Kaiserman JCC
Wynnewood, PA

There's something about this place ™

PHILLYJCC.COM

Benefits Guide

PLAN YEAR | **2016-2017**

That's why at Kaiserman JCC we are committed to providing a comprehensive employee benefit program to help our employees stay healthy, feel secure and to maintain a work/life balance.

Stay Healthy

- Medical Plan Options
- Health Reimbursement Arrangement (HRA)
- Dental Plan Options

Feeling Secure

- Life and Accidental Death & Dismemberment
- Disability Insurance
- Voluntary Benefits

Resources

- Benefits Hotline
- Health Advocate

Additional benefit information and forms can be obtained through your Human Resource Department extension 128.
Additional questions can be referred to the Benefit Hotline at 1-800-442-1413.

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Discovering Your Benefits

Kaiserman JCC recognizes the important role employee benefits play as a critical component of employee compensation. This benefit guide will provide you with a general overview of the benefits that Kaiserman JCC offers so you can make informed decisions for yourself and your family.

Who is Eligible and When:
New employees are eligible the first of the month following 60 days of consecutive full-time employment for Medical, Dental, Long Term Disability, Life insurance, and Voluntary Benefits.

Eligible Employee

- Union Employees working 20 hours a week or more are elibile to participate in the benefits outlined in this guide.
- Non-Union Employees working at least 30 hours a week are eligible to enroll in the Medical, Dental, and Colonial benefits.
- You are eligible for the Life/AD&D and Long Term Disability if you work 35 hours or more on a weekly basis.

Please contact HR for information regarding the payroll contributions associated with participation in the Medical, Dental, and Colonial benefits.

Eligible Dependents

- Legal Spouse
- Same and Opposite Sex Domestic Partners
    - Please contact HR for eligibility, definitions and further information
- Dependent children, legally adopted children, step-children, children for whom you and/or your spouse are a court appointed legal guardian
    - Provide medical & dental coverage for children up to age 26, regardless of student status
    - Marital status of the child is not relevant, but children and spouses of your child are not eligible
    - You must contact Human Resources within 30 days of your child's loss of coverage in order for your child to be eligible to continue coverage under COBRA

Qualifying Life Events

Please note once you have made your benefit election they cannot be changed during the plan year unless you experience a qualifying life event. The most common life events include but are not limited to:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Termination or commencement of spouse's employment

If you need to make changes to your current benefit elections due to a qualifying life event, you must notify Human Resources within 30 days of the date of event. You must also provide supporting documentation.

Medical Insurance

Below are the three medical plan options available to you through Independence Blue Cross. The benefits renew on November 1st of each year. Please note that the accumulation period for the deductible and out-of-pocket maximum is the contract year (November 1st – October 31st).

Plan Feature	Personal Choice PPO Silver	Keystone HMO Platinum	Keystone DPOS Platinum
In Network	**Base**	**Buy up #1**	**Buy up #2**
Primary Care Physician Required	No	Yes	Yes
Referrals Required	No	Yes	Yes*
Deductible (Plan Year)	$2,500/$5,000	$0	$0
Out of Pocket Maximum (Plan Year)	$6,000/$12,000	$3,200/$6,400	$3,200/$6,400
Preventive Care	Covered 100%	Covered 100%	Covered 100%
Primary Care Office Visit	$30 copay	$20 copay	$20 copay
Specialist Office Visit	$60 copay	$40 copay	$40 copay
Emergency Services (not waived if admitted)**	80% after ded	$125 copay	$125 copay
Routine Vision Exam	Covered 100% Every Year	Covered 100% Every Year	Covered 100% Every Year
Vision Hardware (1 visit per calendar yr)	Up to $100 Allowance	Up to $100 Allowance	Up to $100 Allowance
Inpatient Hospitalization**	80% after ded	$150/day; Max. 5 days	$150/day; Max. 5 days
Outpatient Surgery**	80% after ded	$45 copay – Ambulatory Surgery Center $185 copay - Hospital-Based	$45 copay – Ambulatory Surgery Center $185 copay - Hospital-Based
Laboratory	Covered 100%-Freestanding 50% after ded - Hospital-Based	Covered 100%	Covered 100%
Radiology**	Routine / Complex – 80% after ded	Routine - $30 copay Complex - $60 copay	Routine - $30 copay Complex - $60 copay
Durable Medical Equip.	50% after ded	50%	50%
Prescription Drugs **Generic** **Brand** **Non-Preferred** **Mail Order**	 $7 copay 50% up to $125 50% up to $250 2x the copay	 $7 copay $45 copay $75 copay 2x the copay	 $7 copay $45 copay $75 copay 2x the copay
Out of Network			
Deductible (Plan Year)	$7,500/$15,000	N/A	$2,000/$4,000
Co-Insurance	50%	N/A	50%
Out of Pocket Maximum (Plan Year)	$25,000/$50,000	N/A	$5,000/$10,000

*Referrals are required for routine radiology/diagnostic, spinal manipulation, & physical /occupational therapy.
**Item eligible for partial reimbursement thru HRA. See page 8 for details.

- This comparison is intended to highlight your available benefits. Please refer to specific plan documents for plan details and maximums. Any differences between the above comparison and plan documents, the plan documents/contract will prevail.
- Preauthorization may be required for some benefits, please refer to the insurance carrier policy for details.

What is a PPO plan?
PPO stands for Preferred Provider Organization. PPO plans **do not require** a Primary Care Physician (PCP) or referrals for Specialists. It does have In and Out of Network benefits.

What is a HMO plan?
HMO stands for Health Maintenance Organization. HMO plans, requires you **must choose** a Primary Care Physician from a network of local healthcare providers who will refer you to in-network specialists or hospitals when necessary. All your care is coordinated through the chosen PCP. It does not have Out of Network beneftis.

What is a DPOS plan?
DPOS Stands for Direct Point of Service. DPOS plans require you to designate a Primary Care Physician and obtain referrals for **some** specialists (routine radiology/diagnostic, spinal manipulation, and physical /occupational therapy). It allows coverage for In and Out of Network.

What is Contract Year Out of Pocket Maximum?
The Out of Pocket Maximum refers to the maximum amount of money you will spend on copays, coinsurance, and deductible during the contract year. The contract year is November 1st – October 31st.

Questions to consider when making a plan selection:
- Are all my doctors in-network?
- Do I mind getting a referral to see a specialist?
- Do I go to a specialist enough during the year to make getting a referral inconvenient?
- Would I rather have less money come out of my paycheck but have to get a referral if I need to see a specialist and stay in network?
- Would I rather pay more money each paycheck to not have to get a referral and be able to see any doctor I want?

IBC Online Valuable Tool
By logging onto www.ibxpress.com you can do the following:
- Request ID Cards and print a temporary ID card
- View medical and prescription benefits
- Check claims status
- Obtain forms
- Enroll in special programs
- Change your Primary Care Physician (PCP)

Find a Doctor
www.ibx.com
- Click “Search” under Find a Doctor
- Enter in your search criteria
    - Select a Plan
        - DPOS or HMO – Keystone HMO/POS/Direct POS
        - PPO – Personal Choice PPO
- Click “Submit”

Dental Insurance

Benefits You Receive:

Benefits are offered through Aetna. The plan year begins on November 1st, however, the deductibles, benefit maximums, and limitations are based on a calendar year. Below is a summary of the plan benefits.

Type of Service	DMO	PPO	
	In-Network	In-Network	Out-of-Network*
Annual Deductible (Applies to Basic & Major Services)	None	$25/$75	$25/$75
Annual Benefit Maximum	None	$1,000	$1,000
Preventive Services **Cleanings, Exams, X-rays**	100%	100% - No deductible	100% - No deductible
Basic Services **Fillings, Scaling, Simple Extractions**	100%	100%	80%
Major Services **Crowns, Dentures, Denture repairs**	50%	60%	50%
Orthodontic Services (Children up to age 19)	50%	50% after $50 deductible	50% after $50 deductible
Orthodontic Lifetime Maximum	$0	$1,500	$1,500

*Please note using an Out of Network provider will result in higher out of pocket expenses. Balance billing may occur.

How do I find a participating Aetna Dentist?

To locate a dentist in the Aetna Dental Network, visit www.aetna.com and select "Search DocFind". Enter your search information and select "Dentist" for type of provider. Select your plan network - **"Dental Maintenance Organization (DMO®)"** for the DMO network or **"Dental PPO/PDN with PPO II Network"** for the PPO network.

- This summary is intended to highlight your available benefits. Please refer to specific plan documents for plan details and maximums. Any differences between the above comparison and plan documents, the plan documents/contract will prevail.

Health Reimbursement Account (HRA)

Benefits You Receive:

Kaiserman Jewish Community Center provides you with a Health Reimbursement Arrangement to help minimize your out-of-pocket medical expenses. If you are enrolled in one of the medical plans you can receive reimbursements for the following services up to the amount indicated below. The reimbursement amount will be subject to the actual amount incurred for service rendered under the in network portion of the plan. Your dependents are not eligible for reimbursement.

- Emergency Room Copay – Up to $50 per visit
- Inpatient Hospitalization (including Mental Health and Substance Abuse) – Up to $200 per in-patient admission
- Inpatient Maternity Hospitalization – Up to $200 per admission
- Outpatient Surgery – Up to $50 per occurrence
- MRI, PET Scan and CAT Scans – Up to $50 per occurrence

To be eligible for reimbursement you are required to submit to HR an HRA claim form along with a copy of the invoice for services within 60 days of the date of service. Please note you will only be reimbursed for actual expenses incurred by you that were not reimbursed through an FSA or other tax advantaged account and were remitted within 60 days from the date the expense was incurred.

Long Term Disability Insurance

Benefits You Receive:

Kaiserman JCC, Inc. provides Long Term Disability insurance through UNUM at no cost to you. In the event you become disabled from an injury or sickness, disability income benefits are provided as a source of income. Below is a summary of the LTD benefit.

	Long Term Disability
Percentage of Income Replaced	66 2/3%
Maximum Benefit	$8,000 per month
Benefits Begin	After 180 days of disability
Benefits Duration	**Under age 68** - Paid for 24 months **Age 68** - Paid to age 70, but not less than 1 year **Age 69 and over** - Paid for 12 months

Life and AD&D Insurance

Benefits You Receive:

Kaiserman JCC, Inc. provides full-time employees with $10,000 of group life and accidental death and dismemberment (AD&D) insurance through UNUM and pays the full cost of this benefit.

Reduction Schedule –
Basic Group Term Life and Basic Accidental Death and Dismemberment benefits reduce by 35% of the original amount at age 65 and further reduce to 50% of the original amount at age 70. Benefits terminate at retirement.

Other Features – (Refer to the Certificate of Coverage for additional details.)

- Accelerated Benefit
  - If you are diagnosed with a terminal illness you may receive a portion of your life insurance benefit.
- Conversion
  - Allows you to convert your life insurance benefit to a whole life policy if your employment terminates.
- Waiver of Premium
  - In the event of your total disability, allows your coverage to continue at no cost.

Voluntary Benefits

Take Advantage of What Colonial Life Has to Offer!

Have we got news for you! As a valued employee you have the opportunity to apply for personal insurance products! These benefits can enhance your current benefits portfolio and can be customized to fit your individual needs. Also:

- **Coverages are available for you *and* your family, with most products.**
- **You will enjoy the convenience of premium payment through payroll deduction.**
- **You will have the ability to take most coverage with you if you change jobs or retire!**

Disability Insurance – replaces a portion of your income to help make ends meet if you are totally disabled due to a covered accident or covered sickness. This coverage supplements your employer paid plan to help you maintain your lifestyle.

Accident Insurance – helps offset unexpected medical expenses, such as deductibles and co-payment that can result from a fracture, dislocation or other covered accidental injury. Provides a $50 Wellness Benefit.

Cancer Insurance – helps offset the out-of-pocket medical and nonmedical expenses related to cancer that most medical plans may not cover. This coverage also provides benefits up to $100 for specified cancer-screening test.

Critical Illness Insurance – complements your major medical coverage by providing a lump-sum benefit you can use to help pay the direct and indirect costs related to a covered critical illness. Provides a $50 Wellness Benefit.

Life Insurance – 3 types of coverage to help fit your individual needs and helps provide financial security for your family members. Family coverage also available

With Colonial Life, you can select benefits that meet your individual needs and make your benefits count, and your insurance needs can be reviewed in just a few short minutes in a special one-on-one consultation!

Contact your local Dedicated Service Team at
1-800-613-2958 or Service@YourColonialLife.com
to review your options or to enroll right away.

Account Director: Petrina Skiles
Account Coordinator: Lindsay DeJesus

Don’t miss your chance to learn more about this exciting opportunity!

Colonial Life℠
Making benefits count.

Health Advocate

Benefits You Receive:

Health Advocate is designed to help handle healthcare and insurance related issues by cutting through the red tape and barriers so often cause frustration and problems. There is no cost to you or your dependents to utilize this valuable service. In addition to your dependents, your parents and in-laws may contact Health Advocate for assistance.

Their trained staff will assist you with a wide range of medical and administrative issues, helping you to more easily navigate the health care system:

They can help you:

- Find the best doctors, hospitals and specialists to meet your needs
- Schedule timely appointments
- Resolve insurance claim issues
- Answer questions about test results, treatments, and medications
- Transfer medical records
- Locate and research the newest treatments
- Set up elder care

Simply call the toll free number (1-866-695-8622) to see what Health Advocate can do for you.

Benefit Hotline

Benefits You Receive:

You have direct access to a Benefit Specialist who can assist you with any questions or concerns you may have relative to any of your Kaiserman JCC benefits. It is as simple as picking up the phone and dialing 1-800-442-1413 for any of the following reasons:

- Benefit Questions
- Eligibility
- Plan Design Information
- ID Cards
- COBRA Questions
- Forms

The Benefits Hotline is available to you and your dependents Monday through Friday 9am through 5pm EST.

Contact Information

Carrier Contact Information
Please find the carrier websites and telephone numbers listed below for your reference.

Coverage	Carrier Name	Website	Telephone #
Medical	Independence Blue Cross	www.ibx.com	1-800-275-2583
Dental	Aetna	www.aetna.com	1-877-238-6200
Life & ADD	UNUM	www.unum.com	1-800-421-0344
Long Term Disability	UNUM	www.unum.com	1-800-421-0344
Voluntary Benefits	Colonial	www.coloniallife.com	1-800-613-2958 ext 100
Health Advocate	Health Advocate	www.healthadvocate.com	1-866-695-8622
Benefits Hotline	Benefits Hotline	N/A	1-800-442-1413

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

Federally Required Notices Related To Your Benefits Program

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

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

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

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

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

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 610-896-7770.

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.