	$ 23.80	$ 38.28
	Dental High	$ 16.13	$ 35.03	$ 32.01	$ 50.88

*To elect Employee/Spouse or Family coverage, your spouse must not be eligible for medical benefits through his/her own employer.

Additional Center Benefits

Life Insurance

- **Basic Life & AD&D Insurance** – The Center provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance through Mutual of Omaha, and pays the full cost of this benefit.
  - Benefit is 50% of the employee's annual salary up to a maximum of $50,000.

- **Voluntary Life Insurance** – Employees who want to supplement their group life insurance benefits may purchase additional coverage through Mutual of Omaha. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through bi-weekly payroll deductions. You can purchase:
  - Coverage on yourself in $10,000 increments to a maximum of $500,000.
  - Coverage for your spouse in $10,000 increments to a maximum of $250,000. The spouse's election cannot exceed 50% of the employee's elected amount.
  - Coverage on dependent children for $10,000.

  The following amounts are guaranteed issue for employees when initially eligible for coverage.
  - Employee - $150,000
  - Spouse - $30,000
  - Children - $10,000

  Evidence of Insurability Form (EOI) will need to be completed for late entrants, increases in coverage, or any election in excess of the Guaranteed Issue Amounts.

Disability Insurance

- **Short Term Disability –** Full time employees can purchase short term disability coverage through Mutual of Omaha to help provide income in the event you become disabled from a non-work related injury or sickness, for up to 12 weeks.
  - 7 day elimination period for both Accident and Illness. (benefits begin on 8th day, subject to claim approval)
  - You can purchase 60% of your covered weekly earnings.
  - 3/6 pre-existing condition limitation. A condition you have been diagnosed with, treated for, taken prescription medicines for, etc. during the 3 months prior to enrolling in the plan, will not be covered as an approved disability for the first 6 months in the plan.

- **Long Term Disability** - The Center provides full-time employees with long-term disability income benefits through Mutual of Omaha and pays the full cost of this coverage. In the event you become disabled from a non-work related injury or sickness, disability income benefits are provided as a source of income.
    - Benefits begin after 90 days of disability
    - Paid at 60% monthly benefit
    - Benefit duration – Reduced Benefit Duration to your SSNRA (Social Security Normal Retirement Age)

Age at Disability	Maximum Benefit Duration
61 or less	To age 65, your SSNRA, or 3 ½ years; whichever is longest
62	Your SSNRA or 3 years and 6 months; whichever is longest
63	Your SSNRA or 3 years; whichever is longest
64	Your SSNRA or 2 ½ years; whichever is longest
65	2 years
66	1 year and 9 months
67	1 year and 6 months
68	1 year and 3 months
69 or older	1 year

Retirement Plan Benefits

- **Pension Plan Benefits**

The purpose of the Center's pension plan is to provide all eligible employees with additional income at retirement. It is a defined contribution plan so employees do not make plan contributions; rather the Center makes contributions based upon 3% of eligible employees' base wages into a Group Retirement Annuity Account.

- Eligibility requirements are employees who are at least 21 years of age, one year of credited service and a minimum of 1,000 base hours worked during the year.
- Vesting (ownership) occurs after completing years of service requirements as outlined in the Summary Plan Description.
- Contributions are funded by the Center after the last pay period of the plan year.

- **403(b) Tax Sheltered Annuity**

Participation in a Tax Sheltered Annuity is an excellent way to accumulate personal savings in anticipation of your retirement years. Under present IRS rules, you do not pay any Federal income tax on money put into your plan or on interest earnings until you withdraw cash from the plan.

- Employees are 100% vested in their contributions.
- All employees of the Center are eligible to participate.
- You are permitted to contribute up to an annual limit ($18,000 in 2016 under age 50; $24,000 age 50 and over) each calendar year.
- You can enroll at any time and are allowed to make changes to contribution amounts as needed throughout the year.
- You can enroll online at www.LincolnFinancial.com or over the phone by calling 800-234-3500.

Tuition Reimbursement

The Center encourages the self-development of its employees. Through tuition reimbursement, financial support is available to eligible employees who are enrolled in a relevant formal degree program or relevant vocational program that is directly related to their job responsibilities within the organization.

- Full-time employees can receive up to $2,500 (undergraduate) or $3,000 (graduate) per fiscal year. Part-time employees receive a pro-rated amount.
- Tuition expenses, not including lab, service or other fees are eligible.
- Request and approval prior to course starting, a grade of C or better and a paid itemized receipt is required for reimbursement.

Paid Time Off

- **Paid Time Off (PTO) –** The Center recognizes the important need for you to balance your work and family issues. Whether it be a vacation, to care for a sick child, personal errands, or just a day off, it is important to have the time to address these issues. To respond to the many demands on your time, the Center is pleased to provide paid time off that offers flexibility and requires personal responsibility for managing your paid time off.
    - Paid time off is accrued each pay period and can be used after your first 90 days, although accrual is retroactive back to start date.
    - You accrue PTO based on years of service and job classification.
    - You are awarded additional PTO accrual upon your three, six, nine and twelve year service anniversary.
    - Regular part-time employees receive a pro-rated accrual of PTO.
    - The Center offers an annual cash-out option to eligible employees.

- **Holidays –** The Center provides 6 paid holidays to full time employees (pro-rated for part time employees).

- **Jury & Witness Duty –** The Center encourages you to fulfill your civic responsibilities by serving jury duty when required. If eligible, you may request up to fifteen (15) days of paid jury duty leave over any "rolling" one-year period.

- **Bereavement Leave –** In the event of a death of a member of your immediate family, the Center will grant up to three (3) consecutive, regularly scheduled paid days off as bereavement leave.

Length of Service Bonus

The Center pays an annual length of service bonus to defined categories of employees who have met the eligibility requirements. Length of service bonus will be paid out on the 19th pay period of each year as a separate check. The bonus is an annual payment if all service requirements have been met for the year. Please see policy for more detail regarding eligibility.

The Length of Service Bonus Payment is as follows when all eligibility criteria are met:

	5-9 Years	10-14 Years	15-19 Years	20+ Years
Full Time	$500	$750	$1,000	$1,500
Part-Time & Pool	$250	$375	$500	$750

Leaves of Absence

- **Military Leave –** The Center will grant a leave of absence for military service, training or other obligations and reemployment following military service in compliance with the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA). Employees participating in annual mandatory reserve activities up to ten (10) working days per calendar year will be compensated at their regular rate of pay. For military service exceeding ten (10) working days for a period of as long as five (5) years, the leave of absence will be unpaid.

- **Family and Medical Leave Act (FMLA)** – The Center provides an unpaid medical and family leave of absence in accordance with State and Federal Family and Medical Leave Acts for up to 12 weeks (26 weeks for military caregiver leave) during a rolling 12 month period to you if you are temporarily unable to work due to one of the following reasons:
    - For the birth and care of a newborn child.
    - For placement of a child for adoption or foster care with you.
    - To care for an immediate family member (child, spouse, parent) with a serious health condition.
    - For a serious health condition of your own that makes you unable to perform your job responsibilities.
    - Qualifying exigency leave for families of members of the military when the military member is on active duty or called to active duty.
    - Military caregiver leaver to care for an ill or injured service member (up to 26 weeks).

  Eligibility for FMLA:
    - Must have worked for the Center at least 1,250 hours in the preceding twelve (12) months.
    - Must have been employed for at least twelve (12) months.

- **Personal Leave –** The Center recognizes your need to take time off from work to fulfill major family and personal obligations. Typically, any other Center sponsored leave program, such as Family and Medical Leave (FMLA), would not cover these instances. In order to provide you and the Center with another option to maintain our employment relationship, we offer a personal leave program. The approval of a personal leave of absence is at management discretion. Staffing needs, workload, and Center needs are some of the factors considered in the decision process.

Contact Information

Type of Benefit	Provider Name	Contact Information
Medical	Aetna	800-962-6842 www.aetna.com
Dental	Aetna	877-238-6200 www.aetna.com
Life Insurance	Mutual of Omaha	800-877-5176
Disability Insurance	Mutual of Omaha	800-877-5176
Health Reimbursement Arrangement (HRA)	Eflex, a TASC division	877-933-3539 www.eflexgroup.com
Flexible Spending Accounts (FSA)	TASC	800-422-4661 www.tasconline.com
Employee Assistance Program	Health Advocate	866-799-2728 www.healthadvocate.com/members
Health Advocate	Health Advocate	866-799-2728 www.healthadvocate.com/members
Benefit Hotline	Benefit Hotline	800-442-1413
Retirement	Lincoln Financial	800-234-3500 www.LincolnFinancial.com

Human Resources	Contact Information
Ailee Strausser	Tel 215-371-1843 Fax 215-371-3006 Email: astrausser@abramsoncenter.org
Ateya Mayo	Tel 215-371-1841 Fax 215-371-3006 Email: amayo@abramsoncenter.org
Laura Tracz	Tel 215-371-1847 Fax 215-371-3006 Email: ltracz@abramsoncenter.org
Razinn Gibson	Tel 215-371-1844 Fax 215-371-3006 Email: rgibson@abramsoncenter.org
Kari Gansky	Tel 215-371-3608 Fax 215-371-3006 Email: kgansky@abramsoncenter.org
Karen Baldwin	Tel 215-371-1842 Fax 215-371-3006 Email: kbaldwin@abramsoncenter.org

Federally Required Notices Related To Your Benefits Program

Important Notice from Abramson Center for Jewish Life 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 Abramson Center for Jewish Life 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. Abramson Center for Jewish Life has determined that the prescription drug coverage offered by the Abramson Center for Jewish Life plan 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 Abramson Center for Jewish Life coverage will not be affected. You can keep your existing coverage or join a Medicare drug plan as a supplement to, or in lieu of, your coverage under the Abramson Center for Jewish Life plan.

Abramson Center for Jewish Life medical plan includes a prescription drug plan as follows:

Prescription Drug Card Benefit	Aetna Choice POS II HDHP	Aetna Select HMO
Retail - Up to 30 day	$2,000/$4,000 deductible then $5 / $20 / $40	$10 / $40 / $60
Mail Order - Up to 90 day	$2,000/$4,000 deductible then $10 / $40 / $80	$20 / $80 / $120

If you do decide to join a Medicare drug plan and drop your current Abramson Center for Jewish Life coverage, be aware that you and your dependents may not be able to get this coverage back until the Abramson Center for Jewish Life's next annual open enrollment (or if you experience a special enrollment event).

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 Abramson Center for Jewish Life 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 October 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 Abramson Center for Jewish Life 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:	July 1, 2016
Name of Entity/Sender:	Abramson Center for Jewish Life
Contact – Position/Office:	Ailee Strausser – Human Resources Director
Address:	1425 Horsham Road, North Wales, PA 19454
Phone Number:	215-371-1843
Email:	astrausser@abramsoncenter.org

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/
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_assistanc.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)

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 within 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 you have 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 SCHIP.

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 (215)371-1800.

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.