2021-2022

LOWER MAKEFIELD TOWNSHIP

EMPLOYEE BENEFITS GUIDE

TOWNSHIP OF LOWER MAKEFIELD
BUCKS COUNTY, PENNSYLVANIA

In Beautiful Bucks County

2021 BENEFITS OVERVIEW

WELCOME TO THE 2021 BENEFITS OPEN ENROLLMENT

Lower Makefield Township's annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This Benefit Guide addresses some of the most frequently asked questions associated with the Lower Makefield Township benefits package. As this is only a summary of the benefits offered, for more detailed plan information, please access the vendor websites indicated throughout this document or contact CBIZ Benefit Hotline for further assistance.

WHAT CAN YOU DO AT OPEN ENROLLMENT?

- ✔ Add or remove dependents
- ✔ Add or change plans
- ✔ Enroll in coverage for the first time
- ✔ Waive coverage

WHAT ACTION IS REQUIRED FOR OPEN ENROLLMENT?

All employees must complete the Benefits Election Enrollment form; even if you are not making any changes or waive coverage.

If you are making any changes, the applicable carrier enrollment form must be completed.

Changes include make a new election, changing plans, dropping coverage, or adding or dropping dependents.

The deadline to return completed forms is Monday, June 14th!

If you do not take advantage of Open Enrollment, you will not be able to make changes to your benefit election until the next Open Enrollment period unless you have a qualifying life event during the plan year such as:

- ♦ Marriage/divorce/legal separation
- ♦ Death/disability
- ♦ Reduction/increase in work hours
- ♦ Dependent becomes ineligible
- ♦ Change in spouse's eligibility
- ♦ Birth/adoption/legal custody of a child

IMPORTANT DATES

Open enrollment runs

May 31st through June 14th

2021 BENEFITS AT A GLANCE

- ■ Medical benefits provided through Independence Blue Cross
  - ⁎ Personal Choice HDHP Plus 5B with Health Reimbursement Arrangement
  - ⁎ Personal Choice HDHP 3C with Health Savings Account
- ■ Dental benefits provided through Health Now Administrative Services
  - ⁎ Adult Orthodontia Services added!
- ■ Life Insurance provided through Standard
  - ⁎ Update your beneficiary!
- ■ Short and Long Term Disability provided through Standard

TIP **REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.**

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CONTACT INFORMATION

If you have any questions regarding your benefits, please contact one of the carriers or a CBIZ representative as listed below.

MEDICAL INSURANCE

Independence Blue Cross
www.ibx.com
800-275-2583

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

If enrolled in HDHP Plus 5B
HealthNow
mywealthcareonline.com/myhnas
800-518-8332

HEALTH SAVINGS ACCOUNT (HSA)

If enrolled in HDHP Plus 3C
Optum Bank
www.optumbank.com
866-234-8913

DENTAL INSURANCE

HealthNow
877-804-4629

LIFE AND DISABILITY

Standard Insurance
www.standard.com

CBIZ BENEFIT HOTLINE

800-820-5090
Email: pabenefits@cbiz.com

Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As a full-time employee of Lower Makefield Township, you have the choice between two medical plan options:

◊HDHP Plus 5B HRA as administered by HealthNow

◊HDHP 3C with HSA funding

For each, your deductible will run from July 1 – June 30.

While both plans give you the option of using out-of-network providers, you can save money by using in-network providers because Independence Blue Cross has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and Independence Blue Cross UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

All non-uniform employees hired **after** January 1, 2020 will be automatically enrolled in the Personal Choice HDHP 3C with HSA.

All non-uniform employees hired **before** January 1, 2020 will be under no obligation to enroll in this plan but can if they so choose.

Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

? How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

? Will I receive a new Medical ID card?

You will receive an ID card in the mail if you are electing medical coverage for the first time or making a change.

? Does the deductible run on a calendar year or policy year basis?

A policy year basis; from July 1st through June 30th.

? How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

? I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin on the 1st of the month following your employment for regular full-time employees.

HDHP vs. PPO

HOW TO GET STARTED

SELECT YOUR MEDICAL PLAN

- OPTION 1: **HDHP PLUS 5B WITH HEALTH REIMBURSEMENT ARRANGEMENT (HRA)**
- OPTION 2: **PERSONAL CHOICE HDHP 3C WITH HEALTH SAVINGS ACCOUNT (HSA)**

HDHP PLUS 5B WITH HRA HIGHLIGHTS

- Combined with the HRA benefit, in network plan benefits mirror Personal Choice 10/20/70
- Routine preventive exams are covered at 100%
- Open Access; primary care physician designation and referrals are not required.

PERSONAL CHOICE HDHP 3C WITH HSA HIGHLIGHTS

- LMT will fund your Health Savings Account (HSA)
- Routine preventive exams are covered at 100%
- Open Access; primary care physician designation and referrals are not required.

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.ibx.com.

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

TELEHEALTH—MDLIVE

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

Retail Telehealth, or a "virtual visit," lets you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! Independence Blue Cross partners with MDLive to bring you care from the comfort and convenience of your home or wherever you are. Benefits include "visits" for Behavioral Health and Dermatology services.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

Primary Care vs. Urgent Care vs. ER

MEDICAL OPTION 1: PERSONAL CHOICE HDHP PLUS 5B (HRA)

Independence Blue Cross	Personal Choice HDHP Plus 5B
In-Network *Administered through HRA as Personal Choice 10/20/70*	
Deductible (calendar year) Individual / Family	None
Coinsurance (Member Pays)	0%
Out-of-Pocket Maximum Individual / Family (includes deductible, coinsurance & copays)	None
Office Visit Primary Care Physician / Specialist	$10 / $20 copay
Preventive Care	Covered at 100%
Diagnostics Lab X-ray Major Diagnostics (MRI, CT, PET…)	 Covered at 100% $20 copay $20 copay
Urgent Care	$40 copay
Emergency Room	$40 copay
Outpatient Surgery/Procedure	$75 copay
Inpatient Hospital Services	$75/day copay; Max $375
Prescription Drug Retail (at participating pharmacies) Mail Order (90-day supply)	 $10 Generic/ $20 Brand Covered 100%
Out-of-Network *Out of Network Expenses are not reimbursable by the HRA*	
Deductible Individual / Family	$5,000 / $10,000
Member Coinsurance	50%
Out-of-Pocket Maximum Individual / Family	$10,000 / $20,000

For payroll deduction amount please refer to the Benefit Enrollment Form - Election Agreement

All DPW employees, exempt employees, management staff, and civilian employees hired **before** January 1, 2020 can elect to enroll in the Personal Choice HDHP Plus 5B Administered through HRA as Personal Choice 10/20/70 medical plan.

All non uniform employees hired **after** January 1, 2020 will be automatically enrolled into the Personal Choice HDHP 3C with HSA funding medical plan.

HEALTHNOW (HRA)

Accessing your HealthNow account online is as easy as 1-2-3. Go to mywealthcareonline.com/myhnas to **Sign In** or **Register**.

To Register, follow the following steps:

1. Click the Register button to create an account
2. On the Registration screen, enter your information in all the required fields marked with a red asterisk (*)
   - Registration ID; select Employer ID and enter "**BCIB81**" or enter your Health Now HRA Debit Card number
   - Employee ID is the Employee SSN without dashes)

HEALTHNOW DEDICATED SERVICE TEAM

A service team will be available to assist you Monday - Friday, 8:30 a.m. to 9:00 p.m.
Just call (800) 518-8332

PERSONAL CHOICE HDHP PLUS 5B & HRA PROCESS

Important Information Regarding your HDHP Plus 5 B (HRA) Medical Benefit:

At the point of service you must present your Independence Blue Cross (IBC) card. IBC will generate an Explanation of Benefits (EOB) statement. The health care provider will send you an invoice. HealthNow/CBIZ will need both the EOB and invoice (they need to match) before processing the claim for payment. Once you receive both documents you can email to CBIZ or process the claim on the HealthNow portal. Note that Out of Network providers are not reimbursable under the Health Reimbursement Account (HRA).

To simplify and speed up the process we recommend you do the following:

Set up your personal IBC Account (www.ibxpress.com)

- This will allow you to directly monitor your claims activity as they move through the IBC system.

Provide CBIZ your current IBXpress login information

- CBIZ will print EOB's needed to process claims if this information is available to them.
- If password is changed in the future; email the new one to CBIZ at PlymouthClientServices@cbiz.com
- Dependents over age 18 on your medical plan will need their own IBXpress login information. This information will also need to be provided to CBIZ so EOB's can be printed for their expenses.

Set up your Health-Now account (see page 8)

- This will allow you to check on all your claims activity, and review claims that have been paid by HealthNow including the date check was processed and check number.
- You do not need to provide CBIZ your HealthNow login information.

Important Information Regarding your Prescription Benefit:

The RX program copay is **$10 (generic)/$20 (brand).** An invoice will be generated and sent to you for the copay by CBIZ. Payment instructions will be stated on your invoice. **Please remember it is the employee's responsibility to keep records of prescription transactions and send copies to CBIZ.**

<u>At the Pharmacy</u>

1. Present your IBC Personal Choice card and HealthNow HRA credit card (<u>if prescription is over $10.00</u>).
2. The HRA card can be used as payment at the Pharmacy
   - If prescription is under $10.00 please do not use your HRA card and pay for this with another form of payment.
3. Keep the pharmacy receipt (the one attached to the bag) and email to CBIZ at PlymouthClientServices@cbiz.com
   - Receipt sent to CBIZ **<u>MUST</u>** show the name of the prescription. Just sending the store receipt does not fulfill your responsibility. **If the drug name is not listed on the receipt you will be invoiced at the highest RX copay ($20.00).**
   - If you pay your copay at point of sale CBIZ will still need the receipt showing copay was paid.

<u>Using Mail Order</u>

You will need to complete a Future Scripts mail order form using your HealthNow HRA credit card as payment; include a copy of the RX from your doctor for each prescription. Send form directly to **Future Scripts.**

MEDICAL OPTION 2: PERSONAL CHOICE HDHP PLUS 3C (HSA)

Independence Blue Cross	Personal Choice HDHP Plus 3C
In-Network	
Deductible (calendar year) Individual / Family	$3,000/$6,000
Coinsurance (Member Pays)	10%
Out-of-Pocket Maximum Individual / Family (includes deductible, coinsurance & copays)	$6,550/$13,100
Office Visit Primary Care Physician Specialist	10% after deductible
Preventive Care	Covered 100%
Diagnostics Lab & X-ray Major Diagnostics (MRI, CT, PET...)	10% after deductible
Urgent Care	10% after deductible
Emergency Room	10% after deductible
Outpatient Surgery/Procedure	10% after deductible
Inpatient Hospital Services	10% after deductible
Prescription Drug Retail (at participating pharmacies) Mail Order (90-day supply)	(All copays apply after deductible) $20/$40/$60 2 times retail copay
Out-of-Network	
Deductible Individual / Family	$5,000 / $10,000
Member Coinsurance	50%
Out-of-Pocket Maximum Individual / Family	$10,000 / $20,000

For payroll deduction amount please refer to the Benefit Enrollment Form - Election Agreement

All DPW employees, exempt employees, management staff, and civilian employees hired **before** January 1, 2020 can elect to enroll in the Personal Choice HDHP Plus 5B Administered through HRA as Personal Choice 10/20/70 medical plan.

All non uniform employees hired **after** January 1, 2020 will be automatically enrolled into the Personal Choice HDHP 3C with HSA funding medical plan.

Lower Makefield Township will fund your 2021 HSA account: $3,500 single coverage or $6,500 for family coverage.

(For new hires HSA funding amount will be prorated).

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

- Regular payroll deductions on a pre-tax basis, and
- Lump-sum contributions of any amount, anytime, up to the maximum limit.

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep — the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the company, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future — even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses — even if they're not covered by your medical plan.

What Is A Health Savings Account?

Contribute up to
$3,600 Single, or $7,200 Family
[Combined Employer and Employee Contribution]

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2021 are $3,600 for Single and $7,200 for Family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications (such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

HEALTH SAVINGS ACCOUNT (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications (such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

THIS MAY BE THE BEST PLAN OPTION FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.

FREQUENTLY ASKED QUESTIONS

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your plan year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to Independence Blue Cross (IBC). You should not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from IBC that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to www.ibxpress.com.

ADDITIONAL BENEFITS

IBXPRESS MEMBER PORTAL

The IBXpress member portal provides access to a personalized, secure website to help manage your health and benefits. The site allows you to:

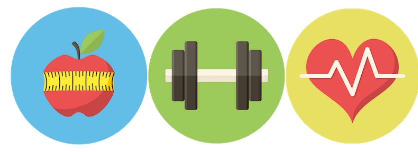
- Access benefit information
- View processed claims and print Explanation of Benefits statements
- Find a doctor
- Download forms
- Print an ID Card

Register at www.ibxpress.com

HEALTHY LIFESTYLES WELLNESS REIMBURSEMENTS

Your IBC medical Plans include wellness reimbursements. Take advantage of everything your membership offers to reach and maintain your wellness goals.
Below is a summary of the reimbursement programs available to you.

- Fitness: Receive up to $150/year if you work out 120 times within a 365 day period.
- Weight Management: Receive up to $150 back when you participate in an approved weight management program; includes Weight Watchers®.
- Tobacco Cessation: Receive up to $150 back when you complete an approved program to help quit using tobacco.

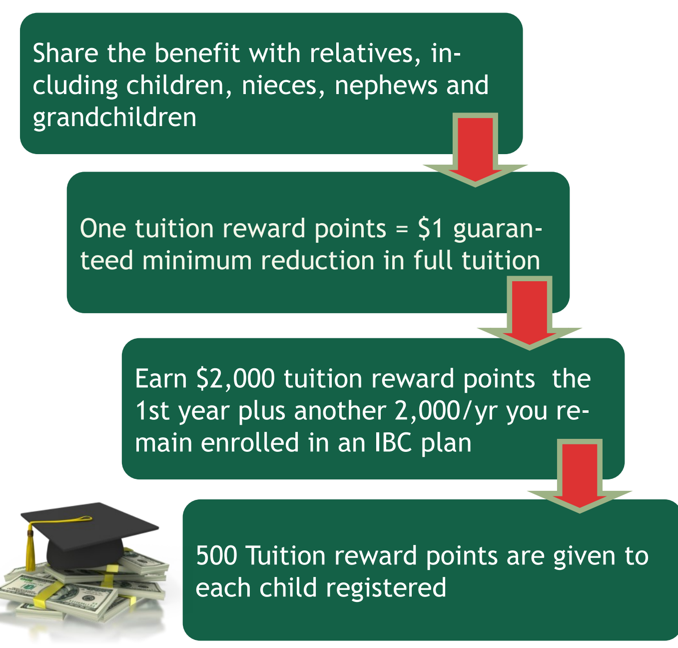


MEMBER ADVANTAGES

- Free nutrition counseling visits: 6 visits/year with a participating registered dietitian, your doctor, or another network provider
- Discounts on health products and services:
  - ◊Fitness gear
  - ◊Gym memberships
  - ◊Laser vision correction
  - ◊Hearing aids
- Health coach: Available 24/7 to answer health questions and address concerns

COLLEGE TUITION BENEFIT

This program gives employees a way to accrue rewards for college tuition savings for your children or other family members. It works much like a scholarship program, where the tuition rewards can accumulate up to one year of tuition at participating colleges.



To register go to www.ibx.CollegeTuitionBenefit.com
Lower Makefield Township's CID # 36812
Password is your IBC member number

ACUPUNCTURE BENEFIT

What is acupuncture? Acupuncture is a health practice that involves using needles placed under the skin to stimulate points in the body and ease symptoms. Studies suggest acupuncture may help ease chronic pain and certain other conditions and is a reasonable option for people with chronic pain to consider.
How does Independence cover acupuncture? Members are covered for 18 acupuncture visits for pain management and certain other conditions:

- Headache (migraine, tension)
- Post-operative and chemotherapy-induced nausea, vomiting
- Nausea from pregnancy
- Low back pain
- Pain from osteoarthritis of knee/hip
- Chronic neck pain

Acupuncture for these conditions is available without precertification.

DENTAL INSURANCE

REVIEW YOUR DENTAL PLAN

Health Now Administrative Services (HNAS) administers the dental benefit. It is an indemnity plan, which means you can seek care from any licensed dentist without concern for a specific network.

Dependent children are **eligible until the end of the month** in which they turn age 26.

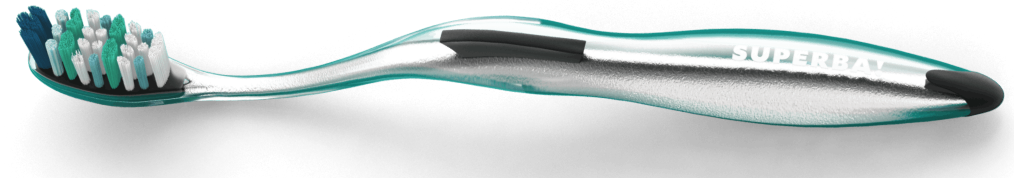
What Is Dental Insurance?

DENTAL BENEFITS		
Annual Maximum	Police: $1,800 All other Active Employees: $1,500	Based on the calendar year. Orthodontia services excluded from this maximum.
Orthodontia Lifetime Maximum	Police: $1,800 All other Active Employees: $800	Available to children and adults
	Plan Pays	
Diagnostic / Preventive Services	100%	■ Oral Evaluations ■ Cleanings ■ X-Rays ■ Fluoride Treatments ■ Sealants ■ Space Maintainers
Basic Services	100%	■ Fillings ■ Endodontics ■ Simple & Surgical Extractions ■ General Anesthesia
Major Services	50%	■ Periodontics (Scaling & Root Planning) ■ Periodontal Surgery ■ Crowns ■ Inlays/Onlays ■ Bridges & Dentures ■ Prosthodontics
Orthodontia Services	50%	■ Diagnostics & Treatment for children & adults

Filing a Dental Claim

Filing a claim: A Claim of Benefits must be submitted for each expense. Many providers will submit the claim on your behalf. If another plan is the primary payor, a copy of that plan's Explanation of Benefits (EOB) must accompany the claim. Additional information may be needed from you, the patient, or the health care Provider in order to establish the circumstances of a claim or the correct benefit. If so, you will receive a notification of a delay and/or a request for information, your prompt response will assist in the quick processing of the claim.

Submit claims to: HealthNow Administrative Services, PO Box 211034, Eagan, MN 55121



LIFE INSURANCE AND AD&D

BASIC LIFE AND AD&D

Lower Makefield Township provides Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

- All Active Employees: $100,000
- Elected Supervisors: $10,000

This coverage is offered through STANDARD INSURANCE at no cost to you.

REVIEW YOUR LIFE INSURANCE POLICY

- ADD YOUR SPOUSE
- ADD YOUR DEPENDENTS
- INCREASE YOUR COVERAGE

What Is Life And AD&D Insurance?

VOLUNTARY SUPPLEMENTAL LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what Lower Makefield Township provides. Standard guarantee issues coverage during your initial enrollment period — which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life & AD&D:** minimum $10,000 to a maximum of $500,000 in $10,000 increments. Guarantee issue up to $50,000.
- **Optional Spouse Life & AD&D:** minimum $5,000 $250,000 maximum in $5,000 increments. Guarantee issue up to $25,000. The coverage amount for your spouse cannot exceed 100% of your supplemental life election.
- **Optional Child Life & AD&D:** minimum $2,000 up to $10,000 maximum in $2,000 increments. Guarantee issue up to $10,000. The coverage amount for your child(ren) cannot exceed 100% of your supplemental life election.

If you don't enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability (EOI) form and be approved by Standard before you're able to get coverage in the future.

Please note:
You must be enrolled in voluntary life and/or ADA& life coverage in order for your spouse, and/or eligible dependent children to enroll.

Annual Benefit Increase for Employees & Spouses
Current participants may increase the employee or spouse benefit by one increment up to the applicable Guarantee Issue amount without medical questions.

DID YOU KNOW? LOWER MAKEFIELD TOWNSHIP provides you Basic Life and AD&D AT NO CHARGE.

Voluntary Life and AD&D and Dependent Life Options and Costs

	Monthly Rates per $1,000 of coverage		
Standard	Age	Employee	Spouse*
Voluntary Life	<29	$0.086	$0.054
	30-34	$0.093	$0.071
	35-39	$0.110	$0.082
	40-44	$0.125	$0.094
	45-49	$0.197	$0.145
	50-54	$0.306	$0.222
	55-59	$0.488	$0.543
	60-64	$0.614	$1.059
	65-69	$0.882	$1.960
	70-74	$1.456	$4.252
	75+	$4.632	$12.607
	Child(ren)	$0.200	

Spouse rate is based on the employee's age.

DISABILITY INSURANCE

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is offered through Standard. Lower Makefield Township pays 100% of the premium cost.

Benefits are paid on the 1st day for an accident and the 8th for sickness. Benefits can continue for up to 26 weeks.

Benefit:
- All Active Employees: $300
- Active Public Works Employees: $150

LONG-TERM DISABILITY INSURANCE

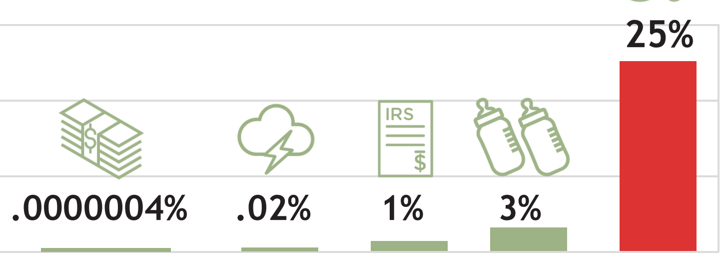
Long-Term Disability insurance is offered through Standard at no cost to you.

The benefits begin after a 180 day waiting period and continue through age 65 or SSNRA if you remain disabled.

Benefit:
- All Active Employees: $5,000
- Active Public Works Employees: $2,500

WHAT'S MORE LIKELY?

Many workers think these events are more likely than becoming disabled during their careers. But here are the actual odds:



Winning Mega Millions	Being struck by lightening	IRS Audit	Having Twins	Becoming Disabled
.0000004%	.02%	1%	3%	25%

In fact, nearly **40 million** American adults live with a disability.

What Is Disability Insurance?

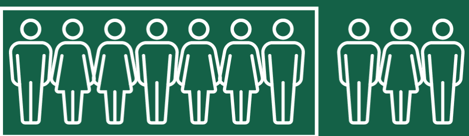
REVIEW YOUR DISABILITY COVERAGE

- SHORT-TERM DISABILITY
- LONG-TERM DISABILITY

COULD YOU PAY THE BILLS IF YOU WEREN'T WORKING?

Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

Nearly **70%** of workers that apply to Social Security Disability Insurance **are denied.**



RESOURCES

VIDEO RESOURCES

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- HDHP With HSA Overview

INSURANCE 101

- Benefits Key Terms Explained
- How To Read An EOB
- What Is A Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What Is A Health Savings Account?

ANCILLARY BENEFITS

- What Is Dental Insurance?
- What Is Life And AD&D Insurance?
- What Is Disability Insurance?

CBIZ BENEFIT HOTLINE

The Benefit Hotline provides you with direct access to benefit specialists who can assist you with any questions or concerns you may have about the benefits available to you as a Lower Makefield Township employee. Call the Benefit Hotline at (800) 820-5090 (available Monday - Friday, 9:00 a.m. to 5:00 p.m.) or email PABenefits@cbiz.com for help regarding:

- Benefit Questions
- Eligibility
- Plan Design Information
- Claims Issues

CBIZ is happy to help you with all your benefit questions/issues. Below is an overview of the contact information for the different issues you may have. Please use the following contact information:

All medical EOBs, medical invoices and prescription drug receipts should be emailed to PlymouthClientServices@cbiz.com or faxed to (610) 862-2500

All benefit questions/issues can be emailed to PABenefits@cbiz.com or call (800) 820-5090

EMPLOYEE ASSISTANCE PROGRAM (EAP)

A helping hand when you need it. Rely on the support, guidance and resources of your Employee Assistance Program (EAP) through Standard Insurance Company. There are times in life when you might need a little help coping or figuring out what to do. Your EAP which includes WorkLife Services is available to you and your family. It's confidential and available 24/7 by phone, online, live chat, email and text. Your EAP includes up to three face to face assessment and counseling sessions per issue.

Contact EAP by calling (888) 293-6948 online at workhealthlife.com/Standard3

TheStandard

GLOSSARY OF TERMS

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Lower Makefield Township coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Lower Makefield Township coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Lower Makefield Township 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 November to join.

IMPORTANT NOTICES

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 Lower Makefield Township changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: July 1, 2021

Name of Entity/Sender: Lower Makefield Township

Contact-Position/Office: Finance Department

Address: 1100 Edgewood Rd, Yardley PA 19067

Phone Number: 267-274-1199

IMPORTANT NOTICES

MEDICAID CHIP NOTICE

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility—

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IMPORTANT NOTICES

IOWA - Medicaid and CHIP (Hawki)	MONTANA - Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS - Medicaid	**NEBRASKA - Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY - Medicaid	**NEVADA - Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA - Medicaid	**NEW HAMPSHIRE - Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE - Medicaid	**NEW JERSEY - Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS - Medicaid and CHIP	**NEW YORK - Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA - Medicaid	**NORTH CAROLINA—Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI - Medicaid	**NORTH DAKOTA - Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

IMPORTANT NOTICES

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because you have other health coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

Non-Medical

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or SCHIP.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

Rights under COBRA

As a Lower Makefield Township employee, you are eligible for COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985 as amended). This gives employees and their qualified beneficiaries the opportunity to continue health insurance coverage for specified periods of time under the Company's health plan when a "qualifying event" occurs. Some common qualifying events are resignation, termination of employment (other than for gross misconduct), or death of an employee; a reduction in an employee's hours or a leave of absence; an employee's divorce or legal separation; and a dependent child no longer meeting eligibility requirements. Under COBRA, the employee or beneficiary pays the full cost of coverage at the employer's group rates plus an administration fee.

IMPORTANT NOTICES

Family and Medical Leave Act - FMLA

The Family and Medical Leave Act of 1993 ("FMLA") requires Lower Makefield Township. to provide eligible employees with up to 12 weeks per year of leave in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or
- twenty-six work weeks of leave during a single 12-month period is permitted to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

An eligible employee is one who:

- Works for a covered employer;
- Has worked for the employer for at least 12 months;
- Has at least 1,250 hours of service for the employer during the 12 month period immediately preceding the leave*; and
- Works at a location where the employer has at least 50 employees within 75 miles.

Source: http://www.dol.gov/whd/fmla/
Please contact Human Resources if have any questions or need to request leave.

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The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.