36hlex

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It's Time to Enroll!

2026

New Hire Benefits Guide

You have 20 days to enroll in 36Phlex Benefits for 2026!

ENROLLMENT FORMS

The forms that you need to complete for enrollment are on the next few pages of this guide and on the **Contacts & Resources** page (https://www.seiu36.com/contacts-resources/) on our website. The forms on the site can be filled out online. You'll just need to print them out to sign them and then mail them to the Fund Office.

You can use the QR code above to go straight to our site. Just open the camera app on your smart phone or tablet and select the rear-facing camera. Point your camera at the code. A notification should pop up. Click it and you will go to our website. Remember to make sure that you are connected to the internet.

See the instructions at the top of each form to help you understand which forms you need to complete and mail back to the Fund Office.

IMPORTANT REMINDER: Please only fill out the forms that apply to you.

And be sure to review the rest of the Guide to help you with your enrollment for coverage in 2026. We have updated the Guide to make it easier to use this year.

Questions? Contact the Fund Office.

CURRENT OR NEW PARTICIPANTS/MEMBERS: If adding dependents to your coverage, you must complete the dependent enrollment form as well and provide the proper documentation of their dependent status to ensure their enrollment into the Plan.

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND
PHLEX PLAN ENROLLMENT FORM

1515 Market Street, Suite 1020, Philadelphia, PA 19102

IMPORTANT INSTRUCTIONS: You must complete both sides of this form if you are making changes to and/or updating your address, benefit or coverage level selections. Make sure you complete both sides, sign and date the authorization. If you are not making any changes and currently have a member deduction, you must complete all of Side B, including the authorization section.

Side A

Both sides of the form must be completed.

36Phlex Plan Enrollment Worksheet/Form

Participant Last Name	First	Middle Initial	Social Security #

Participant Address:	Street	Apt#	City	State	Zip Code

Date of Birth	Sex	Marital Status	Home Phone Number	Mobile Phone Number

Your 36Phlex Plan Options

Your coverage levels and benefit options are listed below. Circle each of your choices and write the number that appears under your selection in the column to the right on this form *(Phlex Points Used)*. Return the fully completed, signed and dated worksheet/form to the Benefit Fund Office. **Choose one selection from each benefit and only one coverage level for each benefit selected.**

	Coverage Level			
Benefit	Employee Only	Employee + 1	Family	***Phlex*Points Used**
1. Medical (includes Prescription Drug Benefits)				
High Option Plan	**90**	**90**	**90**	
Basic Plan	**85**	**81**	**78**	
Opt-Out: If you choose this option, complete the *Proof Of Other Coverage* form and return with this enrollment form	**50**	**50**	**50**	
2. Dental				
Dental Preferred Provider Plan (PPO)	**7**	**7**	**7**	
Opt-Out	**0**	**0**	**0**	
3. Vision				
Enhanced Vision Plan	**2**	**2**	**2**	
Discount Vision Program	**1**	**1**	**1**	
4. Life Insurance				
$10,000	**0**			
$25,000	**1**			
$50,000	**3**			

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND
PHLEX PLAN ENROLLMENT FORM *continued*

1515 Market Street, Suite 1020, Philadelphia, PA 19102

Side B

36Phlex Plan Enrollment Worksheet/Form

5. Total *Phlex*Points Used: (Add up the points used in items 1 through 4 from the front side.)

If your *Phlex*Point total (Line 5 above) is greater than 100, you must make a monthly contribution towards the cost of your benefits. Use the formula below to calculate the amount of your monthly contribution.

Line 5 Total	Minus 100	Times $5	Equals	Your Monthly Payroll Deduction For Benefits
	-100	X $5	=	$

If the number of points in Line 5 is less than 100, you have *Phlex*Points that you may deposit in one or both of the Reimbursement Accounts. For Benefit Year 2026, each *Phlex*Point is worth $5.

6. Reimbursement Accounts

	Number of *Phlex*Points to contribute	Amount (*Phlex*Points times $5)
Health Care Reimbursement Account		
*Dependent Care Reimbursement Account		

***Reimbursement capped at $2,500 unless you are married and filing a joint tax return.**

Authorization—Important!

My signature below indicates that I have read and understood this enrollment form and the descriptive materials made available to me by the SEIU Local 32 BJ, District 36 BOLR Welfare Fund. I request to arrange for the above coverage and direct my employer to deduct any required contributions from my pay. I understand that these elections will remain in effect unless I have a qualified change in family status or change my status during annual open enrollment. I certify that the information on this form is complete and accurate to the best of my knowledge. I understand that if this information changes in the future, I am obligated to notify the Fund Office within 31 days (or within 90 days for a change related to the birth of a child; or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP). Failure to do so may affect benefit coverage.

Should my employer refuse to deduct the amount as a pre-tax deduction, I understand that I will be responsible to remit the monthly amount to the Fund. Failure to remit the monthly amount will result in a reduction of the life insurance benefit.

Participant Signature **(PLEASE SIGN YOUR NAME HERE)** Date Signed

Last Four Digits of Your Social Security Number

IMPORTANT INSTRUCTIONS:
Complete this form and return it to the Fund Office if you are adding new dependents to your coverage. This form has two sides. **Remember to complete both sides and sign and date on the second page of this form.**

Side A

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
DEPENDENT ENROLLMENT FORM

Please complete the information requested on **both** sides of this form to add your spouse and/or child/children to the Plan. For your spouse, we need a copy of your state certified marriage certificate. For natural child/children or stepchild/stepchildren, please attach a copy of the certified birth certificate naming both parents. For adopted child or children, please supply adoption documentation. Additional documentation such as a Qualified Medical Child Support Order may be required. **To update your dependent's Primary Care Physician (PCP) information, call 800-275-2583 or go to www.ibx.com and login or register yourself to update a PCP and download a temporary ID card.**

Participant/Member's Name				Participant/Member's Social Security Number		
1. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	
2. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	
3. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
DEPENDENT ENROLLMENT FORM *continued*

Side B

For each dependent you have named, please let us know whether this dependent has coverage under another group health plan besides your group health plan with SEIU Local 32 BJ, District 36. **Print** yes or no in Column 2. If you wrote yes, please complete columns 3 through 7.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
Name of Covered dependent	Is this dependent covered under another group health plan?	Name of Subscriber or Policyholder	Relationship to Subscriber/ Policyholder	Name of Carrier or Health Plan	Group Number	Participant's Name

I certify that the information on both sides of this form is correct and acknowledge that if I, the Fund participant or my dependents willfully misuse or misrepresent any information about eligibility for any other group health coverage provided either through the course of their own employment or coverage provided from another source (i.e. parent, stepparent, or spouse's health coverage), the Fund has the right to terminate benefits for myself and my dependents. Furthermore, should my dependents acquire group health coverage through their own employment, that of a spouse parent or stepparent, I will immediately notify the Fund Office.

Signature: _____ Date: _____

IMPORTANT INSTRUCTIONS: Only complete this form and return it to the Fund Office if you are waiving Fund coverage for yourself.

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND

1515 Market Street, Suite 1020, Philadelphia, PA 19102

Proof of Other Coverage Form—Member

Complete This Form to Opt Out of Medical Coverage

In order to waive coverage, you must complete this form to provide proof that you have other medical coverage. **Note: If you opt out of coverage for yourself, your dependents will automatically waive their coverage as well.**

Please complete this form **ONLY IF** you elect to "Opt-Out" as your medical plan choice. Attach a copy of the identification card from your other insurance coverage. Please return this form, along with your Enrollment Form, to the Fund Office. Thank you for your cooperation.

If you are enrolling in the Health Reimbursement Account, you must provide proof that you are enrolled in other coverage (another group health plan) and proof that the other coverage is Minimum Value. A group health plan provides Minimum Value if the coverage has an actuarial value of at least 60 percent under the actuarial value of a standard plan as determined by the IRS. You must attach a copy of the ID card listing all the covered individuals and a copy of the other plan's Summary of Benefits and Coverage (SBC). If you do not provide this proof, you will be ineligible to receive any benefits from the Health Reimbursement Account. Please contact the Fund Office if you have difficulty obtaining this proof to determine what other proof of Minimum Value might be acceptable.

My Other Medical Coverage Is Provided Through:

Employer Name or Plan: _____

The insurance carrier is: (for example, Blue Cross/Blue Shield or HMO name):

_____

Opt Out of Health Reimbursement Account

If you are currently enrolled in a Healthcare Reimbursement Account (HRA), once per year you have the option to permanently opt out of the HRA and waive future reimbursements to the account. If you wish to opt out of the HRA, check the box below:

☐ I wish to permanently opt out of and waive all future reimbursements to the Healthcare Reimbursement Account (HRA). I understand that once I opt out, all amounts in my account will be forfeited from the effective date of the "Opt Out" election.

Your Authorization

By signing this form, I am rejecting the medical coverage offered under the SEIU Local 32BJ, District 36 BOLR Welfare Fund 36Phlex Plan for 2026 and certify that I have the medical coverage indicated above.

Your Signature: _____ Date: _____

Please print name: _____

Special Enrollment Rights

You may enroll for medical coverage during the year if you get married, acquire a new dependent, or lose your other medical coverage. To be eligible for this special enrollment, you must send a written request to the Fund Office within 31 days of the event (or 90 days from the birth of a child; or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP).

IMPORTANT INSTRUCTIONS: Only complete this form and return it to the Fund Office if you are waiving Fund coverage for your dependents.

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND

1515 Market Street, Suite 1020, Philadelphia, PA 19102

Proof of Other Coverage Form—Dependents

Complete This Form to Opt Out of Coverage for Dependents Only

In order to waive coverage for your dependent(s), you must complete this form and provide proof that the dependent(s) has/have coverage elsewhere.

Remember: If you opt out of coverage for yourself, your dependents will automatically waive their coverage as well. This form is for waiving coverage for your dependents only.

Attach a copy of the identification card from your other insurance coverage.

Please return this form to the Fund Office. Thank you for your cooperation.

Dependents' Coverage is Provided Through:

Employer Name or Plan: _____

Your Authorization

By signing this form, I am rejecting the coverage offered for my dependent(s) under the SEIU Local 32BJ, District 36 BOLR Welfare Fund for 2026 and certify that my dependent(s) has/have the coverage indicated above.

Please list the names and dates of birth of the dependent(s) you are disenrolling:

Dependent's Name: _____ Date of Birth: _____

Dependent's Name: _____ Date of Birth: _____

Dependent's Name: _____ Date of Birth: _____

Participant Signature: _____ Date: _____

Please print name: _____

Special Enrollment Rights

You may enroll for medical coverage during the year if you get married, acquire a new dependent, lose your other medical coverage, or experience another form of a qualified change of status. To be eligible for this special enrollment, you must send a written request along with appropriate documentation to the Fund Office within 31 days of the event (or 90 days from the birth of a child; or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP).

IMPORTANT INSTRUCTIONS: Only complete both sides of this form, sign and date both sides and return it to the Fund Office if you are new to the Plan or you are making changes to your information on file at the Fund Office.

Side A

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
DEMOGRAPHIC CENSUS FORM

PLEASE PRINT AND COMPLETE ALL INFORMATION ON BOTH SIDES OF THE FORM. WE MUST HAVE BOTH YOUR DEMOGRAPHIC INFORMATION AND BENEFICIARY INFORMATION COMPLETED, SIGNED, AND DATED. INCOMPLETE INFORMATION COULD CAUSE A DELAY IN PROCESSING YOUR CLAIMS.

Full Name (Last, First, MI)	Social Security Number	Date of Birth	Marital Status	Gender	Language

Street Address (include Apt # if applicable)	City	State	Zip Code	Primary Physician Name	Physician Address

Home Phone No. (include area code)	Cell No. (include area code)	Email Address

Name of Employer	Date of Hire	Union Start Date	Job Classification

Dependent Information (Last, First, MI) of each dependent	Social Security No.	Date of Birth	Gender	Relationship to participant (spouse, son, daughter)

Name of Other Insurance Carrier	Name of Insured	Policy/Group No.	Identification number

Insurance Carrier's Address	City	State	Zip Code	Phone No. (include area code)

Signature of Fund Participant	Date	
		☐ Yes, I would accept updates about my benefits via text ☐ No, Don't update me about my benefits via text

Side B

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
BENEFICIARY INFORMATION FORM *continued*

Your beneficiary may be any person or persons you choose to name. However, if you are married, there may be certain benefits payable only to your spouse, unless your spouse consents to a different designation in writing at the time of retirement. This beneficiary designation form will apply to any Death Benefits available from the various Funds. Proceeds are paid to contingent beneficiary(ies) only if there are no surviving primary beneficiary(ies). If multiple primary and contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. Please be sure to complete the form in full, sign and date the form. This form will be invalid unless you sign and date it certifying your designation.

Participant's Name	Social Security Number	Date of Birth	Name of Employer
Participant's Address	**City**	**State**	**Zip Code**

Primary Beneficiary(ies) Information (You can name up to four primary beneficiaries)

Beneficiary's Name	Address	Telephone No.	Relationship to Participant	Social Security No.	Benefit Percentage Must equal 100%

Contingent Beneficiary(ies) Information (Contingent beneficiaries will only receive a benefit if there are no surviving primary beneficiaries)

Beneficiary's Name	Address	Telephone No.	Relationship to Participant	Social Security No.	Benefit Percentage Must equal 100%

Please Print Participant's Name	Participant's Signature	Date

What's Inside

This Enrollment Guide is available in Albanian, Chinese, German, Italian, Polish, and Spanish on our website. Go to the "Documents & Forms" section of the "Contacts & Resources" page (https://www.seiu36.com/contacts-resources/). Please note that the forms are only available in English.

Ky udhëzues regjistrimi është i disponueshëm në gjuhën shqipe në faqen tonë të internetit. Shkoni te seksioni "Dokumentet dhe formularët" të faqes "Kontaktet dhe burimet" (https://www.seiu36.com/contacts-resources/). Ju lutemi vini re se formularët janë të disponueshëm vetëm në anglisht.

本注册指南可在我们的网站上找到中文版。转到"联系人和资源"页面的"文档和表格"部分 (https://www.seiu36.com/contacts-resources/)。 请注意，表格仅提供英文版本。

Dieser Leitfaden zur Einschreibung ist auf unserer Website in deutscher Sprache verfügbar. Gehen Sie zum Abschnitt „Dokumente & Formulare" der Seite „Kontakte & Ressourcen" (https://www.seiu36.com/contacts-resources/). Bitte beachten Sie, dass die Formulare nur auf Englisch verfügbar sind.

Questa guida all'iscrizione è disponibile in italiano sul nostro sito web. Vai alla sezione "Documenti e moduli" della pagina "Contatti e risorse" (https://www.seiu36.com/contacts-resources/). Tieni presente che i moduli sono disponibili solo in inglese.

Niniejszy Przewodnik Rekrutacyjny jest dostępny w języku polskim na naszej stronie internetowej. Przejdź do sekcji „Dokumenty i formularze" na stronie „Kontakty i zasoby" (https://www.seiu36.com/contacts-resources/). Należy pamiętać, że formularze są dostępne wyłącznie w języku angielskim.

Esta Guía de Inscripción está disponible en español en nuestro sitio web. Vaya a la sección "Documentos y formularios" de la página "Contactos y recursos" (https://www.seiu36.com/contacts-resources/). Tenga en cuenta que los formularios solo están disponibles en inglés.

Welcome to the SEIU Local 32BJ District 36 BOLR Welfare Fund

2026

Need a form? Check the front of this Guide–and on our website!

The forms that you need to complete for enrollment are on the first few pages of this guide and on the Contacts & Resources page (https://www.seiu36.com/contacts-resources/) on our website. The forms on the site can be filled out online. You'll just need to print them out to sign them and then mail them to the Fund Office.

Each form will tell you the conditions under which you should fill it out. Only complete the forms that apply to you. Tear each completed form on the perforated edge and mail to the Fund Office using the return envelope included in this guide.

In this guide and the accompanying materials, you will find the information, forms, and instructions that you need to enroll for Phlex benefits coverage in 2026.

Please review the enclosed materials carefully, and consider your family's needs before enrolling in coverage. The 36Phlex Plan gives you the flexibility to only enroll in what you need. For example, if your family already has medical coverage under your spouse's plan, you might use your 36Phlex benefits for dental and vision coverage. The choice is yours.

You must return your completed *36Phlex Plan Enrollment Worksheet/Form* (included in the front of this book) to the Fund Office no later than 20 days after you receive this enrollment packet.

What You Need to Do Now

After you've read this guide:

1. Complete both sides of your ***Demographic Census/Beneficiary Form***. If adding dependents to the plans, complete the Dependent Enrollment form. Proper documentation must be provided in order to enroll dependents.
2. Review your ***36Phlex Plan Enrollment Worksheet/Form*** to see your available options and PhlexPoint costs.
3. Review this Guide carefully. Consider which benefit options are best for you and your family.
4. Complete, sign, and date your ***36Phlex Plan Enrollment Worksheet/Form***. Be sure to choose a level of coverage for medical, dental, vision, and life insurance coverage.
5. You must have a PCP (primary care physician). You can choose one by contacting Independence Blue Cross at 800-ASK-BLUE (800-275-2583), or go online to ***www.ibx.com. You must select a PCP to minimize your out-of-pocket costs***.
6. If you are waiving medical coverage:
   - Complete and sign the ***Proof of Other Coverage Form***, and verify your other coverage with a copy of your medical ID card; and
   - Return all necessary forms in the enclosed reply envelope.
7. Complete the enclosed ***Social Security Data Match*** form, and supply a copy of your Social Security card. If adding dependents to the plan, you must also provide copies of their Social Security cards.

Note: If your forms are incomplete, they will be returned to you. If any of your forms are returned, you must complete the missing information and return the forms to the Fund Office within 72 hours.

IMPORTANT: Status Change Reminder

Your 36Phlex Plan benefit decisions will remain in effect for the rest of this year. You may change your Medical, Dental, Vision, or Reimbursement Account elections during the year only if you have a change in status. Qualified changes in status are:

- A change in your marital status (such as marriage, divorce, or annulment);
- A change in the number of your dependents (such as birth, legal adoption of your child, placement of a child with you for adoption, or death of a dependent);
- Certain changes in employment status that affect benefits eligibility for you, your spouse, or children, such as: termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, or a change in work schedule (for example, between full-time and part-time work or a decrease or increase in hours);

- Your child is no longer eligible for coverage;
- Entitlement to Medicare or Medicaid (applies only to the person entitled to Medicare or Medicaid);
- Change to comply with a state domestic relations order pertaining to coverage of your dependent child;
- Your, your spouse's, or child's eligibility for COBRA coverage;
- A significant increase in the cost of coverage or a significant reduction in the benefit coverage under your or your spouse's healthcare plan;
- The addition, elimination, or significant curtailment of a coverage option;
- A change in your spouse's or child's coverage during another employer's annual enrollment period when the other plan has a different period of coverage; or
- A change in dependent care providers or costs if the providers are not relatives of the employee (applies only for Dependent Care Reimbursement Account).

You must notify the Fund Office in writing of your request for a change in coverage within 31 days of the change in status (the deadline is 90 days for adding a newborn child; or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP), and you must provide proof of the event.

An Overview of the 36Phlex Plan Benefits Program

The 36Phlex Plan is a benefits program offering basic benefits such as medical, dental, vision, and life insurance coverage, and choice. You can pick and choose from a menu of coverage options and levels of coverage to ensure that you create a benefits package that meets your specific needs.

How the Plan Works

The plan uses a point system, called PhlexPoints. Each benefit costs you an amount of PhlexPoints.

If the benefits you choose cost **less than 100 PhlexPoints**, you may use your remaining PhlexPoints to:

- Enroll in a Healthcare Reimbursement Account; and/or
- Enroll in a Dependent Care Reimbursement Account.

If your benefits cost 100 PhlexPoints or more, you will NOT be eligible to participate in the reimbursement accounts.

If your benefits cost **more than 100 PhlexPoints**, you will have to contribute to the cost of your coverage. See your Enrollment Form to figure out the amount of your contribution.

This document and the materials in your enrollment packet provide a summary description of your SEIU Local 32BJ, District 36 BOLR Welfare Fund benefits and the changes that will be effective January 1, 2026. These materials supplement other descriptions of your Plan benefits. The changes described in these documents and the enclosed materials are effective as of January 1, 2026. The Fund hopes to continue the Plan and the benefits mentioned in these documents and described in your benefits booklet indefinitely, but reserves the right to amend, suspend or terminate the Plan, in whole or in part, at any time and for any reason. Neither receipt of this enrollment packet nor enrollment in any of the benefits offered under the Plan constitutes a contract of employment. Please read these documents carefully and keep this important information with your other benefit materials for future reference.

36Phlex Phact!

REMEMBER: Choose carefully! Once the 20-day enrollment is over, you will not be able to change your elections until the next Open Enrollment period in 2026, for coverage effective January 1, 2027, unless you have a qualified status change.

36Phlex Phact!

Questions? Call the Fund Office at 215-568-3262 ext. 1400 or at 800-338-9025 ext. 1400.

Basic Facts

Who's Eligible?

You are eligible for the 36Phlex Plan if you work in covered employment, and your employer is required through a collective bargaining agreement to make contributions on your behalf to the Fund.

If you are eligible to participate in the 36Phlex Plan, you may also enroll your eligible dependents for medical, dental and vision benefits. Your eligible dependents include:

- Your legal spouse (including a same-sex spouse)
- Children from birth to age 26
- Stepchildren up to age 26
- Adopted children (from the date of placement in your home) up to age 26
- Children placed for adoption
- Children over age 26 incapable of sustaining employment by reason of mental impairment or physical handicap

Any child for whom you gratuitously assume support will not be considered a dependent.

Enrolling Dependents

You must complete and submit the following information to enroll your dependents into the Plan:

- **Dependent Enrollment Form** (remember to complete both sides)
- **Document Dependent Status**—examples of documentation include:
  - Valid state marriage license for spouse
  - Valid state birth certificate naming both parents for natural or stepchildren under age 26
  - Proof of adoption for a legally adopted child under age 26
  - If required to add your children under age 26 as a result of a Qualified Medical Child Support Order, please provide a copy of the Order
  - Proof of Social Security number
  - If you have a child who must remain on your coverage beyond age 26 by reason of physical or mental impairment as a result of which they are unable to support themselves, the Fund Office requires documentation of their disability on a periodic basis. This information must be provided within 31 days after the child's 26th birthday.

REMEMBER: You have 20-days to enroll yourself and your dependents. If we don't receive your enrollment forms within the specified time, you will have to wait until our next open enrollment unless there is a qualifying status change.

Qualified Medical Child Support Order (QMCSO)

If you are required to provide child support and healthcare coverage under a Qualified Medical Child Support Order (QMCSO), contact the Fund Office for an explanation of the information required. A QMCSO is any judgment, decree, or order issued by the court requiring you to provide healthcare coverage for a child. For additional information regarding the procedures for administration of QMCSOs, contact the Fund Office.

Who Pays for Benefits

Your benefit plan and the required contributions are established by a collective bargaining agreement. Your employer makes monthly contributions on your behalf to the Fund, which pays for all or part of your health and welfare benefits. You pay a portion of the cost of the healthcare services you receive through deductibles, copayments, and/or coinsurance.

You may share the cost of coverage by paying a portion of the monthly premium cost through payroll deductions, depending on the benefit option and coverage level you choose.

You May Pay for Coverage on a Before-Tax Basis

If you are required to contribute toward the cost of your coverage, your contributions will be deducted from your paycheck on a before-tax basis. That means that your contributions are taken from your pay before federal and Social Security taxes are deducted. Before-tax contributions lower your taxable income and, therefore, save you money.

For example, if you earn $24,000 but contribute $1,200 a year for coverage, you pay federal income, Social Security, and FICA taxes on $22,800. The treatment of state (and any local) income taxes varies depending on the state. Generally, your contributions are subject to New Jersey state income taxes. However, your contributions are not subject to Delaware, Maryland, or Pennsylvania state income taxes.

Changing Your Benefits

Your benefit elections are effective from the date you enroll until December 31, 2026. You will not be able to change your 2026 Medical, Dental, Vision, or Reimbursement Accounts elections during the year unless you experience one of the qualified changes in status described on pages 2 and 3.

You may also enroll in one of the Medical plans at any time during the year if:

- You waived coverage for yourself or your eligible dependents because you or your dependents had healthcare coverage and lost it due to divorce, legal separation, death, termination of employment, reduction in work hours, or exhaustion of the other plan's COBRA coverage period. In this case, you may enroll yourself and your eligible dependents who lost coverage within 31 days after the loss of coverage.
- You acquire a new dependent through marriage, adoption, or placement for adoption. In this case, you may enroll yourself, your spouse, and your newly acquired dependents provided you enroll within 31 days of the event. If your new dependent is a newborn child, you have 90 days after the birth to request enrollment (or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP).
- If you or your dependent loses Medicaid or Children's Health Insurance Plan (CHIP) coverage because you or your dependent is no longer eligible for that coverage—or if you or a dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP—you may be able to enroll yourself or your dependents in this Plan, provided you request enrollment and provide appropriate documentation within 60 days of the event.

Your Medical Plan Options

You may choose between two medical plans and an opt-out option. Although both medical plans provide coverage for medically necessary care, they work very differently. It is important that you understand each plan before you decide which option is best for you and your dependents.

To be covered by either plan, the medical services or supplies you receive must be medically necessary, appropriate and eligible. However, some services and supplies are not covered at all, while the benefits for other services are limited. Review your Summary Plan Description for more details on what is and is not covered.

Your Medical Plan Choices

- **High Option Plan**—This is a Direct Point of Service (DPOS) Plan. *If you choose the High Option Plan, you will have fewer PhlexPoints to spend on other benefits.*
- **Basic Plan**—This is a Health Maintenance Organization (HMO) Plan. *If you choose the lower cost Basic Plan, the Fund will pass the savings on to you through extra PhlexPoints, which you may spend on other benefits.*
- **Opt Out**—If you have other medical coverage through another employer or your spouse, you may choose to opt out of the Fund's medical plan and spend your PhlexPoints on other benefits. You will need to complete a Proof of Other Coverage form if you choose to opt out. You will need to provide this information to the Fund on an annual basis, for as long as you wish to waive coverage. *This option provides the most PhlexPoints.*

Don't Forget About Preventive Care

It's important to make routine exams, tests, and screenings a priority. Preventive care can catch chronic diseases and infections like cancer, diabetes, and heart disease before they turn into serious health problems. Early detection increases the chances of your recovery.

The first step is to schedule your annual physical with your primary care physician (PCP). Ask which tests and screenings you're due for. For example, the American Cancer Society recommends that individuals start receiving screens for colorectal cancer at age 45. Regular cholesterol testing checks for signs of coronary artery disease. And annual well woman visits can catch breast cancer early.

Preventive care is easy and affordable. Most preventive services are covered at 100% as long as you see an in-network provider.

If you don't have a primary care provider (PCP), you can find one online at www.ibx.com or you can contact Independence Member Services at (800) 275-2583.

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Both medical plans require you to choose a Primary Care Physician and you must obtain referrals for certain services. You may also be required to receive certain services from PCP-designated sites in order for them to be covered. If you do NOT choose a PCP, plan benefits may be limited or not paid at all.

If you change medical plans, confirm that your doctor is accepting new patients and is a participating Primary Care Physician.

Key Differences Between the High Option Plan and the Basic Plan

The chart below summarizes the key differences between the two medical plans. Read the rest of this guide for detailed descriptions of each plan.

High Option Plan	Basic Plan
You must elect a PCP when you enroll	
You may use the doctors and hospitals of your choice. Staying in-network reduces your out-of-pocket costs.	Your PCP must provide your care or refer you to HMO specialists
Deductible applies to out-of-network/ self-referred care services only; your annual deductible is $250 per person and $500 per family	No deductible
Most services covered in-network at 100%, no deductible	Most services covered at 100%
In-network inpatient hospital services covered at 100%, no deductible	Inpatient hospital services covered at 100%, after $100 per day copay (max copay: $500 per admission)
Knee and hip replacement surgery at Blue Distinction Center + covered 100%; services at other network facilities covered at 70%; not covered out-of-network	Knee and hip replacement surgery at Blue Distinction Center + covered 100%; services at other network facilities covered at 70%; not covered out-of-network
You pay a $10 copay for PCMH doctors' visits and $20 for non-PCMH doctors' office visits	You pay a $15 copay for PCMH doctors' visits and $30 for non-PCMH doctors' office visits (includes PCPs) and $40 for specialists
For those services that are covered when provided by an out-of-network provider, the Plan pays 70% after deductible for most eligible expenses	**No out-of-network benefits**
Annual Out-of-Pocket Maximum is $6,750 per person and $13,500 per family.	Annual Out-of-Pocket Maximum is $6,750 per person and $13,500 per family.

Precertification Requirements

Certain services must be approved as medically necessary before you receive treatment. This is called precertification. Some services requiring precertification include:

- ALL nonemergency hospital admissions
- Elective inpatient surgery
- Select durable medical equipment
- home healthcare
- Inpatient hospice care
- MRI/MRA
- CT/CTA scan
- PET scan

Note: This is not a complete list of services. Blue Cross may change the precertification requirements from time to time. Contact Blue Cross Member Services for more information.

Health and Well-Being (Healthy Lifestyles℠)—Working to Support Your Health Every Day!

Most people tend to think about their health and healthcare benefits only when they're sick—or once a year when it's time for their annual physical. In truth, you should think about your health and your healthcare benefits every day.

Here's why. The choices you make every day—the food you choose to eat, wearing a seat belt, taking your medication as directed by your doctor—can have a significant impact on your health either positively or negatively. Independence Healthy Lifestyles Solutions programs can offer you support and guidance as you take positive steps to improve your health and your chances of staying well.

From paying you back for the smart lifestyle choices you make to providing customized solutions as individual as you are, the Healthy Lifestyles Solutions program is designed to keep you healthy. Best of all, the programs are free to you and your eligible dependents. **You must be enrolled in one of the 36Phlex medical plans** to be eligible to participate in the Healthy Lifestyles Solutions program.

For more information, or to enroll in any of the programs under the Healthy Lifestyles Solutions program, call 800-ASK-BLUE Monday through Friday, 8 a.m. to 6 p.m. ET, and follow the prompts for the Healthy Lifestyles Solutions program. You can also find program information online at www.ibx.com or by downloading the IBX mobile app.

Get Healthy AND Rewarded Too!

Get rewarded for taking small steps every day that can add up to big changes in your health. The Healthy Lifestyles Solutions reimbursements offer you:

- Up to $150 back on your fitness center fees
- $150 back on an approved weight-management program
- $150 back for programs to help you quit tobacco

We make it easy for you to earn money back for healthy living with our reimbursements programs. No enrollment is required. You meet the eligibility requirements when you complete 120 visits at an approved facility. Simply submit your documentation to request reimbursement quickly and securely.

Note: These programs are administered by Independence Blue Cross. You must have coverage with Independence at the time of your request for reimbursement.

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You must enroll in the Healthy Lifestyles Solutions program to be eligible. Special restrictions and guidelines apply. The Healthy Lifestyles Solutions program is administered by Independence Blue Cross, and program details can change at any time. Call, go online at www.ibx.com, or download the IBX mobile app to get the most up-to-date information on the Healthy Lifestyles Solutions program.

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You must have elected medical coverage with Independence in order to qualify for the reimbursements.

Behavioral Health Benefits

Your Behavioral Health Benefit is covered through MHC and is not part of your medical benefits with your Independence Blue Cross Medical Plan.

MHC is here to support you and your family who may struggle with substance use or have emotional or mental health issues. MHC's experienced professionals will give you the best possible care and attention. To find out more about the behavioral health benefits and services available to you, at 800-255-3081 or visit their website at www.mhconsultants.com.

Show your MHC card if you need treatment with a Behavioral Health provider. Contact MHC directly at 800-255-3081 to speak to an MHC Case Manager.

MHC can help with issues such as:

- Anxiety/Stress
- Substance Use
- Depression
- Post-traumatic Stress
- Grief
- Family problems
- And much more.

A Snapshot of the High Option Plan Benefits

This chart gives you a quick look at the High Option Medical Plan. Please refer to your Summary Plan Description for complete information about the High Option Plan's benefits.

BENEFIT	IN-NETWORK/REFERRED	OUT-OF-NETWORK/SELF-REFERRED
Annual Deductible	N/A	$250/person; $500/family
Annual Out-of-Pocket Maximum[8]	$6,750/person; $13,500/family	$6,750/person; $13,500/family
Patient-Centered Medical Home Office Visits	100%, after $10 copay	70% after deductible
Doctor's Office Visits (Non-PCMH Primary and Specialist services)	100%, after $20 copay (at non-PCMH provider)	70% after deductible
Routine GYN Exam/Pap Smear *1 per calendar year*	100%	70%, no deductible
Mammogram	100%	70% after deductible
Pediatric Immunizations	100%	70% after deductible
Physical, Occupational or Speech Therapy[4, 5] *up to 30 visits per calendar year*	100%, after $20 copay	Not covered
Cardiac or Pulmonary Rehabilitation *up to 36 visits per calendar year*	100%, after $20 copay	70% after deductible
Chiropractic (Spinal Manipulation)[5] *up to 10 visits per calendar year*	100%, after $20 copay	70% after deductible
Hospital Inpatient[1]	100%	70% after deductible *up to 70 days per calendar year*
Knee and Hip Replacement[1, 2] Blue Distinction Center + All other facilities	 100% 70%	 Not covered Not covered
Urgent Care	$40 copay	70% after deductible
Emergency Room ER Visit 1 & 2 ER Visit 3 plus	 $100 copay (waived if admitted) $200 copay (waived if admitted)	 $100 copay, no deductible (waived if admitted) $200 copay, no deductible (waived if admitted)
Outpatient Lab/Pathology[4,5]	100%	70% after deductible
Dialysis/Radiation/Chemotherapy	100%	70% after deductible
Home Healthcare[1] *up to 200 visits per calendar year*	100%	70% after deductible
Hospice Care[1] *up to 210 days per lifetime*	100%	Not covered
Skilled Nursing Facility[1] *up to 60 days per calendar year*	100%	Not covered
Outpatient Surgery (precertification may be required for some outpatient surgeries)[1]	100%	70% after deductible
Outpatient X-ray/Radiology[1, 4, 5]	100%	70% after deductible
Durable Medical Equipment[1]	100%	Not covered
Ambulance Emergency transport Non-emergency transport[1]	 100% 100%	 100%, no deductible 70% after deductible
Outpatient Private Duty Nursing[1] *up to 360 hours per calendar year*	90%	70% after deductible
Behavioral Health/Substance Use Program (coverage for psychiatric care and substance use) NOTE: Program is **not** part of the medical plan. Call MHC at (800) 255-3081.		
Inpatient[6, 7]	100%	70% after deductible
Non-Office Outpatient Visits[6]	100%	70% after deductible
Outpatient[6]	100%, after $20 copayment	70% after deductible

1 Precertification required for these services. Please contact the member services department of Keystone HPE (Independence Blue Cross) for more information on those services requiring pre-certification.

2 Treatment received at a Blue Distinction Center + facility for knee and hip replacement is covered at 100%; treatment received at a Blue Distinction Center or other any other participating Keystone facility or AmeriHealth designated facility is covered at 70%. There is no coverage for knee/hip replacements done out-of-network.

3 Must go to your chosen Primary Care Physician (PCP).

4 Must go to the PCP-designated site for care to be considered in-network.

5 Referral from Primary Care Physician (PCP) required.

6 In-network services administered by MHC, Inc. not Keystone or AmeriHealth. Contact MHC for a listing of network providers. Call MHC at 800-255-3081 or visit HMC online at www.mhconsultants.com.

7 Precertification required for these services. Contact MHC for more information about pre- certification of services related to Behavioral Health/Substance Use Treatment.

8 Annual Out-of-Pocket Maximum includes expenses to meet your annual deductible, as well as money you spend in copayments and coinsurance during the year. There is a separate Out-of-Pocket Maximum for prescription drugs (see page 11).

A Snapshot of the Basic Plan Benefits

This chart gives you a quick look at the Basic Medical Plan. The Basic Plan has in-network coverage only. Referrals are required. There is NO coverage for out-of-network providers or facilities. Please refer to your Summary Plan Description for complete information about the Basic Plan's benefits.

BENEFIT	IN-NETWORK
Annual Out-of-Pocket Maximum* **	$6,750/person; $13,500/family
Doctor's Office Visits[3]	PCMH Provider: 100%, after $15 copay Non-PCMH PCP: 100%, after $30 copay; Specialist: 100% after $40 copay
Routine GYN Exam/Pap Smear *1 per calendar year; no referral needed*	100%
Mammogram Screening—*no referral needed*	100%
Pediatric Immunizations	100%
Physical and Occupational Therapy[4, 5] *up to 30 visits combined per calendar year*	100%, after $40 copay
Cardiac and Pulmonary Rehabilitation[5] *up to 36 visits per calendar year*	100%, after $40 copay
Speech Therapy[5] *up to 20 visits per calendar year*	100%, after $40 copay
Chiropractic (Spinal Manipulation)[5] *up to 20 visits per calendar year*	100%, after $40 copay
Hospital Inpatient[1]	100%, after $100 per day copay; (Max copay: $500 per admission)
Knee and Hip Replacement[1, 2] Blue Distinction Center + All other facilities	 100% 70%
Urgent Care	$50 copay
Emergency Room ER Visit 1 & 2 ER Visit 3 plus	 $100 copay (not waived if admitted) $200 copay (not waived if admitted)
Outpatient Lab/Pathology[4, 5]	100%
Dialysis/Radiation/Chemotherapy[5]	100%
Home Healthcare[1]	100%
Hospice Care[1]	100%
Skilled Nursing Facility[1] *up to 120 days per calendar year*	100%, after $50 per day copay; (Max copay: $250 per admission)
Outpatient Surgery[5]	100%, after $50 copay
Outpatient X-ray/Radiology[4, 5]	Routine/Diagnostic: 100%, after $40 copay MRI/MRA, CT/CTA Scan, PET Scan: 100% after $80 copay
Durable Medical Equipment & Prosthetics[1, 5]	70%
Ambulance (*non-emergency ambulance services require precertification)*	100%
Outpatient Private Duty Nursing[1, 5] *up to 360 hours per year*	90%
Behavioral Health/Substance Use Program (coverage for psychiatric care and substance use) NOTE: Program is **not** part of the medical plan. Call MHC at (800) 255-3081.	
Inpatient[6, 7]	*100%, after $100 per day copay (Max copay: $500 per admission)*
Non-Office Outpatient Visits[6]	100%
Outpatient	100%, after $30 copay
No benefits are paid for out-of-network services.	

1 Precertification required for these services. Please contact the member services department of Keystone HPE (Independence Blue Cross) for more information on those services requiring pre-certification.

2 Treatment received at a Blue Distinction Center + facility for knee and hip replacement is covered at 100%; treatment received at a Blue Distinction Center or other any other participating Keystone facility or AmeriHealth designated facility is covered at 70%. There is no coverage for knee/hip replacements done out-of-network.

3 Must go to your chosen Primary Care Physician (PCP).

4 Must go to the PCP-designated site for care to be considered in-network.

5 Referral from Primary Care Physician (PCP) required.

6 In-network services administered by MHC, Inc. not Keystone or AmeriHealth. Contact MHC for a listing of network providers. Call MHC at 800-255-3081 or visit HMC online at www.mhconsultants.com.

7 Precertification required for these services. Contact MHC for more information about pre- certification of services related to Behavioral Health/Substance Use Treatment.

8 Annual Out-of-Pocket Maximum includes expenses to meet your annual deductible, as well as money you spend in copayments and coinsurance during the year. There is a separate Out-of-Pocket Maximum for prescription drugs (see page 11).

Important Terms

Annual Copayment Maximum—

is the most you will pay out of your pocket in copayments for in-network services you receive during the year. Once you reach your annual maximum, the plan pays 100% of the cost for in-network services for the rest of the year.

Blue Distinction Center + —

Blue Cross-designated outpatient surgical centers specializing in knee and hip replacement. Blue Distinction Centers + meet high standards of quality, cost, expertise, effectiveness and efficiency.

Coinsurance—

is the percentage of eligible costs that you pay for services, after the deductible has been paid.

Copayment—

is the flat dollar amount you pay for some medical services at the time care is received.

Deductible—

is the portion of your covered expenses that you pay each year before your medical plan begins to pay benefits for specified services.

In-Network Providers—

are a select group of providers and facilities that have agreed to charge negotiated fees for their services. When you use these providers, you are receiving "in-network care."

Medically Necessary Expenses—

are covered by the plans if they are services or supplies considered to be necessary and appropriate and covered by the plan. Some services and supplies are not covered at all, while the benefits for other services (such as chiropractic care) are limited. In addition, the expense must be incurred while the patient is covered under the plan, unless specifically provided otherwise.

Out-of-Network Providers (High Option Plan only)—

are doctors, healthcare providers or facilities that are not part of the select group of providers under the High Option Plan.

Patient-Centered Medical Home (PCMH)—

Blue Cross has identified certain doctors, including PCPs, who participate in a Patient-Centered Medical Home (PCMH). A PCMH is an office or group of doctors who work together to better coordinate and personalize your care. Getting care at a PCMH and selecting a PCMH doctor as your PCP will save you money.

Plan Allowance (High Option Plan only)—

is the amount the plan pays for a specific medical service in a designated geographic area. You are responsible for the charges above the plan allowance if you do not use a network provider.

Primary Care Physician (PCP)—

is sometimes referred to as a "family doctor." This is the doctor who provides first contact when you have a health concern. The PCP also provides continuing care and referrals to specialists as needed. Blue Cross has designated certain doctors as "PCPs"; you must consult your Blue Cross Physician Directory to select an eligible PCP.

Self-Referred Care (High Option Plan only)—

is care you do not receive from your PCP or care you receive without a referral from your PCP. This is the most expensive way to receive care. For self-referred care, the plan generally pays 70% of the plan allowance after you meet the annual deductible.

Prescription Drug Benefits

Prescription drug coverage, provided through CVS Caremark, starts automatically when you enroll in medical coverage under one of the 36Phlex Plan options. You can get up to a 30-day supply of medication by going to any network pharmacy and showing your CVS Caremark Prescription Drug ID card. You can get up to a 90-day supply of maintenance medications by going directly to any CVS Pharmacy or by using the CVS Caremark Mail Order Pharmacy. **You will not be eligible for prescription drug benefits if you opt out of the medical plan.**

Your Copays

Each time you fill a prescription, you will pay a copay depending on the classification of the drug. There are three tiers of prescription drugs:

- **Generic**—Prescription drugs that are the lower-cost equivalents of brand-name drugs. They are approved by the U.S. Food and Drug Administration and have the same active ingredients as their brand-name equivalents.
- **Formulary**—A list of brand-name drugs chosen by a panel of physicians and pharmacists. The drugs on the formulary are carefully chosen for their effectiveness, safety and cost.
- **Non-formulary**—Brand-name drugs not on the formulary. *You pay 100% of the cost of non-formulary drugs.*

If your prescription is for:	Retail (30-day supply)	Retail (90-day supply)*	Home Delivery (90-day supply)
	You Pay		
Generic Drugs	$7	$14	$14
Formulary Brand-Name Drugs	$22	$44	$44
Non-Formulary Drugs	You pay 100% of the cost.		

**To fill a prescription for a 90-day supply of medication at a retail pharmacy, you must use a CVS Pharmacy.*

Your Annual Out-of-Pocket Maximum

There is an Annual Out-of-Pocket Maximum limit for prescription drug expenses. Once you reach the Annual Out-of-Pocket Maximum, the Plan pays 100% of your prescription drug costs. Your copays apply to the Annual Out-of-Pocket Maximum. Expenses paid for drugs not covered under the Prescription Drug Plan do not apply. There is a separate Annual Out-of-Pocket Maximum for medical benefits.

The Prescription Drug Annual Out-of-Pocket Maximums are:

- Single: $1,950
- Family: $3,900

What's a Formulary?

A formulary is a list of generic and brand-name drugs. The formulary was developed by a committee of physicians and pharmacists at CVS Caremark. The committee regularly reviews and updates the formulary based on the latest information available about each drug's effectiveness.

You can find the current formulary by signing up at **www.caremark.com**. The formulary is subject to change during the year as new drugs are added, brand drugs have generic alternatives, or their status on the formulary changes.

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90-day retail fills available only at CVS Pharmacies.

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Using the CVS Caremark Mail Order Pharmacy for maintenance medications will save you money.

Dental Benefits

Regular, professional dental care is not only essential to good health, but it also can prevent serious or costly problems. That's why our Dental Plan, provided through Delta Dental, covers a full range of dental services, including diagnostic and preventive care.

Chart of Dental Benefits

Deductible	None
Annual Maximum Benefit	$3,000 per person per year
Preventive and Diagnostic Care • Oral exam, cleaning, bitewing X-rays (twice a year); full-mouth X-rays every 36 months • Fluoride treatments up to age 19 (limits apply) • Sealants or space maintainers (age limits apply)	100%
Basic Restorative • Fillings	100%
Major Restorative • Repairs of existing crowns • Inlays, onlays, crowns, cast restorations • Bridges and dentures	50%
Endodontics • Root canal	80%
Periodontics • Gum treatment	80%
Orthodontia	50% $1,000 lifetime maximum

How Using a Participating Dentist Can Save You Money

This is an example of how using a Delta Dental network dentist can save you money.

Procedure: Crown	If you use a participating dentist	If you use a non-participating dentist
Dentist's fee	$900	$900
Delta Dental's contracted rate (eligible expense)	$700	$700
Plan pays (50% of contracted rate)	$350	$350
You pay	$350	$550 (difference between Delta's contracted rate and the dentist's $900 fee)

Note: This chart is for illustration purposes only. Actual costs will vary.

Predetermine Benefits for Treatment Over $300

If your treatment is expected to cost $300 or more, ask your dentist to "predetermine benefits" with Delta Dental before treatment starts (this means evaluating whether the suggested treatment is appropriate and determining how much the Plan will pay for the care). With predetermination, you know exactly how much the Plan will pay—and how much you will pay. That way, you can make financial arrangements before the treatment begins.

To predetermine benefits, your dentist needs to send a claim form to Delta Dental describing the proposed treatment and the estimated charges. Delta Dental will send you a statement showing the services that will be covered and how much the Plan will pay. You can review the treatment plan with your dentist and agree on the services to be performed. After treatment is completed, return the original statement, with dates of services and necessary signatures, to Delta Dental for payment.

Please review your Summary Plan Description for a complete list of dental limitations and exclusions.

Vision Benefits

The 36Phlex Plan offers you two options for vision coverage:

- **An enhanced vision program**—Care is provided through a network of optometrists and ophthalmologists. You must receive care from participating doctors or optometrists to receive maximum benefits; and
- **A discount vision program**—This program allows you to receive discounted rates for eye exams, eyeglasses, and contact lenses.

You may enroll yourself or choose coverage for you and your family.

The Enhanced Vision Plan—How the Plan Works

You have the option to receive eye care from a National Vision Administrator (NVA) participating provider or any other eye care specialist. However, you receive maximum benefits when you use a participating eye doctor or optometrist.

- **When you use a participating provider,** you receive maximum benefits because the plan pays the full cost or a large portion of the cost for most routine services; some limits apply.
- **When you use a non-participating provider,** the plan will reimburse you for exams, eyeglass frames, and lenses, or contact lenses, according to a schedule. You pay the full cost when you receive services. Then, you must file a claim to be reimbursed for the plan's share of the cost.

What the Plan Pays

When you receive services from an NVA participating provider, the plan pays the cost for an eye exam once every 24 months. For children under 19, the play pays for an eye exam once every 12 months.

The plan also pays for one pair of new lenses and frames, or contact lenses, up to $120 every 24 months. For children under 19, the plan will pay for new lenses and frames or contact lenses up to $120 every 12 months.

When you receive services from a non-participating vision provider, the plan will pay up to $30 for an eye exam once every 24 months. For children under 19, the plan will pay up to $30 every 12 months.

The plan also pays up to $60 for lenses and up to $60 for frames, or up to $120 for contact lenses, once every 24 months for children and adults.

Expenses Not Covered (Please note that this is only a partial listing.)

The Vision Plan does not cover:

- Fundus photography;
- Medical or surgical treatment of the eyes; services or materials provided as a result of workers' compensation law or obtained by any governmental agency or program; or
- Plain or prescription sunglasses.

Please review your Summary Plan Description for a complete list of vision limitations and exclusions.

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Under the Discount Vision Plan, there is no limit to the number of times you may use your ID card to get eye care services or eyewear. However, you cannot use your card combined with any special offers, such as coupons or special promotions.

Under the Enhanced Vision Plan, you cannot use your card combined with any special offers, such as coupons or special promotions.

Discount Vision Program—How the Plan Works

The Discount Vision Care Program is not a full-coverage plan. If you enroll in this plan, you get a discounted rate from certain providers for products and services available to the general public.

The Discount Vision Program is provided by National Vision Administrators (NVA). NVA has a network of participating ophthalmologists, optometrists, and opticians to service you. You must use a participating NVA provider and show your NVA ID card to get the discounted services. Just choose a participating provider by calling NVA at 800-672-7723, or call the Fund Office.

Expenses Not Covered (Please note that this is only a partial listing.)

The Discount Vision Program does not cover:

- Medical or surgical treatments of the eyes;
- Drugs or medications;
- Non-prescription lenses;
- Examination or materials not listed as a covered service;
- Services or materials provided by federal, state, or local government, or workers' compensation; and
- Low-vision aids.

Please review your Summary Plan Description for a complete list of vision limitations and exclusions.

Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

Today, life insurance is more than a "peace of mind benefit"—it is one of life's necessities.

Life insurance is designed to offer protection to your family, or anyone who counts on your income, if you die. Accidental Death and Dismemberment (AD&D) insurance pays a benefit to you if you suffer an accidental loss of a limb or your eyesight, and pays a benefit to your beneficiary(ies) if you die as the result of a covered accident. Your life insurance benefit is only payable if you die while in active covered employment. Any AD&D benefit payable as a result of your accidental death is equal to the amount of your life insurance and is paid in addition to your life insurance benefit. The amount of your AD&D benefit depends on the type of accidental loss. Exclusions and certain limitations may apply. See your Summary Plan Description, or call the Fund Office for details.

Providing financial security for your loved ones if you die is important. The Fund pays the full cost of $10,000 of life insurance and $10,000 in AD&D coverage for you. You may choose to buy a larger amount of life and AD&D insurance as explained below.

Dependents are not eligible for life and AD&D insurance coverage.

Amount of Life Insurance

Because the amount of coverage that's right for each person varies, the 36Phlex Plan offers you three coverage amounts:

- $10,000
- $25,000
- $50,000

See your enrollment form for the amount of PhlexPoints you need to buy life and AD&D insurance coverage.

Don't Forget—Your Beneficiary

To make sure any benefits are paid to the person you want, you must name your beneficiary—and keep your beneficiary designations up to date as your life changes. If you are newly eligible, or have changes in your dependent status, complete a Demographic Census/Beneficiary Information form. Contact the Fund Office if you need a new form. Return the form to the Fund Office.

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This life insurance benefit is generally only payable if you die while in active covered employment.

Any AD&D benefit payable as a result of your accidental death is equal to the amount of your life insurance and is paid in addition to your life insurance benefit.

The amount of AD&D benefit depends on the type of accidental loss. See your Summary Plan Description, or call the Fund Office for details.

Exclusions and certain limitations may apply. See your Summary Plan Description for a complete list of exclusions and limitations.

Short-Term Disability Benefits

If you are a full time employee and your employer makes an additional contribution to the Fund for short-term disability benefits, you are eligible for short-term disability benefits. Short-term disability benefits provide you and your family with a supplemental weekly payment if you become disabled and cannot work due to a non-work-related illness or injury.

The specific time allowance for a short-term disability is determined by the diagnosis and established disability guidelines. However, no short-term disability can exceed the maximum benefit of 26 weeks. For short-term disability benefits to be considered, you must complete a short-term disability claim form, and you must provide documentation from a legally qualified doctor certifying that you are disabled and unable to perform your normal work duties. Please note: MHC providers can also certify disability.

If you're eligible, you'll receive a weekly benefit equal to a percentage of your regular pay, up to a weekly maximum, while you are disabled and remain under the direct regular care of a legally qualified doctor or your care is being managed by an MHC Mental Health/Substance Use provider.

Your short-term disability claim begins on the fourth working day after you visit your doctor as a result of your disability. Short-term disability benefits will not be paid for any period in which you missed work before you visited your doctor.

Short-term disability forms must be submitted on time. If you are out of work on a continuing disability that exceeds a month, you must submit continuation forms ("blue forms") on a regular basis—usually once a month. See the form for more information about timing and deadlines. Contact the Fund Office to get a form. You will only receive eligibility credit while you are receiving short-term disability benefits.

For more information about short-term disability benefits, see your Summary Plan Description or call the Fund Office at (215) 568-3262 or (800) 338-9025 outside the local calling area.

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If you are out of work longer than a month, you should continue to get your disability forms completed on a regular basis, typically monthly.

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The physician certifying your disability MUST be a network physician.

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"Legally qualified physician" includes Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Dental Surgery (DDS), Doctors of Dental Medicine (DMD), or Doctors of Podiatric Medicine (DPM).

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Any claim for short-term disability must be filed with the Fund Office within 60 days from the initial date of your disability. Be sure that all sections are completed and signed by you , your employer and your attending physician before submitting to the Fund Office.

Reimbursement Accounts

Depending on the benefit choices you make, you may be eligible to participate in the Fund's Reimbursement Accounts.

Two Separate Accounts

There are two separate accounts—a Healthcare Reimbursement Account and a Dependent Care Reimbursement Account. You may choose to participate in one or both accounts. If you choose to participate in both accounts, you can't transfer money from one account to the other—or use the money in the Healthcare Reimbursement Account to pay for dependent care expenses or vice versa.

It's important that you estimate your expenses carefully before contributing your PhlexPoints to these accounts, because **you will lose any balance remaining in this account after April 15.** See ***Use It or Lose It Deadline*** for details.

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You must enroll or re-enroll for these accounts because participation does not automatically continue from year to year.

Who's Eligible

You're eligible to participate in the Reimbursement Accounts if your PhlexPoint total is less than 100. If your benefits cost **less than 100 PhlexPoints**, you may choose to deposit the remaining PhlexPoints into one or both of the reimbursement accounts. Each PhlexPoint you deposit into a reimbursement account has a value of $5. For example, if the cost of the benefits you choose is 81 PhlexPoints, you will have 19 PhlexPoints available to deposit into a Reimbursement Account. That means you will have $95 each month (19 PhlexPoints times $5) to deposit into your account. The IRS sets limits for how much money you can contribute to your Reimbursement Account. Your monthly contributions cannot exceed the IRS limit.

***REMINDER*: Over-the-counter drugs without a physician's prescription are not eligible for reimbursement.**

36Phlex Phact!

Proper documentation must be included with the appropriate claim form. Submit the request for reimbursement to the Benefit Fund Office.

Healthcare Reimbursement Account

With any benefit plan, there are some items that are not covered such as plan deductibles and copayments. By depositing all or a portion of your PhlexPoints into your Healthcare Reimbursement Account, you can set aside money to pay for healthcare—medical, prescription drug, dental, and vision care—expenses that are not reimbursed by any plan. When you submit the required documentation for eligible expenses, you're paid tax-free from your account.

How the Healthcare Reimbursement Account Works

You decide how many of your PhlexPoints you want to contribute based on your estimated expenses for the coming year. You may contribute up to the total amount of your remaining PhlexPoints, up to limits set by the IRS.

Healthcare Reimbursement Account Worksheet	
Healthcare	**Estimated Expenses**
Deductibles	$
Your share of covered expenses (copayments and/or coinsurance)	$
Items not covered or partially covered by Fund benefits	$
Medical and/or dental expenses over plan limits	$
Medical and/or dental expenses over UCR charges	$
Other expenses not covered by Fund benefits, but which can be deducted on your income tax return	$
Total Annual Expenses	$

Eligible Healthcare Expenses

Only certain healthcare expenses are eligible for reimbursement. Eligible expenses include:

- Deductibles, copayments, and coinsurance amounts;
- Prescription drugs purchased in the United States;
- Expenses that are not covered, or are partially covered under your medical, dental, or vision plan; and
- Expenses beyond maximum medical and/or dental benefit limits, and/or above usual, customary, and reasonable (UCR) charges or plan allowances.

Healthcare Expenses Not Eligible for Reimbursement

You cannot use your healthcare account to reimburse:

- Expenses reimbursed by any other medical/dental/vision plans;
- Non-prescription items to maintain general health, such as vitamins, cosmetics, and shampoos;
- Health club, spa, or exercise class fees;
- Weight-loss or smoking-cessation programs without a doctor's prescription;
- Cosmetic surgery (unless performed to correct a congenital deformity, or deformity resulting from injury or disease);
- Contributions or premiums for healthcare coverage, for you, your spouse, and/or your children; and
- Over-the-counter medicines unless prescribed by your physician.

Use-It-or-Lose-It Deadline

IRS regulations allow you to use the Reimbursement Accounts (if you're eligible) to reimburse yourself for eligible expenses incurred through March 15 of the year following the year in which you made the contribution; any dollars not spent by that date are forfeited, subject to the IRS' rollover rules. That means any money remaining in your Reimbursement Account(s) on December 31 may be used to reimburse expenses you incur through March 15 of the following year.

Note: You must submit expenses incurred during the grace period to the Fund Office by April 15 of the following year.

Dependent Care Reimbursement Account

If you must pay someone to care for dependents so that you (and your spouse, if you're married) can work, consider setting up a Dependent Care Reimbursement Account to pay yourself back for eligible dependent care expenses. These expenses include the cost of a day care or elder care center or the cost of a caregiver. You cannot use the Dependent Care Reimbursement Account for health-related expenses for dependents (the Healthcare Reimbursement Account covers those expenses).

36Phlex Phact!

You may use the Dependent Care Spending Account if you are responsible for caring for an eligible dependent—and you must pay someone else to provide this care so that you can work. If you're married, you may use this account only if you both work, or if your spouse is a full-time student or disabled and unable to care for himself or herself. In other words, if one of you stays home to care for the dependents, or attends school part-time, you can't use the account.

Who Qualifies as a Dependent

The expenses must be for "qualified dependents," which include:

- Your dependent children under age 13 at the time the expense is incurred if you claim them as a dependent on your federal tax return; and
- Other dependents, such as your spouse, elderly parent, or an older child, if they are physically or mentally disabled, unable to care for themselves, and you claim them as dependents for tax purposes.

Eligible Dependent Care Expenses

Here are some of the expenses for which you can use the Dependent Care Account (provided the expenses are necessary for you and your spouse to work):

- Care in your home (the care provider cannot be your dependent or your child under age 19);
- Licensed preschool or kindergarten (only the cost of care is an eligible expense if it can be separated from the cost of schooling);
- Qualified day care or family care center that requires a fee for service; it must also meet state and federal regulations if it cares for more than six non-resident people at a time;
- Before-school and after-school programs; and
- Summer day camp (not overnight camp).

Dependent Care Expenses That Are Not Eligible

You cannot use your Dependent Care Reimbursement Account to reimburse:

- Care not related to employment (such as a babysitter during your non-working hours);
- Expenses the IRS would not consider eligible for a federal tax deduction;
- Expenses paid by another policy or plan (including health insurance, Medicare, or other federal or state program);
- Expenses for any period other than the calendar year in which you set up the account, or expenses incurred while you were not a participant in this plan;
- Nursing homes; and
- Overnight camp.

Proof of Expense

When you file your claim for reimbursement, you must complete a claim form and provide an itemized bill or proof that the expense is eligible to the Fund. Your request for payment must include the care provider's taxpayer identification number (TIN). For individual providers, the TIN is usually that person's Social Security number. If the person works in your home, you are responsible for filing an employer's return with the IRS and for paying Social Security tax on wages paid to that employee.

Federal Tax Credit or Dependent Care Reimbursement Account?

There are actually two tax-favorable options available when paying for day care—this Dependent Care Reimbursement Account or the government's Federal Child Care Tax Credit. You cannot claim the same expenses under both the Dependent Care Reimbursement Account and the federal tax credit, but you may:

- use the Dependent Care Reimbursement Account; or
- use the federal tax credit. (Under current law, and depending on your adjusted gross income, you may take a tax credit for 20% to 35% of your dependent care expenses. The maximum amount that can be used to determine the tax credit is $3,000 for one child and $6,000 for two or more children. So, if your credit is 20%, the maximum credit for one child is $600 (20% of $3,000).)

The expenses you reimburse through the Dependent Care Reimbursement Account directly offset dollar for dollar the expenses you can submit for a federal tax credit. For example, if you have one child and receive a $3,000 reimbursement from your Dependent Care Account, you have exhausted the available expenses ($3,000) you could claim for one child as a tax credit.

Whether the tax credit or the Dependent Care Reimbursement Account is the better method in your case depends on your gross income and tax filing status. To get more information about which option best meets your needs, you should check with your personal tax advisor.

Planning Your Dependent Care Account Deposit

You may find it helpful to use the worksheet on the following page to estimate your dependent care expenses for next year. When calculating your total expenses for the year, consider changes that may occur.

For example:

- Will you be adding to your family?
- Will your dependent turn age 13 during the year?
- Does your spouse intend to stop working this year?

Remember, you **lose what you don't use**—so estimate carefully.

Dependent Care Reimbursement Account Worksheet	
Dependent Care	**Estimated Expenses**
Day care, babysitting	$
Licensed preschool or kindergarten	$
Before-school and after-school day care programs	$
Summer day camp	$
Household services related to dependent care	$
Social Security (FICA) tax for care provider	
Other eligible household services	$
Total Annual Expensed Cost	$

Important Notices

SEIU Local 32 BJ, District 36 BOLR Welfare Fund ("the Fund") is required to provide the following important notices to you. Please review them carefully so you understand your rights and responsibilities.

HIPAA Special Enrollment Rights

If you are declining enrollment in the health insurance plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends and provide supporting documentation. In addition, if you have a new dependent as a result of marriage, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the health insurance plan, provided that you request enrollment within 31 days after the marriage, adoption, or placement for adoption. If you have a new dependent as a result of birth, you may be able to enroll yourself and your dependents in the health insurance plan, provided that you request enrollment within 90 days after the birth (or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP).

The Fund will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in Fund coverage. Note that this 60-day extension applies **only** to enrollment opportunities due to Medicaid/CHIP eligibility changes.

Enrollment materials must be completed and all proof of dependent status provided to the Plan within 31, 60 or 90 days of the request for Special Enrollment. If you are unable to complete the enrollment materials and provide proof of dependent status within the time frame (for example, if additional time is needed to obtain a birth certificate for a newborn), the deadline may be extended.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you and your eligible dependents may continue medical coverage for up to 18 months if coverage ends because:

- You terminate employment for any reason (other than gross misconduct), or
- You have a reduction in work hours.

COBRA also allows for your eligible dependents to continue their medical coverage for up to 36 months if coverage would otherwise end because:

- You die,
- You and your spouse divorce or legally separate,
- You become eligible for Medicare, or
- Your dependents are no longer eligible for coverage under the medical plan.

You and your dependents generally may elect to continue coverage anytime within the first 60 days after coverage ends or 60 days from the date the notice is received, whichever is later. Continued coverage takes effect on the first of the month following the date of the

event that caused coverage to end, as long as you pay the necessary premium. You may only continue the coverage that was in effect one day prior to the event. However, you may make changes to your elections each year during the annual open enrollment period. If the medical plan changes, those changes will also apply to coverage under COBRA.

To receive coverage under COBRA, you and/or your eligible dependents are required to make a timely election and make monthly premium payments.

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. In the case of a plan participant who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician 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; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedema

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for other benefits under the plan.

HIPAA Privacy Notice Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the SEIU Local 32 BJ, District 36 BOLR Welfare Plan (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. You may also obtain a copy of the Privacy Notice by contacting the Fund Office at 215-568-3262, Extension 1400 or 800-338-9025, Extension 1400 (outside the local calling area).

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the SEIU Local 32 BJ, District 36 BOLR Welfare Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **The SEIU Local 32 BJ, District 36 BOLR Welfare Fund has determined that the prescription drug coverage offered by SEIU Local 32 BJ, District 36 BOLR Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Whether or not you enroll in a Medicare prescription drug plan, your current prescription drug coverage will continue as long as you continue to meet the eligibility requirements of the SEIU Local 32BJ, District 36 BOLR Welfare Plan. Your current coverage pays for other health expenses in addition to prescription drugs, and, provided you continue to meet the Fund's eligibility rules, you will still be eligible to receive all of your health and prescription drug benefits even if you choose to enroll in a Medicare prescription drug plan.

If you enroll in a Medicare prescription drug plan and you are an active participant, your coverage with this Plan will be primary and Medicare will pay on a secondary basis after this Plan has paid its benefits.

If you decide to join a Medicare drug plan and drop your current SEIU 32BJ, District 36 BOLR Welfare Fund coverage, you will only be able to get it back if you meet the Fund's eligibility and enrollment rules, including special enrollment rules.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SEIU Local 32 BJ, District 36 BOLR Welfare Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SEIU Local 32 BJ, District 36 BOLR Welfare Fund changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Important Information

The following chart provides important information about this Medicare Part D Notice.

Date	Provided at hire and annually thereafter
Name of Entity Sender	SEIU 32 BJ, District 36 BOLR Welfare Fund
Contact – Position/Office	John J. Rongione, Administrator
Address	1515 Market Street Suite 1020 Philadelphia, PA 19102
Phone Number	215-568-3262, Extension 1400

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

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 **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 **866-444-EBSA (3272)**.

The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility.

PENNSYLVANIA	**Medicaid and CHIP**
Medicaid Website	https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Medicaid Phone	800-692-7462
CHIP Website	https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone	800-986-KIDS (5437)
NEW JERSEY	**Medicaid and CHIP**
Medicaid Website	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone	800-356-1561
CHIP Premium Assistance Phone	609-631-2392
CHIP Website	http://www.njfamilycare.org/index.html
CHIP Phone	800-701-0710 (TTY: 711)
NEW YORK	**Medicaid**
Medicaid Website	https://www.health.ny.gov/health_care/medicaid/
Medicaid Phone	800-541-2831
DELAWARE	**Medicaid and CHIP**
Medicaid Website	http://dhss.delaware.gov/dhss/dmma/medicaid.html
Medicaid Phone	302-571-4900 or 866-843-7212
CHIP Website	http://dhss.delaware.gov/dhss/dmma/dhcp.html
CHIP Phone	302-571-4900 or 866-843-7212
MARYLAND	**Medicaid and CHIP**
Medicaid Website	https://health.maryland.gov/mmcp/Pages/home.aspx
Medicaid Phone	855-642-8572
CHIP Website	https://mmcp.health.maryland.gov/chp/pages/home.aspx
CHIP Phone	855-642-8572 (TTY 711)

To see if your state has a premium assistance program, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights	
You have the right to:	• Get a copy of your health and claims records • Correct your health and claims records • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated
Your Choices	
You have some choices in the way that we use and share information as we:	• Answer coverage questions from your family and friends • Provide disaster relief • Market our services and sell your information
Our Uses and Disclosures	
We may use and share your information as we:	• Help manage the health care treatment you receive • Run our organization • Pay for your health services • Administer your health plan • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests and work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information below.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

- Contact you for fundraising efforts
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

October 2018

Tyema Sanchez
Privacy Officer
215-568-3262, Extension 1400

Continuation Coverage Rights Under COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Fund Office.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **www.medicare.gov/medicare-and-you**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Notes

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