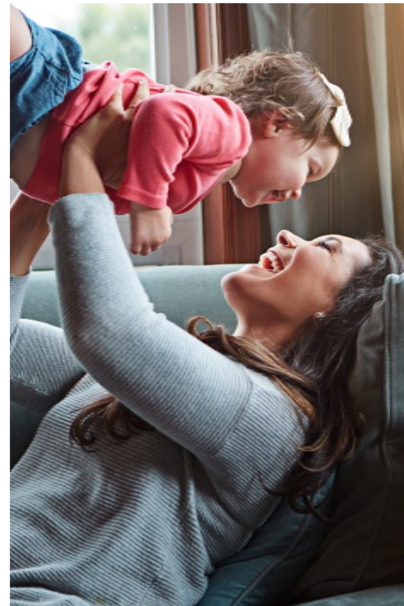

2023

EMPLOYEE BENEFITS GUIDE

WELCOME TO **[[CLIENT NAME]]**

We all have different needs that influence the choices we make every day. [[Client Name]] embraces these differences providing you with the freedom to select quality benefit options that work best for your personal situation. We encourage you to take the time to carefully review this guide and learn about all of the benefits available to you during this new hire period.
The benefits that you select will be effective until December 31, 2023.

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ELIGIBILITY & ENROLLMENT

WHO IS ELIGIBLE?

The benefits outlined in this guide are available to all [[Client Name]] employees who met the eligibility guidelines. Dependents or any person you have a legal court order to provide coverage for may be covered up to age 26. Please contact Human Resources to confirm if you are eligible for benefits.

HOW DO FACULTY AND PROFESSIONAL STAFF ENROLL FOR BENEFITS?

[[Client Name]] faculty and professional staff enroll for benefits via the **[[Client Name]] Benefits** portal. You can log in to My [[Client Name]] Benefits through **[[Client Portal]]** by selecting the Employees tab and then the **My [[Client Name]] Benefits** link under the Benefits Administration heading. Most elections are annual elections and cannot be changed during the year unless you experience a qualified life event.

WHAT IS A QUALIFIED LIFE EVENT?

Medical, prescription drug, dental, vision and health and dependent care spending account contributions are made on a pre-tax basis. This reduces your taxable income, therefore reducing the taxes you owe. However, this also means that once selected, you generally cannot change your coverage until the next open enrollment period. The exception to this rule is if you have a qualified life event. The change to your benefits must correlate directly with the qualified life event. Appropriate qualified events include:

- Marriage or divorce
- Death of a spouse, same-sex domestic partner, or dependent child
- Birth or adoption of a child
- Spouse's termination of employment or new job
- Change of employment status from full-time to part-time or vice versa
- Taking an unpaid leave of absence
- Returning to work after a leave of absence
- Open enrollment of spouse's plan

UNDERSTANDING YOUR MEDICAL PLAN OPTIONS

KEYSTONE POINT OF SERVICE PLAN

The Keystone POS plan allows you to pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. **POS plans also require you to get a referral from your primary care doctor in order to see a specialist.** You maximize your coverage by having care provided or referred by your primary care physician (PCP). Of course, with Keystone Point-of-Service, you have the freedom to self-refer your care either to a Keystone participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply.

The most important aspect to know of the Keystone POS network is that it is local to the Greater Philadelphia area. If you live in the Greater Philadelphia area and you are covering dependents in the area as well, you will be able to find great providers in-network. For those that travel extensively, live outside of the area, or cover dependents in other areas of the country, this may not be the best fit.

PERSONAL CHOICE PPO PLANS

BASIC & HIGH OPTIONS

With Personal Choice PPO plans, you can choose to see any doctor or visit any hospital in the Personal Choice network. You will also enjoy in-network coverage anywhere in the United States when you use providers who participate in the BlueCard® PPO network.

You'll pay less when you choose doctors and hospitals in the Personal Choice network, and more if you choose to see doctors and hospitals out-of-network. You don't need to get referrals, so you can see any specialist you want without needing permission from a primary care physician (PCP), or family doctor. Due to the flexibility that these plans offer, as well as the limited out of pocket expenses that you will incur at the time of service, the premiums are higher in comparison to the Keystone POS and CDHP.

[[Client Name]] offers two Personal Choice Options, the Basic and High Plan. The plans have similar features; however, **the High Plan option has richer tier 2 in-network benefits.**

CONSUMER DIRECTED HEALTH PLAN

Our Consumer Directed Health Plan (CDHP) is a high-quality, low cost medical plan, with a higher deductible than the Keystone POS and Personal Choice plans. **The CDHP is offered in conjunction with a Health Savings Account (HSA).**

HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a tax-advantaged medical savings account owned by the faculty or professional staff member and designed to be used in conjunction with a federally qualified high deductible health insurance plan. Money contributed to the account is not subject to federal tax at the time of deposit (pre-tax dollars). Unlike amounts in flexible spending accounts that are forfeited if not used by the end of the year, unused HSA funds remain available for use in later years, are portable and can grow tax-free through investment earnings, just like an IRA.

For 2023, the HSA contribution maximums, are **$3,550** for individual coverage and **$7,100** for family coverage. The annual catch-up contribution for age 55 and older is $1,000.

The contributes up to $500 to each HSA account with individual coverage or $1,000 for those with family coverage based on the effective date of your enrollment. If enrollment occurs outside of Open Enrollment, the contributions made to the HSA will be prorated based on the table below.

	1/1—3/31	4/1—6/30	7/1—9/30	10/1 - 12/31
Individual Coverage	$500	$375	$250	$125
Family Coverage	$1,000	$750	$500	$250

* Employer funding will be credited in your HSA account after your first medical premium deduction.

TIER 1 PROVIDERS

[[Client Name]] has partnered with Independence Blue Cross (IBC) for many years to offer excellent Health benefits to our employees. IBC offers the most robust Provider Network in our region, and also offers the BlueCard PPO network to those living and traveling outside of the Greater Philadelphia area. There is a significant financial incentive to remain in-network.

In an effort to enhance the benefits package even further, [[Client Name]] is partnering with Tower Health, as well as The of Pennsylvania (HUP) Hospital. If you or a dependent family member enrolled in one of the [[Client Name]] Health Plans receives services at Tower Health, or HUP, your medical out-of-pocket cost will be reduced in relation to receiving care at any other provider in the Independence network.

TIER 1: **Tower Health and HUP providers**

TIER 2: **IBC network excluding Tower Health and HUP providers**

TIER 3: **All other providers that are not in the IBC network. If you utilize Tier 3 providers, you will have the highest out-of-pocket cost.**

For a list of Tier 1 preferred providers, visit **www.samplebenefitsportal.com.**

MEDICAL & PRESCRIPTION DRUG PLANS AT-A-GLANCE

	KEYSTONE POINT OF SERVICE			PERSONAL CHOICE PPO - BASIC			PERSONAL CHOICE PPO - HIGH			CDHP WITH HSA		
BENEFIT DESCRIPTION	**TIER 1 NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**TIER 1 NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**TIER 1 NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**TIER 1 NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
IS A REFERRAL NEEDED TO SEE A SPECIALIST?	Yes			No			No			No		
EMPLOYER HEALTH SAVINGS ACCOUNT CONTRIBUTION	N/A			N/A			N/A			Individual: $500 / Family: $1,000		
DEDUCTIBLE (INDIVIDUAL/FAMILY)	None	None	$500 / $1,500	None	$300 / $600	$1,000 / $2,000	None	None	$500 / $1,000	$1,500 / $3,000	$2,000 / $4,000	$5,000 / $10,000
OUT-OF-POCKET MAXIMUM (INDIVIDUAL/FAMILY)	$1,500 / $3,000	$2,000 / $4,000	$3,000 / $9,000	$1,000 / $2,000	$2,000 / $4,000	$3,000 / $6,000	$1,000 / $2,000	$2,000/ $4,000	$3,000 / $6,000	$6,450 / $12,900	$6,450 / $12,900	$10,000 / $20,000
PREVENTIVE CARE SERVICES	No charge	No charge	Plan pays 70%	No charge	No charge	Plan pays 70%	No charge	No charge	Plan pays 80%	No charge	No charge	Plan pays 50%
PRIMARY CARE PHYSICIAN (PCP)	No charge	$20 copay	Plan pays 70%*	No charge	$20 copay	Plan pays 70%*	No charge	$15 copay	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
SPECIALIST OFFICE VISIT	$10 copay	$40 copay	Plan pays 70%*	$10 copay	$30 copay	Plan pays 70%*	$10 copay	$25 copay	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
OUTPATIENT SERVICES	No charge	$40 copay	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
HOSPITAL PHYSICIAN/ SURGEON FEES	No charge	No charge, $50 facility fee per visit	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*	No charge*	:Plan pays 80%*	Plan pays 50%*
DIAGNOSTIC LABORATORY	No charge	$20 copay Blood work: no charge	Plan pays 70%*	No charge	Plan pays 90%*, Blood work: no charge	Plan pays 70%*	No charge	No charge	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
DIAGNOSTIC X-RAY/IMAGING (MRI, CT-SCAN)	No charge	$80 copay	Plan pays 70%*	No charge	Plan pays 90%*	Plan pays 70%*	No charge	No charge	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
EMERGENCY ROOM	$100 copay	$100 copay	Covered at in-network level	$100 copay	$100 copay	Covered at in-network level	$100 copay	$100 copay	Covered at in-network level	No charge*	Plan pays 80%*	Covered at in-network level
URGENT CARE CENTER	No charge	$35 copay	Plan pays 70%*	No charge	$35 copay	Plan pays 70%*	No charge	$35 copay	Plan pays 80%*	No charge*	Plan pays 80%*	Plan pays 50%*
OUTPATIENT SERVICES FOR MENTAL HEALTH/BEHAVIORAL/SUBSTANCE ABUSE	Not available	$40 copay	Plan pays 70%*	Not available	$30 copay	Plan pays 70%*	Not available	$25 copay	Plan pays 80%*	Not available	Plan pays 80%*	Plan pays 50%*
PRESCRIPTION DRUG BENEFITS												
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)	Generic: $10 copay Preferred Brand: $30 copay Non-Preferred Brand: $50 copay			Generic: $10 copay Preferred Brand: $30 copay Non-Preferred Brand: $50 copay			Generic: $10 copay Preferred Brand: $30 copay Non-Preferred Brand: $50 copay			Generic: $10 copay* Preferred Brand: $30 copay* Non-Preferred Brand: $50 copay*		
MAIL ORDER (UP TO A 90-DAY SUPPLY)	Generic: $20 copay Preferred Brand: $60 copay Non-Preferred Brand: $100 copay			Generic: $20 copay Preferred Brand: $60 copay Non-Preferred Brand: $100 copay			Generic: $20 copay Preferred Brand: $60 copay Non-Preferred Brand: $100 copay			Generic: $20 copay* Preferred Brand: $60 copay* Non-Preferred Brand: $100 copay*		

* The plan year deductible must be satisfied before the plan will pay for services.

TALK TO A DOCTOR 24/7 WITH MDLIVE

Whether it's the weekend or you're traveling out of town, with MDLive, IBC plan members have access to medical care via phone or video consultation—*anytime, anywhere*.

WHAT IS MDLIVE?

MDLive is a national network of U.S. board-certified doctors available 24/7/365 to diagnose, treat and prescribe medication, if necessary, for many common medical issues.

Contact MDLive for non-emergency medical conditions such as:

- Allergies
- Asthma
- Acne
- Pink eye
- Ear infections
- Sinus issues
- Respiratory infections
- Urinary tract infections
- Cold and flu symptoms

Using MDLIVE is a convenient option when it's not possible to visit your doctor's office. Services are completely confidential. It is quality care when you need it most.

HOW MUCH DOES IT COST?

MDLive is available at no cost to members enrolled in the Keystone POS and Personal Choice PPO plans. CDHP with HSA plan members pay only a $40 copay per consultation.

To contact MDLive, call **1.877.764.6605**, visit **mdlive.com/ibx**, or download the MDLive App.

DENTAL PLAN OPTIONS

	BASE PLAN		PREMIER PLAN	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
CALENDAR YEAR DEDUCTIBLE	$50 Individual $150 Family	$50 Individual $150 Family	$50 Individual $150 Family	$50 Individual $150 Family
CALENDAR YEAR MAXIMUM (PER PATIENT)	$1,000	$1,000	$1,500	$1,500
PREVENTIVE & DIAGNOSTIC SERVICES Exams, Cleanings, Bitewing X-rays (each twice in a calendar year), Fluoride Treatment (twice per calendar year, children to age 19)	Plan pays 100% no deductible	Plan pays 100% after deductible	Plan pays 100% no deductible	Plan pays 100% after deductible
BASIC SERVICES Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible
MAJOR SERVICES Crowns, Gold Restorations, Bridges, Dentures, Inlays, Onlays, Prosthesis, Implants	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 60% after deductible	Plan pays 60% after deductible
OTHODONTIA Dependent children up to age 19 only Lifetime Benefit Maximum: $1,000	Not Covered	Not Covered	Plan pays 50% no deductible	Plan pays 50% no deductible

MONTHLY CONTRIBUTIONS	**FULL-TIME EMPLOYEES**		**PART-TIME EMPLOYEES**		**FULL-TIME EMPLOYEES**		**PART-TIME EMPLOYEES**	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
EMPLOYEE	$9.82	$9.82	$4.91	$14.73	$14.58	$14.58	$7.29	$21.87
EMPLOYEE & SPOUSE	$29.05	$29.05	$14.52	$43.58	$47.68	$47.68	$23.84	$71.52
EMPLOYEE & CHILD(REN)	$29.05	$29.05	$14.52	$43.58	$47.68	$47.68	$23.84	$71.52
FAMILY	$29.05	$29.05	$14.52	$43.58	$47.68	$47.68	$23.84	$71.52

To locate participating dental providers, visit **www.cigna.com**.

VISION CARE PLAN

ABOUT THE VISION CARE PLAN

With the [[Client Name]] Vision Care Plan, administered by Davis Vision, you may receive services from in-network or out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if
you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.

LOCATE PARTICIPATING PROVIDERS OR TO REQUEST A CLAIM FORM

Visit the Davis Vision website at **www.davisvision.com** or call **1.800.999.5431**.

BENEFIT DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK
EXAM	No Charge	$40 Reimbursement
FRAMES	NON-DAVIS COLLECTION FRAMES: Up to $130 allowance (plus 20% discount off overage) VISIONWORKS FRAMES AT VISIONWORKS LOCATIONS NATIONWIDE: Up to a $150 allowance (plus 20% discount off overage)	$50 Reimbursement
LENSES Single Vision Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses	No Charge	 $40 Reimbursement $60 Reimbursement $80 Reimbursement $100 Reimbursement
CONTACT LENSES (IN LIEU OF EYEGLASSES)	DAVIS COLLECTION (DAILY, SPECIALTY, AND DISPOSABLE) No Charge NON-DAVIS COLLECTION Contacts: Up to $130 allowance Evaluation: Up to $60 allowance (plus 15% discount off overage)	$80 Reimbursement
FREQUENCY Vision Exam / Lenses / Frames	Once per calendar year	Once per calendar year

MONTHLY CONTRIBUTIONS	FULL-TIME EMPLOYEES		PART-TIME EMPLOYEES	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
EMPLOYEE	$2.16	$2.17	$1.08	$3.25
EMPLOYEE & SPOUSE	$4.99	$4.99	$2.49	$7.49
EMPLOYEE & CHILD(REN)	$4.99	$4.99	$2.49	$7.49
FAMILY	$4.99	$4.99	$2.49	$7.49

FLEXIBLE SPENDING ACCOUNTS

TRANSIT ACCOUNT

The Transit benefit allows you to set aside up to $270 per month (on a pre-tax basis) that can be used for qualified transit to commute to and from work, such as: mass transit, train, subway, bus fares, and ferry rides. You have until the 5th of the month to make a change to your transit election, and it will become effective the following month.

You'll receive a debit card that can used to pay for transit expenses; however, please note that your contribution must be deducted from your paycheck before the funds are loaded onto your card.

HEALTHCARE FSA

Your Healthcare Flexible Spending Account (FSA) funds can be used to pay for out-of-pocket healthcare expenses incurred by you and your dependents. Eligible expenses include office visit copays, non-cosmetic dental procedures, prescription drugs, eyewear, LASIK eye surgery and more. **The maximum you can contribute to the Healthcare FSA is $2,750.**

DEPENDENT CARE FSA

The Dependent Care FSA is used for expenses related to the care of eligible dependents. Eligible expenses include Au Pair, baby-sitting or dependent care to allow you to work or actively seek employment, day camps, preschool or after school programs, and adult/eldercare for adult dependents.

The maximum that you can contribute to the Dependent Care FSA is $5,000 if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is $2,500.

USE IT OR LOSE IT

The FSA plan year runs from January 1, 2023 to December 31, 2023. You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period. If you do not use the money you contributed, you will only be able to carry over up to $500 in to the 2024 plan year. Amounts over $500 will be forfeited.

IMPORTANT

If you elect the Health Saving Account (HSA), you may not participate in the Healthcare FSA. However, you may elect up to $2,750 in a Limited Purpose FSA, which can be used for out-of-pocket dental and vision expenses only.

SHORT & LONG TERM DISABILITY BENEFITS

SHORT-TERM DISABILITY

[[Client Name]] provides employees the option to purchase Short-Term Disability (STD) insurance through Lincoln Financial Group. STD coverage protects a portion of your income in the event you are incapable of working due to a qualified illness or injury. This plan is available to [[Client Name]] regular full-time employees.

BENEFIT/PROVISION	STANDARD	ENHANCED
PERCENTAGE OF INCOME REPLACED	60%	60%
MAXIMUM BENEFIT PER WEEK	$2,700	$2,700
DURATION	90 days	90 days
ELIMINATION PERIOD	30 days	14 days

LONG-TERM DISABILITY

All active, regular full-time employees are eligible for the Lincoln Financial Group Long-Term Disability (LTD) plan. **This plan is available to employees at no cost – [[Client Name]] pays 100% of the LTD premium.**

BENEFIT/PROVISION	
PERCENTAGE OF INCOME REPLACED	60%
MINIMUM BENEFIT PER MONTH	$100
MAXIMUM BENEFIT PER MONTH	$20,000
ELIMINATION PERIOD	90 days

LIFE AND AD&D INSURANCE

BASIC LIFE AND AD&D

[[Client Name]] provides 100% employer paid basic life and AD&D coverage for each full-time employee offered through The Lincoln Financial Group. For your specific amount, please contact your Human Resources administrator.

GUARANTEED ISSUE AMOUNTS

During the new hire process, you will be able to elect a certain amount of coverage without Evidence of Insurability (EOI). **If you choose to not enroll in Supplemental Term Life Insurance now, you may be required to submit EOI at a later time.** The coverage amounts can found below per coverage.

SUPPLEMENTAL EMPLOYEE LIFE AND AD&D INSURANCE COVERAGE

All benefit-eligible employees working at least 30 hours per week have the option to purchase supplemental life insurance coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions.

You can purchase the following amounts of coverage:

SUPPLEMENTAL EMPLOYEE TERM LIFE INSURANCE	
BENEFIT INCREMENTS	$1,000
MAXIMUM AMOUNT	1x-4x annual earnings up to $2,500,000
GUARANTEED ISSUE AMOUNT	$1,000,000

SUPPLEMENTAL SPOUSAL TERM LIFE INSURANCE	
BENEFIT INCREMENTS	$10,000
MAXIMUM AMOUNT	$150,000
GUARANTEED ISSUE AMOUNT	$30,000

SUPPLEMENTAL CHILD(REN) TERM LIFE INSURANCE	
BENEFIT INCREMENTS	$5,000
MAXIMUM AMOUNT (birth to age 26)	$10,000

MASS MUTUAL WHOLE LIFE

[[Client Name]] is happy to offer whole life insurance through Mass Mutual. This offering provides coverage at a set premium, builds cash value over time, and allows you to borrow from the cash fund if needed. Additionally, the plan pays a death benefit to your loved ones.

ENROLLMENT INFORMATION

During the new hire process, you will be able to elect a certain amount of coverage without Evidence of Insurability (EOI). If you choose to not enroll in Whole Life Insurance now, you may be required to submit EOI at a later time. The coverage amounts can be found below:

ELIGIBILITY

Employees residing in the United States., Ages 18-75

BENEFIT AMOUNTS

Minimum: $10,000 (increments of $5,000) up to:

- Guaranteed issue: Maximum* $100,000
- Express Issue Maximum: $250,000 per enrollment

* The Guaranteed Issue maximum contains amounts from all certificates

CONSIDER THE ADVANTAGES

PROVIDES GUARANTEES WHICH INCLUDE

- Death Benefit
- Level Premiums
- Cash-value accumulation

DIVIDEND ELIGIBLE INCLUDING

- Cash
- Dividend Accumulations
- Paid-up additional insurance

PORTABLE, LIFELONG COVERAGE

- Ownership of the policy, along with accumulated cash values and can take it with you if you ever leave the company.
- Additionally, if you leave the you can change your dividend option and have your dividend payments reduce your premium!

TAX ADVANTAGES

- Generally, income-tax-free death benefit
- Tax deferred cash-value growth

TERMINAL ILLNESS PROVISION

- Receive an advance, or acceleration, of a portion of your death benefit if diagnosed with a terminal illness expected to result in death within 12 months.

WHOLE LIFE RATES

Rates are based on the amount of coverage selected, and your age. The Benefit Express enrollment system will calculate your rate based on your election.

[[CLIENT NAME]] RETIREMENT PLAN

DEFINED CONTRIBUTION 403(B)

[[Client Name]]'s retirement plan is a defined contribution 403(b) and Roth 403(b) program and provides for employee contributions and contributions.

ELIGIBILITY TO PARTICIPATE IN THE PLAN

All employees are eligible to defer pre-tax dollars out of their pay into the plan except for student employees, co-op positions, temporary, casual and per diem employees.

ELIGIBILITY TO RECEIVE CONTRIBUTIONS

Once enrolled in the plan, full-time, benefit-eligible faculty and professional staff are eligible for contributions in their first available pay. Part-time employees become eligible the first of the month following completion of 1,000 hours worked within a year. All eligible employees must be an active participant in the plan in order to receive contributions in either circumstance

Adjunct and Union employees may participate in the plan with their own contributions. They are not eligible for contributions.

IMPORTANT ITEMS TO NOTE FOR 2023

- The 2023 limit for your contribution is $19,500. This is an IRS limit and not that of [[Client Name]].
- If you are 50 or older, you may contribute up to an additional $6,500 in 2023.

HOW TO ENROLL

To enroll in or make any changes to your 403(b) plan (this includes increasing or decreasing the contributions), follow these steps:

- Log in to [[Client Name]]One, select the Employee Tab.
  Then select the 403b Plan Management link under the Benefits Administration header and follow the instructions provided.
- When enrolling, please note that you will need to know the percentage that you want to contribute. Changes can be made to the retirement plan on a month to month basis, if desired. The system will advise when the deduction will be effective.

Full-time Faculty and Professional Staff who do not elect into the 403(b) Plan within 31 days of their hire date will be automatically enrolled with our default vendor, TIAA, at a 2 percent per pay contribution rate. If you do not wish to participate, you must actively waive participation in the retirement plan. To ensure that you are not defaulted, please be sure to enroll within your 31-day enrollment window that coincides with your Health Benefits Enrollment.

EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE CONNECT℠

Employees have access to confidential support for life's challenges through EmployeeConnect℠, and employee assistance program offered through Lincoln Financial Group and powered by ComPsych. EmployeeConnect gives you unlimited 24/7 access to licensed professional counselors to help you with personal, family and work/life issues.

You can access the following services anytime, online or with a toll-free call:

- Information, resources, and referrals on family matters, such as child and elder care; kennels and pet care; event and vacation planning; moving and relocation; car buying; college planning; and more
- Legal information and referrals for situations requiring expertise in family law, estate planning, landlord/tenant relations, consumer and civil law, and more
- Financial guidance, including household budgeting, and short and long-term planning
- In-person help for short-term issues (up to five sessions with per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and subsequent meetings at a reduced fee

Visit **www.GuidanceResources.com** (user name = LFGsupport; password = LFGsupport1). Or talk with a specialist at **888.628.4824**.

PERSONAL TIME OFF

[[Client Name]] is happy to offer a competitive personal time package consisting of vacation, sick and holiday time for its employees. See below for more information or visit **www.samplebenefitsportal.com**.

	FULL TIME EXEMPT	NON-EXEMPT	PART-TIME
VACATION	At Hire: 13.34 hours per monthly pay period or 20 days per year.	0-5 years of service: 4.62 hours per bi-weekly pay period or 15 days per year.	Pro-rated based on the number of hours per week the Professional Staff Member is regularly scheduled to work in relation to the standard 40 hour work week.
SICK TIME	One sick leave day per month up to a maximum of 12 sick days per year. Accrual of sick leave for part-time Professional Staff Members is pro-rated based on the number of hours per week the Professional Staff Member is regularly scheduled to work in relation to the standard 40-hour workweek.	Non-exempt full time accrue 3.70 hours per biweekly pay with maximum of 12 sick days per year.	A minimum of one (1) hour of sick time shall accrue for every forty (40) hours worked. Individuals shall not accrue more than forty (40) hours of sick time in a rolling 12-month period. If the individual has worked at least 6 months they will be credited forty (40) hours of sick leave, but cannot use it unless the time has been earned based on hours worked.
HOLIDAYS	Benefit eligible, professional staff are eligible for recognized Holidays according to their schedule.	Benefit eligible, professional staff are eligible for recognized Holidays according to their schedule.	Benefit eligible, professional staff are eligible for recognized Holidays according to their schedule which is prorated for part-timers.
FLOATING HOLIDAYS	Professional Staff Members qualify for sixteen (16) hours of Floating Holiday leave each fiscal year.	Professional Staff Members qualify for sixteen (16) hours of Floating Holiday leave each fiscal year.	Floating Holiday Leave hours for Part-time Professional Staff Members are pro-rated based on the number of hours per week the Professional Staff Member is regularly scheduled to work in relation to the standard 40 hour work week.

BENEFITS CONTACTS & RESOURCES

BENEFITS / RESOURCES	PROVIDER NAME	PHONE NUMBER	CONTACT INFORMATION
MANAGE BENEFITS / FLEXIBLE SPENDING ACCOUNTS	Benefit Express	1.844.690.3992	Sign in through the Benefits link on the Employees tab in www.samplebenefitsportal.com / Email: help@mybenefitexpress.com
MEDICAL	Independence Blue Cross	1.800.ASK.BLUE	ibx.com
PRESCRIPTION DRUG	OptumRx	1.855.796.3480	optumrx.com
DENTAL	Cigna	1.800.244.6224	my.cigna.com
VISION	Davis Vision	1.800.999.5431	www.davisvision.com
HEALTH SAVINGS ACCOUNT	Optum Bank	1.866.234.8913	optumbank.com
WELLNESS AND ADVOCACY	Health Advocate	1.866.695.8622	members.healthadvocate.com
EVIDENCE OF INSURABILITY	Lincoln Financial Group	1.888.287.8494, option 2	www.lfg.com/public/individual
LIFE INSURANCE CLAIMS	Lincoln Financial Group	1.888.787.2129	www.lfg.com/public/individual
LIFE INSURANCE CONVERSION	Lincoln Financial Group	1.800.423.2765, option 1	www.lfg.com/public/individual
LIFE INSURANCE PORTABILITY	Lincoln Financial Group	1.888.786.2688	www.lfg.com/public/individual
FMLA ADMINISTRATION / DISABILITY	Lincoln Financial Group	1.888.786.2688	www.lfg.com/public/individual
WHOLE LIFE INSURANCE	Mass Mutual	1.844.975.7522	www.massmutual.com
VOLUNTARY BENEFITS	CoreStream	1.888.935.9595	[[Client Name]]voluntarybenefits.com

Visit **www.samplebenefitsportal.com** for a full list of benefit providers and resources.

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Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [[Client Name]] may use aggregate information it collects to design a program based on identified health risks in the workplace, [[Client Name]] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) your Primary Care Physician, Health Advocate health coaches, etc. in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

Health Care Reform
Please note: our medical plans are considered compliant with the Patient Protection and Affordable Care Act. There are no annual limits, dependent children can be covered to age 26 and in-network preventive care is covered at 100%. Due to Health Care Reform modifications, Women's Preventive Health Services are now covered in-network at 100%.

As new Health Care Reform requirements become effective, our plans will be modified accordingly. We are fully committed to complying with all regulations and intend to notify you as soon as possible of any change(s).

Patient Protection Model Disclosure
The Independence Blue Cross Keystone POS plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If you do not designate a primary care provider, one will not be designated for you. Independence Blue Cross will send you a letter, reminding you that you still need to designate a primary care provider.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Independence Blue Cross at 215-241-2273 (PA & NJ) or 800-313-8754 (DE).

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Independence Blue Cross or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Independence Blue Cross at 215-241-2273 (PA & NJ) or 800-313-8754 (DE).

Notice of Dependent Status Verification / Eligibility Audit
The reserves the right to request documentation to substantiate that your dependents are eligible to participate in the benefit

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plans. At any time, a Dependent Eligibility Audit could be conducted, where all or a random sample of employees will be asked to provide verification of their dependent's status. If you choose to cover a dependent on our benefit plans, please be prepared to provide the necessary documents to prove dependent status and eligibility, if needed.

Notice Regarding Special Enrollment

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage. Coverage will be effective the first of the month following your request for enrollment.

Loss of coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact the Benefit Service Center at 1-888-971-0101.

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, please speak with Human Resources.

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Notice of Coverage for Newborns and Mothers
Group health plans and health insurance issuers generally 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 a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or 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 issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

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IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program
(KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 1-800-852-3345, ext 5218

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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

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SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

Notice Regarding Wellness Program
A Healthier U is [[Client Name]]'s voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Employees who choose to participate in [[Client Name]]'s wellness program will receive an annual incentive of $400. In order to receive this incentive, an employee must accumulate 400 points. Points are earned by completing specific activities in the Health Advocate portal (e.g. HRA, biometrics, online workshops, challenges).

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching through Health Advocate. You also are encouraged to share your results or concerns with your own doctor.

This benefit guide provides selected highlights of the employee benefits program at [[Client Name]]. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at [[Client Name]]. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. [[Client Name]] reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.