2023

EMPLOYEE BENEFITS GUIDE

[[Client Name]] offers you and your eligible family members a comprehensive and valuable benefits program. This guide has been developed to assist you in learning about your benefit options and how to enroll.

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

INSERT LOGO

Welcome

TO [[CLIENT NAME]]!

INSIDE THIS GUIDE

Questions?

If you have questions about your benefits, please contact our BeneService Member Advocacy Team at **800.563.9929** (Monday through Friday, 8:30 am to 5:00 pm ET) or go to **www.connerstrong.com/beneservice**

What You Need to Know Before Enrolling in Benefits

When Does Coverage Begin?

Coverage will be effective the first of the month following 30 days of employment, provided you complete your enrollment within 45 days of your hire date.

Who is Eligible to Elect Benefits?

If you are a benefits-eligible employee (regular full-time employee scheduled to work a minimum of 30 hours per week), you can enroll in the benefits described in this Guide. Please remember that only eligible dependents can be enrolled. Eligible dependents include: an employee's spouse or civil union partner; if under the age of 26, a natural child, adopted child, foster child, stepchild or grandchild (if court-ordered custody); or a disabled dependent.

Medical, Dental and Vision coverage is available for employees with same-sex domestic partnerships in states that do not recognize civil union partnerships. However, the domestic partnership must be legally recognized by the state and the employee would need to present a certificate to certify such. Opposite-sex domestic partnerships are not covered.

Required Documentation

[[Client Name]] requires documentation of dependent status. Please contact Human Resources for a list of acceptable documentation and provide the appropriate copies to [[Client Name]] within 45 days of your date of hire.

You may send your documentation to:

[[Client Name]]
Attn: HR Department
Fax: 856.123.4567
Email: enrollments@[[Client Name]].com

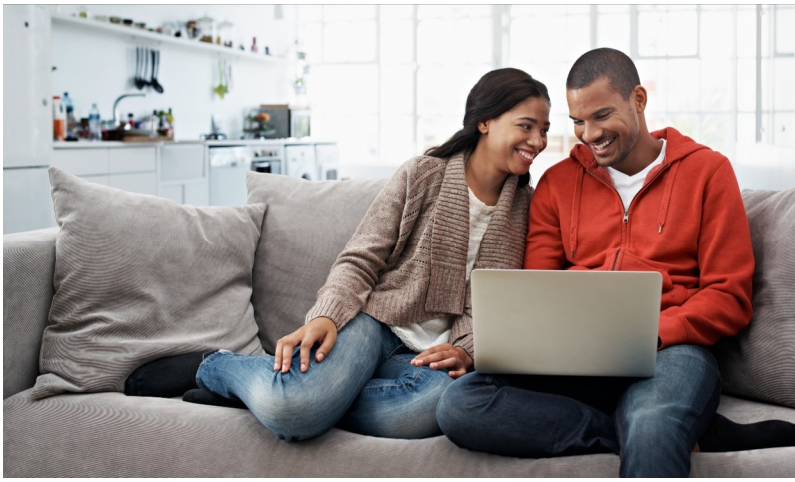
Enrollment Timeline

You MUST enroll online through our enrollment system *benefits*CONNECT. Instructions for accessing *benefits*CONNECT can be found on page 5 of this guide.

You will have 45 days from your date of hire to log on and complete your benefits enrollment.
If you do not enroll within this timeframe, you will not be able to enroll until our next open enrollment, unless you experience a qualifying life event.

Qualifying Life Events

IRS Section 125 prohibits you from changing your enrollment during the plan year unless you experience a qualifying life event, such as: marriage, divorce, death of a spouse, civil union partner or a dependent, birth or adoption of a child, termination or commencement of employment for your spouse/civil union partner, a change in employment status (full-time to part-time or part-time to full-time) for you or your spouse/civil union partner that affects benefits eligibility, or taking an unpaid, medical leave of absence by either you or your spouse/civil union partner.



BeneService

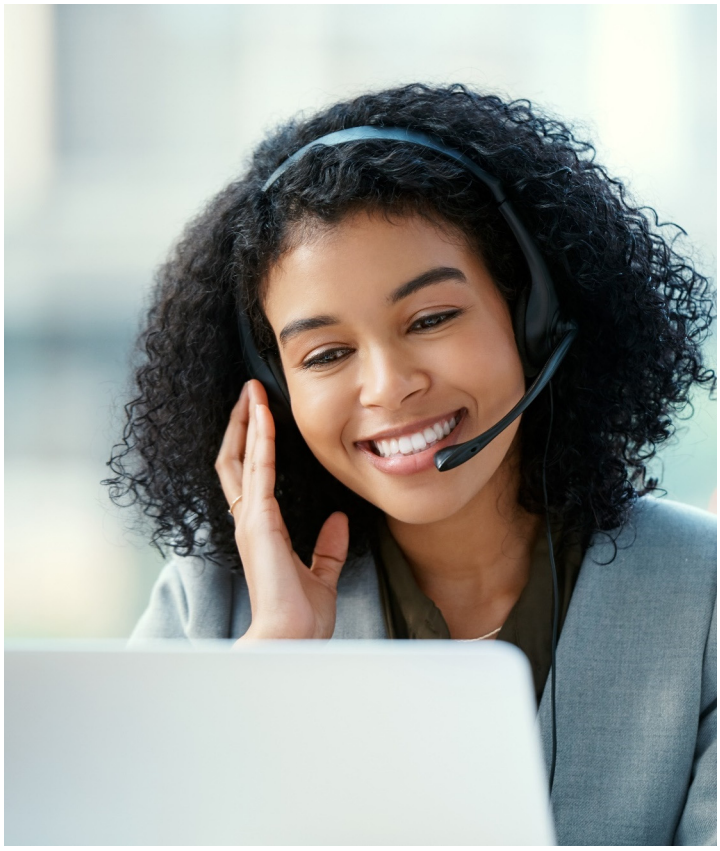
YOUR MEMBER ADVOCACY TEAM

Employee benefits can be complex making it difficult to fully understand your coverage and use it properly. BeneService allows you to speak to a specially trained Client Service Associate who can answer your questions and help you get the most out of your benefits.

You Can Contact BeneService for Assistance if You:

- Believe your claim was not paid properly
- Need clarification on information from the insurance company
- Have a question regarding a bill from a doctor, lab or hospital
- Are unclear on how your benefits work
- Need information about adding or deleting a dependent
- Need help to resolve a problem you've been working on

Client Service Associates are available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.



How to Contact BeneService?

You may contact the BeneService Team in any of the following ways:

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Via the web: **www.connerstrong.com/beneservice**
- Via fax: **856.685.2253**

Online Tools

BENEPORTAL & BENEFITS CONNECT

BenePortal

ONLINE BENEFITS INFORMATION

At [[Client Name]], you have access to a full-range of valuable employee benefit programs. With BenePortal, you are able to review your current employee benefit plan options online, 24 hours a day, 7 days a week!

By using BenePortal, our online tool that houses our benefit program information, you can:

- Review medical/prescription drug, vision, and dental plan options
- Explore additional voluntary employee benefit programs available to you
- Find links to insurance carrier websites
- Download plan documents, affidavits, etc.

Simply go to **www.samplebenefitsportal.com** to access your benefits information today!

*benefits*CONNECT

ONLINE ENROLLMENT SYSTEM

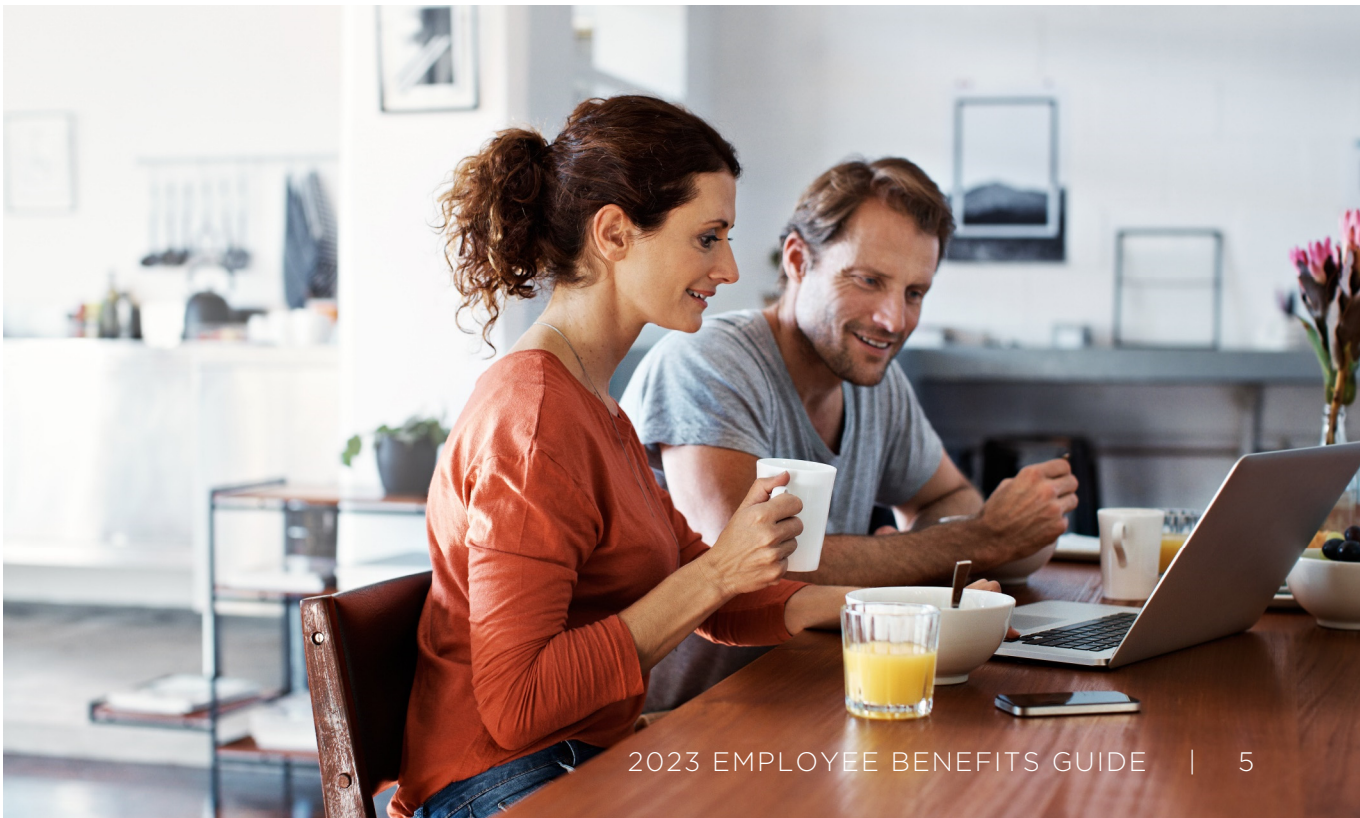
When you are ready to enroll in or make changes to your benefits, you MUST enroll online through our online enrollment system, *benefits*CONNECT.

Before you begin, make sure you have your **Social Security Number**. If you are changing or enrolling your dependents, make sure you also have their **birth dates** and **Social Security Numbers**.

A link to *benefits*CONNECT will be available on BenePortal. Your username for *benefits*CONNECT is (up to) **the first 6 letters of your last name**, followed by the **first letter of your first name**, followed by your **month and date of birth in mmdd format**. Your initial password is your **Social Security number**.

For example: Jane Dovebar (Social Security number is 123-45-6789 and date of birth 12/10/1969) would enter the following:

Username: dovebaj1210
Password: 123456789



Medical Benefits

CIGNA

Eligible employees have the option of enrolling in the Cigna Medical Plan. Plan details and employee contributions for the 2023/2024 plan year are outlined below.

	OA POS Elite Plan	OA POS High Plan	OA POS Mid Plan	HSA-Qualified HDHP
IN-NETWORK BENEFITS				
Deductible Individual/Family	None	$250/$500	$500/$1,000	$1,350/$2,700**
Firm HSA Funding Individual/Family	N/A	N/A	N/A	$650/$1,300
Out-of-Pocket Maximum Individual/Family	$2,500/$5,000	$3,000/$6,000	$4,000/$8,000	$6,550/$13,100***
Preventive Care Services	Covered 100%	Covered 100%	Covered 100%	Covered 100%
PCP Office Visit	$15 copay	$30 copay	Plan pays 80%*	Plan pays 80%*
Specialist Office Visit	$30 copay	$60 copay	Plan pays 80%*	Plan pays 80%*
Diagnostic Laboratory	Covered 100%	Plan pays 90%	Plan pays 80%*	Plan pays 80%*
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	$100 copay	$100 copay	Plan pays 80%*	Plan pays 80%*
Emergency Room	$150 copay	$150 copay	Plan pays 80%*	Plan pays 80%*
Urgent Care Center	$50	$50	Plan pays 80%*	Plan pays 80%*
Inpatient Hospital	$250 copay per admission	Plan pays 90%*	Plan pays 80%*	Plan pays 80%*
Outpatient Surgery	Covered 100%	Plan pays 90% *	Plan pays 80%*	Plan pays 80%*
OUT-OF-NETWORK BENEFITS (SUBJECT TO BALANCE BILLING)				
Deductible Individual/Family	$500/$1,500	$1,500/$3,000	$2,500/$5,000	$3,000/$6,000**
Out-of-Pocket Maximum Individual/Family	$5,000/$15,000	$5,000/$15,000	$10,000/$20,000	$6,550/$13,100
Coinsurance	Plan pays 70%*	Plan pays 70%*	Plan pays 60%*	Plan pays 50%*

* After deductible

** Full Family Deductible: The family deductible must be met if employee covers self and one or more dependent.

*** Once any one individual meets the individual out-of-pocket maximum, their expenses are covered at 100% for the balance of the plan year, all other family members must collectively meet the family out-of-pocket maximum before the plan pays 100%.

Prescription Benefits

CIGNA

If you are enrolled in one of the medical plans, you are automatically enrolled in the corresponding prescription drug plan through Cigna.

	OA POS Elite, High, & Mid Plans	HSA-Qualified HDHP
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)		
Generic	$20 copay	Plan pays 80%*
Preferred Brand	$40 copay	Plan pays 80%*
Non-Preferred Brand	$60 copay	Plan pays 80%*
MAIL ORDER PHARMACY (UP TO A 90-DAY SUPPLY)		
Generic	$40 copay	Plan pays 80%*
Preferred Brand	$80 copay	Plan pays 80%*
Non-Preferred Brand	$120 copay	Plan pays 80%*

* After medical deductible

Cigna 90-Day Prescription for Maintenance Medications

Maintenance medications must be filled in a 90 day supply at a retail pharmacy or Home Delivery pharmacy to be covered under your plan. Maintenance medications are those medications that are taken regularly, over time, to treat an ongoing health condition, such as diabetes, high blood pressure, cholesterol or asthma.

Effective July 1, 2023, you will be able to receive three 30 day fills before your maintenance medication is not covered. **If you haven't switched to a 90-day supply after three fills, your plan won't cover the cost of the medication.**

Having a 90-day supply of your medication on-hand typically means you're less likely to miss a dose.

Where you can fill a 90-day prescription
Your plan also offers a new retail pharmacy network that gives you more choice in where you can fill your 90-day prescriptions. There are thousands of retail pharmacies in the network.

For more information about your new pharmacy network, you can go to www.Cigna.com/Rx90network.

Save on your prescriptions with Mail Order: Cigna Home Delivery Pharmacy

When you use the Cigna Home Delivery Pharmacy to fill your maintenance drug prescriptions, you will receive a 90-day (3-month) supply for two retail copays. In addition to the savings, your prescriptions will be delivered right to your home.

To learn more about using mail order, simply visit www.cigna.com.

Health Savings Account (HSA)

FLEXFACTS

If you participate in the HSA-Qualified HDHP, you may be eligible to participate in a Health Savings Account (HSA). An HSA is a tax-exempt savings account that can be used for contributions, earnings and withdrawals for eligible expenses.

HSA Highlights

- An HSA is portable, meaning that if you leave your employer, you can take your HSA funds with you.
- There is no “use it or lose it” provision with an HSA. If you don’t use the money in your account by the end of the year, it just stays there and collects interest on a tax-deferred basis.
- An HSA includes a banking partner that offers you several investment options that suit your needs.
- An HSA does not require third party substantiation for transactions; however, you should keep records of these transactions in the event of an IRS audit.

HSA Eligibility

You may contribute to an HSA if you:

- Are covered under an HSA Qualified high deductible health plan (HDHP)
- Do not have disqualifying coverage such as other "first dollar" medical coverage etc.
- Are not entitled to (eligible and enrolled) Medicare
- Cannot be claimed as a dependent on someone else's tax return

HSA Eligible Expenses Include:

- Medical and prescription drug deductibles, coinsurance and copayments
- Dental deductibles, coinsurance and copayments
- Orthodontia or other dental care
- Eye exams, contact lenses and glasses

HSA Contributions

The maximum amount that can be contributed to an HSA in a tax year is established by the IRS and is dependent on whether you have single or family coverage in the HDHP plan. For 2023, the contribution limits are: **$3,450** for individual coverage and **$6,900** for family coverage. This annual maximum includes funds contributed by the Firm as well as funds contributed by the employee. The annual catch-up contribution for age 55 and older is $1,000 per month.

If you elect the HSA Qualified HDHP for the new plan year, the Firm will contribute **$650** into your HSA if enrolled as Single or **$1,300** if enrolled as a Family. The Firm funded amount will be available with the first pay of the new plan year.

Employees electing the HSA July 1, 2023 will have 90 days to submit Medical claims with dates of service up to June 30, 2018 if they participated in an FSA for the prior plan year. Any funds up to **$500** after the 90 day run out will need to rollover into a Limited Purpose FSA "LPFSA" for future use.

Getting Started is easy!

If you elect the HSA-Qualified HDHP for 2023 and wish to participate in the HSA, you need to make your election via the ADP enrollment site. If you are turning 65 or older, please see medicare.gov for restrictions on HSA accounts.

Reminder!

Employees in the HDHP may also participate in a Limited Purpose FSA (LPFSA). Funds available in a LPFSA can be used only for eligible dental and vision expenses. Additional information regarding the LPFSA can be found on page 14.

Vision Benefits

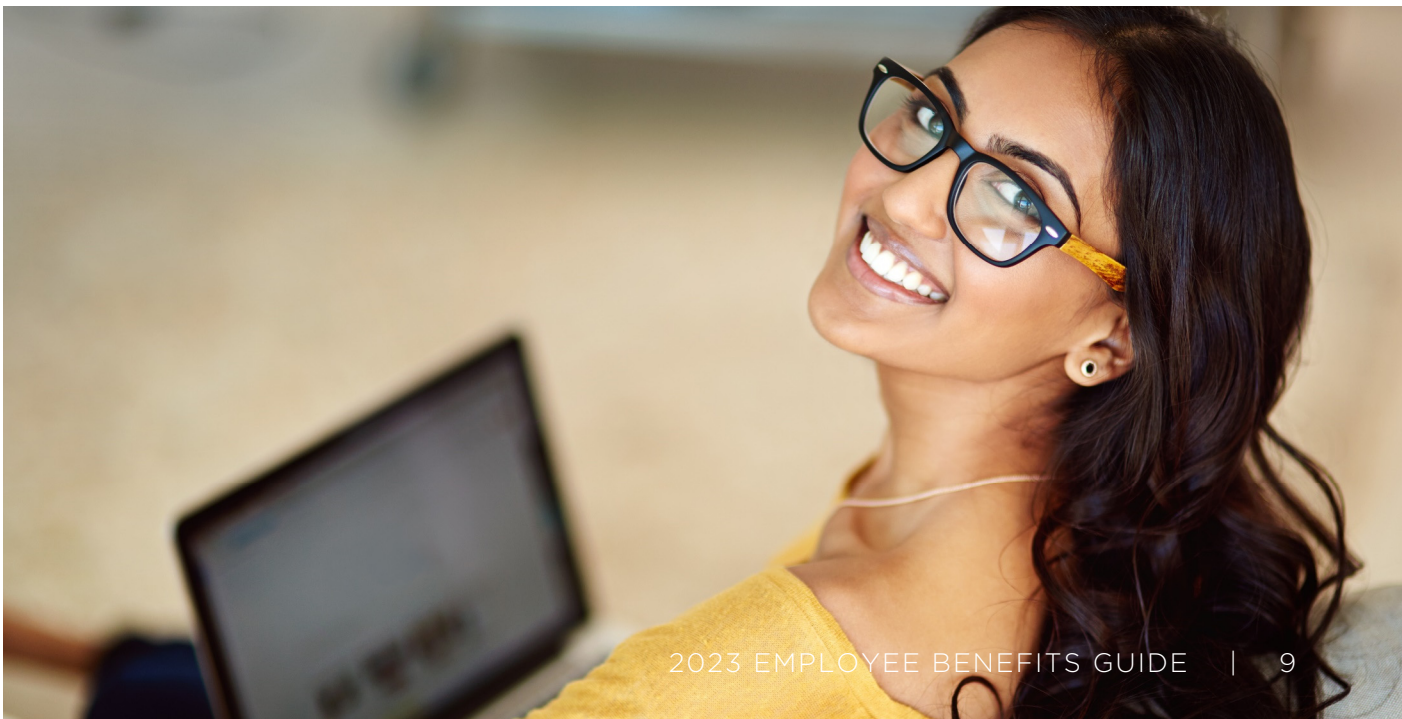
VSP

Eligible employees and their eligible family members may enroll in the VSP Vision plan.

VSP Vision Plan

	IN-NETWORK	OUT-OF-NETWORK
Exam	$20 copay	Reimbursed up to $45
Frames	$130 allowance, 20% off amount over your allowance	Reimbursed up to $47
Lenses • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses	Combined with Exam	Reimbursed up to $45 Reimbursed up to $65 Reimbursed up to $85
Contact Lenses (in lieu of eyeglasses)	$130 allowance	Reimbursed up to $105
Frequency • Vision Exam • Lenses • Frames	12 months 12 months 24 months	12 months 12 months 24 months

To find doctors in your neighborhood, visit www.vsp.com or call 800.877.7195.



Dental Benefits

CIGNA

Below is a summary of the dental plans available to you effective July 1, 2023.

	Core PPO		Buy-Up PPO	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible Individual/Family	$50/$150	$75/$225	$50/$150	$75/$225
Calendar Year Maximum (per patient)	$1,250		$2,250	
Preventive & Diagnostic Services • Exams • Cleanings • Bitewing X-rays (each twice in a calendar year) • Fluoride Treatment (once in a calendar year, children to age 19)	Covered 100%		Covered 100%	
Basic Services • Fillings, Extractions • Endodontics (root canal) • Periodontics, Oral Surgery • Sealants	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible
Major Services • Crowns • Gold Restorations • Bridgework • Full and Partial Dentures	Plan pays 60% after deductible	Plan pays 50% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible
Orthodontia Benefits (children age 19 and below)	Plan pays 50%		Plan pays 50%	
Orthodontia Lifetime Maximum (per patient)	$2,000		$2,000	

Life & Disability Benefits

SUNLIFE

LIFE, AD&D AND LONG-TERM DISABILITY INSURANCE IS 100% PAID BY [[CLIENT NAME]]

Life and AD&D Insurance

Life insurance is provided by [[Client Name]] to all full-time employees at **no cost to you**. In the event of a claim, your beneficiary will be entitled to receive a lump sum dollar amount from this policy. Your beneficiary is the person (or entity) you choose who will receive the death benefit from your policy in the event of a claim. If you do not have a beneficiary, your state's laws determine who receives the benefit. This benefit will reduce beginning at age 65 and will terminate at retirement.

For additional information related to the Life and AD&D policy, please refer to the Life & Disability benefit highlights included in this packet.

Long-Term Disability Insurance

Long-Term Disability insurance is provided by [[Client Name]] to all full-time employees at **no cost to you**. If you are disabled due to a non-work related illness or injury for more than 90 days, you may be eligible to receive a monthly benefit amount from this policy. The benefit can continue up to social security normal retirement age, subject to approval.

For additional information related to the Long-Term Disability policy, please refer to the Life & Disability benefit highlights included in this packet.

SHORT-TERM DISABILITY AND VOLUNTARY EMPLOYEE LIFE ARE 100% EMPLOYEE PAID

Short-Term Disability Insurance

APPLIES TO FULL-TIME STAFF & ASSOCIATES ONLY

- **Weekly Benefit Percent**: 60%
- **Maximum Weekly Benefit**: $1,000
- **Elimination Period** (day on which benefits will be payable for your disability): 1st day for Accidents & 8th day for Illness
- **Maximum Duration of Benefit** (subject to approval): 13 weeks (includes elimination period)

Voluntary Employee Life Insurance

APPLIES TO ALL FULL-TIME EMPLOYEES

- **Employee:** 3x Salary or $1,000,000 ($10,000 increments)
- **Spouse:** 50% of Employee Amount up to $100,000 ($5K increments)
- **Dependent Child(ren):** 15 Days to 19 (25 if full-time student) $10,000
- **Birth to 14 Days:** $500
- **Guaranteed Issue Amounts:** Employee: $100,000 or 3x Salary
  - Spouse: $30,000
  - Child(ren): $10,000
- **Benefit Reduction Schedule:** 65% at age 65; 40% at age 70.

Additional Voluntary Benefits

ALLSTATE

All Full-Time and Part-Time benefit eligible employees may choose to participate in any of the following benefits.

Universal Life Insurance

- Weekly Benefit Percent: 60%
- Maximum Weekly Benefit: $1,000
- Elimination Period (day on which benefits will be payable for your disability): 1st day for Accidents & 8th day for Illness
- Maximum Duration of Benefit (subject to approval): 13 weeks (includes elimination period)

Accident Insurance

- Weekly Plan pays lump sum dollar amount to you in the event of an accidental injury including accidental life insurance, hospitalization and ICU, ambulance services and other medical related expenses.
- Benefit pays $50 for each visit, by a covered insured, to any doctor visit outside of a hospital. Benefit pays a maximum of 2 times per year for individual coverage and a maximum of 4 times per year for individual/spouse, individual/child(ren) or family coverage.
- Individual, individual/spouse, individual/child(ren) and family coverage is available.

Short-Term Disability Insurance

- Plan offers income protection should you be disabled due to sickness, accident or maternity leave.
- Elect up to 60% of your gross monthly salary and choose an elimination and benefit period to meet your specific needs.
- All FULL-TIME and PART-TIME employees are eligible for voluntary short term disability through ALLSTATE.

The Allstate Cancer Insurance at [[Client Name]] **will be discontinued as of July 1, 2023**. Employees currently enrolled in the Allstate Cancer Insurance may keep the policy in place. No new enrollments will be accepted.

For additional information regarding the Allstate benefits, please contact the BenAware Call Center between June 13th and June 20th at **866.591.7328** Monday through Friday, 8:30am to 5:00pm EST.

Flexible Spending Account (FSA)

FLEXFACTS

A **Flexible Spending Account (FSA)** allows you to have money deducted from your pay on a pre-tax basis and put into an account that you can use to pay for eligible expenses. There are three types of accounts: **Medical**, **Dependent Day Care** and **Commuter (Parking & Transit)**.

Traditional Medical FSA

To participate in the FSA you must make an election before the beginning of the plan year via the ADP enrollment site. Your annual election is divided by the number of pays during the year and the funds are taken out of your pay on a pre-tax, semi-monthly basis over the course of the plan year.

The Plan is subject to the Use It or Lose It rules set forth by the IRS. However, the Firm allows you to rollover over $500 of unused Medical FSA funds from the current plan year to the new plan year, starting July 1, 2023. Any Medical FSA funds in excess of $500 remaining in your account after the "run out period" which ends September 30, 2023,will be lost. The "run out period" allows a participant to continue to submit receipts to FlexFacts to be reimbursed for expenses incurred during the 2018/2023 plan year.

Common expenses that are eligible include co-pays, deductibles, prescriptions, vision and dental expenses. The maximum you can elect for the 2023 calendar year is $2,650.

Employees enrolled in HSA cannot enroll in the Traditional Medical FSA.

A complete list of expenses eligible under the medical FSA is available at **www.flexfacts.com**. Click on the FSA Eligible Expense Table link at the bottom of the page and enter in Access Code “flex2023”.

Flexible Spending Account (FSA)

FLEXFACTS

Limited Purpose FSA

Available to HSA participants only. The IRS allows members who participate in a Health Savings Account to also elect a LPFSA. LPFSA participants may contribute up to $2,650 to be used for eligible dental and vision expenses only.

If you participated in the Traditional Medical FSA during the 2018/2023 plan year and you elect to participate in the HSA to coincide with enrollment in the NEW HSA-Qualified HDHP medical plan for the new plan year, unused funds up to $500 in that Traditional Medical FSA will be transferred to a LPFSA.

Dependent Day Care FSA

Common expenses that are eligible include; daycare facilities, after school programs, summer day camp, and in home babysitters. The maximum that you can elect is $5,000 per calendar year per family unit. If you are married filing separately the maximum is $2,500. Dependent children are covered under this account to the age of 13.

If you have unused funds in this account at the end of the plan year, you may still access those funds to pay expenses until September 30th, 2023. Unused funds will not roll over into the new plan year. Participants are still able to submit reciepts for reimbursement to FlexFacts for expenses incurred in the 2018/2023 plan year up until September 30th, 2023.

Parking and Transit Accounts

You can put money aside pre-tax to pay for transit and/or parking at or near your place of employment. The maximum amount you may contribute for parking and transit is $255 per month. Unused funds left in this account at the end of the plan year, will roll over into the new plan year.

Filing a Claim

The full annual election under your medical flexible spending account is available on the first day of the plan year. Dependent care funds are available as they are deducted from your pay.

The easiest way to use your funds is by using your **Flex Facts debit card** at the point of service. The card can be used at any medical or dependent care facility that accepts MasterCard. You can also use your card at most pharmacies. When you use your card, funds are automatically deducted from your account to pay for eligible expenses.

Please note that you should retain all of your receipts. The IRS requires that we request copies of receipts for certain claims. If you are required to send in receipts an e-mail or letter will be sent to you the business day after you use your card.

Contact Flex Facts

CALL: 877.94.FACTS (32287)
Monday - Thursday, 8:30AM to 8:30PM EST & Friday, 8:30AM to 5:30PM EST

EMAIL: support@flexfacts.com

FAX: 888.123.45678

MAIL: ABC Drive, Somewhere, NJ, 00000

Employee Assistance Program (EAP)

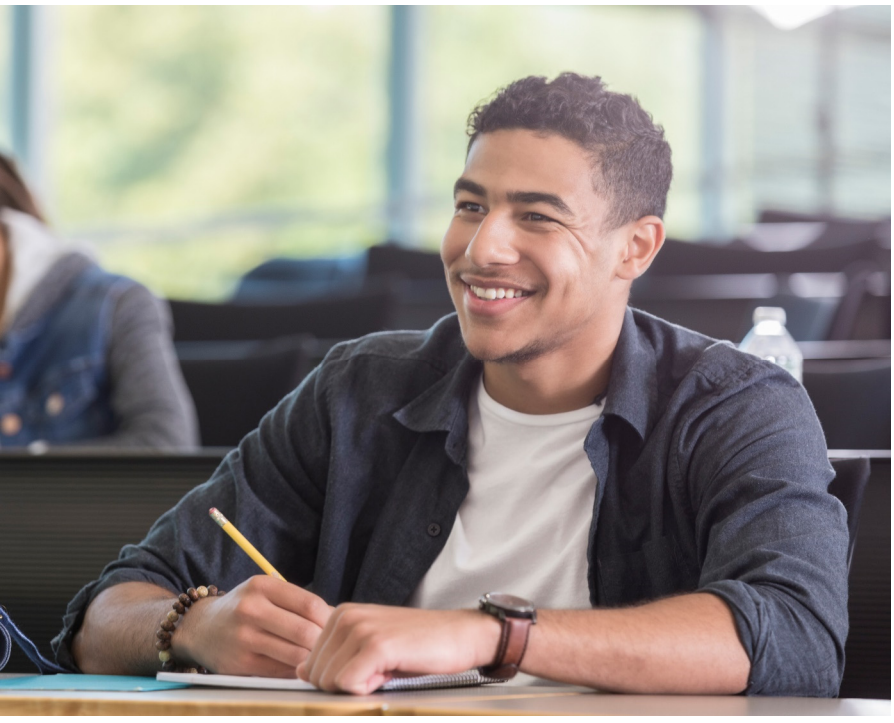
Life can be complicated at times and, sometimes, we all need a little support. Take advantage of the EAP—a free and 100% confidential service available to you and your family.

The Integrated Behavioral Health (IBH) Employee Assistance Program (EAP) is a confidential service that provides you and your family members with support services for a variety of issues associated with daily living. These services include:

- Unlimited telephonic consultations with an EAP Counselor
- Dynamic website featuring over 3,400 helpful resources, such as articles on topics like wellness, training courses, a legal and financial center, and more!
- Referrals to up to three sessions with local counselors—free of charge.

To Contact IBH

Call **800.395.1616** or visit **www.ibhcorp.com**.



The EAP can assist with topics such as:

Education

- Finding a preschool
- College planning
- Tutoring programs
- Financial aid resources

Dependent Care

- Adoption assistance
- Day care
- Special needs care
- In-home services
- Parenting classes
- Elder care

Lifestyle and Fitness Management

- Stress management
- Relationship issues
- Divorce and separation
- Health and wellbeing
- Grief and loss
- Career planning
- Retirement

Legal and Financial

- Budgeting
- Saving and investing
- Home buying
- Retirement planning
- Will making

Pet Care

- Grooming
- Training/behavior
- Boarding & in-home care

Legal Notices

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 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 after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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).

New dependent by marriage, birth, adoption, or placement for adoption
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 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Newborns' and Mothers' Health Protection Act

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).

Women's Health and Cancer Rights Act

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 benefits. If you have any questions, please speak with Human Resources.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 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)

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+ Website: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711

Legal Notices

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

IOWA – Medicaid
Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

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/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
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: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311

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

Legal Notices

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
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

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://health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 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

Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets our needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to https://www.healthcare.gov/marketplace/individual/.

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer Name [[Client Name]]		4. Employer Identification Number 00-0000000
5. Employer Address 123 Somewhere Street		6. Employer phone number (123)-456-7890
7. City Somewhere	8. State New Jersey	9. Zip Code 12345

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

[[Client Name]] reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. 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. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about your Guide, contact Human Resources.