Inspira Health Network
2018-2019 Benefits Guidebook

IT'S IN THE PEOPLE

At Inspira Health Network, we appreciate your commitment to our patients, and we share that commitment to our community of patients, employees, and families. That's why we are proud to offer a benefits plan that's valuable, flexible and competitive. It's valuable because it helps protect you and your family from financial hardship. It's flexible because you may select from an array of benefits based on your personal situation. It's competitive because it's one of the best plans offered within our industry. This guide will help you review your options and enroll in your benefit plans.

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What's Inside

This Benefits Guidebook will help familiarize you with the Inspira Health Network Benefits Program. Please review this Benefits Guidebook and share it with your family. Doing so will enable you to choose the benefit plans and options that best meet your particular needs.

This Benefits Guidebook acts as a decision guide, outlining the choices you can make to enroll in benefits. Whether you are a new employee, experiencing a life event such as a birth or a marriage, or evaulating your benefits during Annual Benefits Enrollment, you can submit your benefit elections online at **www.myinspirabenefits.org**.

If you have any questions regarding enrollment, please contact:

During the Year:

- Call the Employee Benefits Center at 1-800-307-0230 or Inspira's HR Service Center at 1-856-641-MYHR.
- For any voluntary benefit payroll-deduction questions, please call 1-866-402-9863.
- For mid-year benefit changes due to life events, please call 1-800-307-0230.
- To enroll as a newly hired or newly eligible employee, please call 1-866-402-9863.

During the Annual Benefits Enrollment period:

- To enroll in benefits or ask questions, call the enrollment center at 1-800-868-0798.

About Our Plans

Plan Year

The Inspira Health Network benefits plan year extends from April 1st through the following March 31st; Dental and Vision benefits run on a calendar year basis (from January 1st through December 31st). The Flexible Spending Account (FSA) and Health Savings Account (HSA) benefit periods run from April 1st to June 15th of the following year.

Eligibility

You are eligible to enroll in the Benefits Program if you are an active full-time employee or part-time/Baylor employee (20 hours per week and above).

Dependent Coverage

Dependents eligible for coverage include:

- Your same or opposite-sex legal spouse (valid marriage certificate required as proof)
- Your dependent children up to age 26 regardless of marital status, student status, financial dependency, residence, or access to other employer-sponsored health plans.

Please note that Medical/Prescription, Dental, and Vision coverage terminate at the end of the month in which the dependent attains the age limit specified by the plan.

Program Elements

Your benefits include the following "shared cost" elements: Medical/Prescription and Dental coverage. **Inspira Health Network pays most of the costs for these benefits; your contributions cover the rest.**

Basic Life and Accidental Death and Dismemberment Insurance (AD&D) and Basic Long-Term Disability Insurance are provided by Inspira Health Network **at no cost to you.**

In addition, Inspira Health Network makes available a variety of employee-paid benefits. These benefits include Vision coverage and Flexible Spending Accounts (FSAs), as well as Voluntary Benefits such as Supplemental Group Life Insurance, Short-Term Disability, Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance, Identity Theft Protection, Permanent Life Insurance, and Legal Insurance. **Employees who elect these benefits pay 100% of the benefit cost, but receive a discounted rate for being part of the Inspira Health Network group.**

Shared Cost Benefits:
Medical and Prescription
Dental

Company-Paid Benefits:
Basic Life and AD&D
Long-Term Disability (LTD)

Employee-Paid Benefits:
Vision
FSAs
Supplemental Group Life
Supplemental LTD
Short-Term Disability
Accident Insurance
Critical Illness Insurance
Hospital Indemnity Insurance
Identity Theft Protection
Permanent Life
Legal Insurance

Enrolling or Making Changes

Many events in your work or personal life can impact your benefits. Several of the benefit programs require that you enroll within a specified period of time.

NEWLY HIRED EMPLOYEES
31 Days from Date of Eligibility

If you are a newly hired employee, you have 31 days from the date you are eligible to make your benefit enrollment elections. During this time period, you should decide which benefits meet your needs (health, dental, and any other insurance plans), and determine if you want to enroll in a flexible spending account (FSA). If you miss your deadline, then your next opportunity to enroll in benefits is during the Annual Benefits Enrollment period or if you experience a qualifying life event.

You also have 31 days from your eligibility date to make decisions on benefits. You will not be able to enroll until the next Annual Benefits Enrollment period. If you later wish to enroll in these benefits, you much provide Evidence of Insurability.

ANNUAL BENEFITS ENROLLMENT

Each year, we offer an Annual Benefits Enrollment period, during which you can enroll in, or make changes to, your benefits. Employees will be notified of an upcoming Annual Benefits Enrollment period before it begins. Even if you fail to enroll as a newly hired employee and do not experience a qualifying life event, you may enroll during the next Annual Benefits Enrollment period.

QUALIFYING LIFE EVENTS
31 Days From Date of Event

If you experience a qualifying life event, you may make changes to your benefits within 31 days of the event. The Internal Revenue Service (IRS) states that eligible employees may make elections to the plan only once a year; annual enrollment benefit choices are binding through March 31st. The following special circumstances are some of the reasons you may change your benefits during the plan year:

- Marriage, divorce, legal separation
- Birth or adoption (or placement of adoption) of a child
- Death of a covered dependent
- Loss or gain of group insurance coverage for yourself or a covered dependent
- Termination or commencement of your spouse's coverage, in general, when coverage is maintained through your spouse's plan
- Shift from part-time to full-time status (or vice versa) by you or your spouse
- Shift from per diem or flex to part-time or full-time status (or vice versa) by you or your spouse
- When a dependent satisfies or ceases to satisfy eligibility requirements
- Taking an unpaid leave of absence (you or your spouse)
- Gain or loss of eligibility for Medicaid or a Children's Health Insurance Program (CHIP) or for a premium assistance subsidy under these programs (60-day election period)
- A residence or worksite change that impacts health care coverage

If you experience a qualifying life event and would like to update your benefits, you must report the qualifying life event online at **www.myinspirabenefits.org** within 31 calendar days of the event and provide the appropriate documentation. Documentation may include a birth, marriage, or death certificate, divorce decree, or proof of loss or gain of coverage.

Reporting Qualifying Life Events:

The 31-calendar day deadline is a critical factor toward successfully completing a qualifying life event change. If you do not report the qualifying life event online at **www. myinspirabenefits.org** and provide the requested documentation within 31 calendar days of the event (unless otherwise noted), you will not be eligible to make changes until the next Annual Benefits Enrollment period.

Our Medical Plans

Inspira Health Network offers two different medical plans:

- **Horizon Omnia Plan**
- **Horizon MyWay HSA Plan**

You may choose whichever plan best meets the needs of your family, or you may waive medical coverage. While both medical plans cover the same types of services, each provides coverage at a different level and requires you to contribute a different amount per pay period toward the premium. Please refer to the Medical Plan Summaries on the following pages for more specific information about your plan options (including coverage details such as copayments, deductibles, and coinsurance).

Option 1: Horizon Omnia Plan

If you choose this option, you and each covered family member will have access to three levels of providers. Your out-of-pocket costs for health care services will be determined by where you receive care.

1. **Inspira Inner Circle:**
   Inspira providers and facilities; reduced or zero copays. When you receive care, you pay the least at Inner Circle providers and facilities.
2. **Horizon Omnia Tier 1:**
   Horizon affiliated NJ providers and facilities determined by Horizon to be high-quality and low-cost
3. **Horizon Omnia Tier 2:**
   Additional Horizon providers and facilities, both in NJ and across the USA

Aside from Urgent and Emergency care, out-of-network care is not covered under the Horizon Omnia Plan.

Option 2: Horizon MyWay HSA Plan

The MyWay HSA Plan gives you the freedom to spend your health care dollars where you choose—at a higher out-of-pocket cost when you receive care. See pages 6 & 7 to learn about this medical plan.

Option 3: Waiving Coverage

If you are not enrolling in one of our medical plans, you must visit the benefits website at **www.myinspirabenefits.org** and waive coverage.

Finding a Participating Provider

Our medical plans give you access to a national network of doctors and hospitals. To find in-network providers and hospitals:

Step 1: Go to **www.HorizonBlue.com/Inspira**

Step 2: Select "Doctor & Hospital Finder"

Step 3: Use the search fields to select a network and find providers in the Omnia or MyWay HSA plan

Questions?

If you have questions regarding your medical benefits, use the contact information provided below.

By Phone:
Horizon: 1-833-876-3827

Online:
www.HorizonBlue.com/Inspira

Horizon Omnia Plan

Horizon Omnia Plan Summary

Benefit Description	Inspira Inner Circle	Omnia Tier 1	Omnia Tier 2
Annual Deductible	None	$2,000 per person, up to $4,000 per family	$2,500 per person, up to $5,000 per family
Annual Medical Out-of-Pocket Maximum	$5,200 per person, up to $10,400 per family. *Combined across all tiers. Deductible and copays count towards the maximum.*		
Coinsurance *(employee share for select services)*	pay 0%	pay 50%	pay 60%
Doctor's Office Visits			
Primary Care Office Visit	$0	$20 copay	$80 copay
Specialist Office Visit	$0	$30 copay	$100 copay
Routine Adult Physical Exam	$0	$0	$0
Routine OB/GYN Exam	$0	$0	$0
Maternity Care[1]	$0 (first visit only)	$40 (first visit only)	$80 (first visit only)
Well Child Exam	$0	$0	$0
Child Immunizations	$0	$0	$0
Hospital Services			
Inpatient Admission *(including maternity)*	$0	$1,000 copay, then 50% after deductible	$1,000 copay, then 60% after deductible
Surgery in Hospital	$0	50% after deductible	60% after deductible
Inpatient Physician Services	$0	50% after deductible	60% after deductible
Outpatient Services *(non-surgical)*	$0	50% after deductible	60% after deductible
Outpatient Surgery			
Hospital Outpatient Surgery	$0	$500 copay, then 50% after deductible	$500 copay, then 60% after deductible
Surgery in an Ambulatory SurgiCenter	$0	$500 copay, then 50% after deductible	$500 copay, then 60% after deductible
Diagnostics			
Routine Radiology Services	$0	$40 copay per service	60% after deductible
Hi-Tech Radiology Services[2]	$0	$250 copay per service	60% after deductible
Labs			
Non-Routine Laboratory *(no coverage at freestanding labs other than LabCorp)*	$0	$30 in office or LabCorp; Deductible and 50% coinsurance in hospital labs	$30 in office or LabCorp; Deductible and 60% coinsurance in hospital labs

[1] An additional copay may also apply to each ultrasound. Precertification is required for more than 3 ultrasounds.

[2] Hi-Tech Radiology Services consist of MRIs/MRAs, PET Scans, CT/CTA scans, and Nuclear Medicine

Horizon Omnia Plan Summary

Benefit Description	Inspira Inner Circle	Omnia Tier 1	Omnia Tier 2
Emergency Services			
Urgent Care	$20 copay	$60 copay	$100 copay
Emergency Room *(copay waived if admitted)*	$100 copay	$100 copay	$100 copay
Ambulance *(ground transport only)*	$0	$0	$0
Mental Health/Substance Abuse			
Inpatient	$0	$1,000 copay, then 50% after deductible	$1,000 copay, then 60% after deductible
Outpatient Facility	$0	$40 copay	60% after deductible
Office Visit	$0	$40 copay	$80 copay
Therapy Services*			
Short-term Therapies: Physical, Occupational, Speech, Respiratory	$0	Physician's Office: $60 copay Inpatient Hospital: 50% after deductible Outpatient Hospital: $60 copay	Physician's Office: $100 copay Inpatient Hospital: 60% after deductible Outpatient Hospital: 60% after deductible
Chiropractic Care *(40 combined visit maximum)*	N/A	$60 copay	$100 copay
Other Services			
Infertility *(excludes in-vitro fertilization; $5,000 lifetime maximum)*	$0 copay	$60 copay, then 50% after deductible	60% after deductible
Dialysis	$0	50% after deductible	60% after deductible
Skilled Nursing (*100 day limit per year combined)*	$0	50% after deductible	60% after deductible
Home Health Care	$0	50% after deductible	60% after deductible
Hospice Care	$0	50% after deductible	60% after deductible
Private Duty Nursing	$0	50% after deductible	60% after deductible
Durable Medical Equipment	$0	$0	$0
Prosthetics	$0	50% after deductible	60% after deductible
Diabetic Supplies	$0	$0	$0

** **Therapy maximums per year: Physical Therapy:** 60 days Inpatient, 40 days Outpatient, 3 modalities per visit. **Speech Therapy:** 40 visits per condition. **Occupational Therapy:** 40 visits per condition, 3 modalities per visit. **Pulmonary/Respiratory Rehab:** Unlimited. **Cognitive Therapy:** 40 visits per condition, 3 modalities per visit. **Cardiac Rehab:** Unlimited.*

Horizon MyWay HSA Plan

With the Horizon MyWay HSA Plan, you are responsible for a deductible before benefits are paid. This plan includes a Health Savings Account (HSA), allowing you to set aside your own money each paycheck to pay for your health care expenses.

About the MyWay HSA Plan

While the Horizon MyWay HSA Plan has lower employee contributions, you may pay more out-of-pocket upfront for your health care services.

- The Horizon MyWay HSA Plan includes prescription drug coverage through CVS Caremark. See page 8 for prescription drug coverage information.
- If you wish to contribute to the Horizon MyWay HSA Plan's Health Savings Account, you will be required to open an HSA Advantage Direct bank account.
- Once you enroll in this plan, you will receive a MyWay debit card to conveniently pay for eligible health care expenses using HSA funds.
- The most you can contribute to your HSA each year is $3,450 for individual coverage or $6,850 for family coverage. If you are age 55 or older, you may be eligible to make an additional "catch-up" contribution of $1,000 each year.
- HSAs are only available to Horizon MyWay HSA Plan participants: you and your dependents generally cannot have any other coverage. For further details, please see **www.irs.gov/pub/irs-pdf/p969.pdf**.
- If you wish to enroll in a Health Care Flexible Spending Account while in the Horizon MyWay HSA Plan, you must select the **Limited Use Medical FSA**. Until you satisfy your medical plan deductible, this FSA can only be used to cover dental and vision expenses. Once you reach your deductible, you may use this FSA to cover medical expenses, as well.

Using a Health Savings Account (HSA)

When you enroll in the Horizon MyWay HSA Plan, you must set up a Health Savings Account. This is a special kind of bank account where you contribute funds pre-tax from each paycheck.

PLANNING TO MEET THE DEDUCTIBLE

Before the MyWay HSA Plan begins to pay benefits each year, you must first pay for health care services up to the deductible amount: $2,000 per individual, $4,000 for your whole family. Once you meet the deductible, the plan will typically pay 100% of the cost for health care services received **within the network** and 70% of the cost for care received **outside** of the network.

This is where your HSA comes in. You may use your HSA funds both to meet the deductible, and to pay for your share of other health care costs. Your HSA accumulates each year, so you can prepare for any medical issues. **And, of course, preventive medical visits, such as annual physicals, child immunizations, and routine GYN exams, are free of cost and not subject to the deductible.**

Prescription Benefits

The MyWay HSA Plan uses CVS Caremark to administer prescription drug benefits. Under this plan, prescription drugs are treated like any other benefit: you pay out-of-pocket until you meet your annual deductible. Once you have met your deductible, you are responsible for a 20% coinsurance. Preventive medications require no deductible: you pay $0 or 20% coinsurance depending on the drug. You will receive a separate ID card from CVS Caremark for this coverage.

Employees age 65 or older **AND** enrolled in Medicare can enroll in the Horizon HDHP plan, but are **NOT** permitted to contribute to the Health Savings Account.

Horizon MyWay HSA Plan Overview

Benefit Description	In-Network	Out-of-Network
Annual Deductible	$2,000 per individual, $4,000 per family	
Annual Out-of-Pocket Maximum *(includes prescription drugs)*	$6,650 per person, $13,300 per family	$10,000 per person, $20,000 per person
Coinsurance	You pay $0 after deductible	You pay 30% after deductible
Coinsurance, Preventive Services	You pay $0, no deductible	No Benefit
Doctor Office Visits		
Routine Adult or Child Physical	$0 (no deductible)	30% coinsurance (no deductible)
Physician Office Visit *(Primary Care or Specialist)*	$0 after deductible	30% coinsurance after deductible
Diagnostic X-ray & Laboratory	$0 after deductible	30% coinsurance after deductible
Hospital Services		
Inpatient or Outpatient Services	$0 after deductible	30% coinsurance after deductible
Emergency Services		
Emergency Room	$0 after deductible	30% coinsurance after deductible
Ambulance *(ground & air transport)*	$0 after deductible	$0 after deductible
Therapy Services		
Short-Term Therapies: Physical, Speech, Occupational, & Cognitive Rehabilitation	$0 after deductible	30% coinsurance after deductible *40 visits for each therapy per calendar year in- and out-of-network combined; limit of 3 modalities per visit, out-of-network only*
Chiropractic Care	$0 after deductible	30% coinsurance after deductible *30 visits per calendar year in- and out-of-network combined*
Mental Health/Substance Abuse[1]		
Inpatient Services	$0 after deductible	30% coinsurance after deductible
Outpatient Services	$0 after deductible	30% coinsurance after deductible
Other Services		
Vision Care (Exam & Hardware)	$0 after deductible	30% coinsurance after deductible *$100 allowance provided every two years in- and out-of-network combined*
Skilled Nursing	$0 after deductible	30% coinsurance after deductible *120 days per calendar year, following a three or more day prior hospital stay*
Home Health Care	$0 after deductible	30% coinsurance after deductible *90 visits, direct admission*
Hospice Care[2]	$0 after deductible	30% coinsurance after deductible
Private Duty Nursing	$0 after deductible	30% coinsurance after deductible *30 visits per calendar year*
Durable Medical Equipment and Prosthetics	$0 after deductible	30% coinsurance after deductible
Infertility *(excludes in-vitro fertilization)*	$0 after deductible	30% coinsurance after deductible *$5,000 lifetime maximum in- and out-of-network combined*

[1] All Inpatient Facility Mental Health/ Substance Abuse Services must be coordinated through Horizon BCBSNJ (visit **www.horizonblue.com***).*

[2] Eligibility for this benefit requires a confirmed diagnosis of terminal illness with a life expectancy of six months or less.

Prescription Benefits

Both Horizon medical plans include the Inspira Health Network prescription program administered by CVS Caremark. Fill prescriptions by mail or at a retail pharmacy, and pay according to the "tier" of the drug.

Inspira Health Network Prescription Program (administered by CVS Caremark)

	Horizon Omnia Plan		Horizon MyWay HSA Plan
Medication Type	**Retail (30-day)**	**Mail Order or CVS (90-day)**	**Retail/Mail Order**
Preventive (if eligible)	$0	$0	No deductible, pay $0 or 20%.
Generic	$5 copay	$10 copay (up to 90-day)	Pay 20% after deductible
Preferred Brand	$40 copay	$80 copay (up to 90-day)	Pay 20% after deductible
Non-Preferred	$55 copay	$110 copay (up to 90-day)	Pay 20% after deductible
Specialty	N/A	$100 copay (up to 30-day)	Pay 20% after deductible
Rx Out-of-Pocket Maximum	$2,150 per person, up to $4,300 per family		Included in medical max. of $6,650/person, $13,300/ family

You can manage your prescriptions online at **www.caremark.com**. The website includes tools that allow participants to locate a pharmacy, order mail order refills, track mail orders, ask questions, and obtain information on specialty medications.

GENERIC VS. PREFERRED VS. NON-PREFERRED DRUGS

When you get your medications at a pharmacy, you are responsible for paying a copay or coinsurance. In most instances, your cost is the lowest when you select a **generic** version of a prescription. You may be required to select a generic prescription if one is available.

Preferred brand drugs on the CVS Caremark Performance Drug List have the next highest cost, but still cost less than other brand-name drugs. They are chosen for their clinical value and cost-effectiveness.

Choosing **non-preferred** brand name drugs (ie., not on the CVS Caremark Performance Drug List) will result in the highest cost, even though they are covered under the plan.

SPECIALTY PHARMACY SERVICES

CVS Caremark Specialty Pharmacy Services are available to help those with **specialty medication** needs. This program allows you to obtain expensive injectable and oral specialty medications through mail order. Other features include:

- Access to the Advanced Control Specialty Pharmacy list;
- Personal attention from a pharmacist-led CareTeam to help manage your therapy;
- Ordering through a toll-free number;
- Claims assistance to help determine coverage and file the necessary paperwork;
- Confidential and convenient delivery of medications and supplies to the location of your choice; and
- Helpful follow-up calls to offer reminders and answer any questions you may have.

To start taking advantage of these benefits, or if you have general questions concerning CVS Caremark Specialty Services, please call 1-800-237-2767.

Notes on the Horizon Omnia Plan

- **If you order a brand-name drug** when a generic version is available, you will pay the generic copay **plus** the price difference between the brand and generic medication.
- **Save money on maintenance medications** at any CVS Retail Pharmacy or by using CVS Caremark's mail order program! Fill a 90-day order for a 60-day cost, saving you between $5 and $55.

Dental Plans

Good dental health is important to your well-being, and Inspira offers two dental plans to suit your needs. Both dental plans are provided by Horizon Blue Cross Blue Shield of New Jersey.

The Horizon dental plan options allow you the freedom to choose dental providers: you can choose a participating dentist from Horizon's directory (both dental plan options) or you can choose a non-participating dentist (Dental Option Plan only).

You will be reimbursed different amounts depending on the plan you choose (see below), so it is important to examine your options carefully and consider your needs for the coming year.

Dental Plan Summary

This chart summarizes the benefits provided under each dental plan option. For more information, refer to the plan documentation.

Benefit	Horizon Dental Option Plan (in- or out-of-network)	Horizon Dental Choice Plan (in-network only)
Annual Deductible[1]		
Individual	$50	None
Family	$150	None
Annual Maximum[1]	$1,500	None
for Dental Orthodontia	$1,000	None
Visits & Exams	100%[2]	100%
X-Rays	100%[2]	100%
Endodontics	80%[2, 3]	100%[4]
Basic Restorations	80%[2, 3]	100%
Major Restorations	50%[2, 3]	50%
Periodontics	80%[2, 3]	100%[5]
Oral Surgery & Extractions	80%[2, 3]	100%[6]
Prosthodontics & Repairs	50%[2]	50%
Orthodontia[7]	50%	50%

[1] Annual Deductibles and Maximums are based on a calendar year (Jan-Dec).
[2] Annual Maximum applies.
[3] Annual Deductible applies.
[4] Molar and/or complex root canal therapy covered to 50%.
[5] Osseous surgery covered to 50%.
[6] Full or partial bony impaction covered to 50%.
[7] Orthodontia limited to participants up to age 19 for all plans. Fee for normal 24-month banded case (children).

- **The Dental benefit plan year is from January 1 - December 31.**
- **The Horizon Dental Choice Plan** requires you to receive care from a Horizon participating dentist that you must designate. **Find a Horizon dentist at www.horizonblue.com.**
- **The Dental Option Plan gives** you the flexibility to receive care from any dentist of your choice.

Vision Plans

Eye care coverage is available to all eligible employees of Inspira Health Network. Two vision plan options are outlined on the following pages; you may elect only one.

Option 1: **UnitedHealthcare Vision Plan**

The UnitedHealthcare Vision Plan provides you with access to affordable, quality vision care coverage. Through UnitedHealthcare's provider network, you are able to receive a complete eye examination and materials. This plan allows you to obtain services and products every 12 months based on the last date of service.

Benefit	In-Network	Out-of-Network
Service Intervals		
Exam	12 months	
Lenses	12 months	
Frames	12 months	
Contact Lenses *(in lieu of lenses & frames)*	12 months	
Copayments		
Exams	$10 copay	None
Materials	$25 copay	None
Reimbursement		
Eye Exam	Covered in full after copay	Up to $40
Lenses[1,2] (per pair)		
Single	Covered in full after copay	Up to $40
Bifocal		Up to $60
Trifocal		Up to $80
Lenticular		Up to $80
Frames[1]	Covered in full after copay	Up to $45
Contact Lenses* *(in lieu of lenses &frames)* Necessary	Covered in full after copay	Up to $210
Elective	Covered in full after copay	Up to $150

[1] Plan has an in-network materials copay of $25 that applies to lenses and frames or contact lenses. This is a total copay.

[2] UnitedHealthcare Vision provides a discounted cost, reflected in a set price, on the most popular lens options (i.e., coatings, progressives, tints, etc.). Most of the lens options are offered at 20% off of the retail cost.

Using Your UnitedHealthcare Vision Benefits

UnitedHealthcare's network of providers includes private doctors and retail optical providers. To locate a provider near you, visit **www.myuhcvision.com** or call UnitedHealthcare at 1-800-839-3242.

You will not be issued an ID card when you enroll in this plan. Simply identify yourself as a UnitedHealthcare participant to your provider with your Alternate ID or your Social Security number. Dependents are identified by the employee's Alternate ID or Social Security number and date of birth.

If you choose, you may also download an ID card from **www.myuhcvision.com** to bring to your provider.

If you visit an out-of-network provider, you will need to send your itemized receipts, along with the plan participant's Alternate ID and date of birth, to:

UnitedHealthcare
c/o Claims Department
P.O. Box 30978
Salt Lake City, UT 84130.
You may also fax claims to UnitedHealthcare at 1-248-733-6060.

Option 2: **Preferred Vision Plan**

The Preferred Vision Plan allows employees to obtain discounts on vision products and services. These discounts are available exclusively through the Eye Institute of South Jersey, PC, 3071 East Chestnut Avenue, Vineland, NJ.

This plan has no limits on the frequency of use for you or your family, offering discounts on examinations, glasses and contact lens fittings, and unlimited purchase of designer ophthalmic, sun, and sports performance eyewear. Additional benefits include discounts on LASIK and refractive surgeries performed at the Kremer Laser Eye Center. Specific information about plan discounts is outlined in the chart below.

Using Your Preferred Vision Plan

While the Preferred Vision Plan is available to employees at no cost, the discounted products and services are limited to those offered through the Eye Institute of South Jersey and Kremer Laser Eye Center.

For more information or to schedule an appointment, please call:

Eye Institute of South Jersey
1-856-205-1100

PREFERRED VISION PLAN OVERVIEW

Benefit	Discount[1]
Service Frequency	
Exam	No limit – As needed
Lenses	No limit – As needed
Frames	No limit – As needed
Contact Lenses	No limit – As needed
Exams	$35 off
Lenses and Frames	
Single	20% off
Bifocal	20% off
Trifocal	20% off
Lenticular	20% off
Progressive	20% off
Frames	20% off
Contact Lenses	10-20% off all brands
Lens Options	
Polycarbonate Lenses	20% off
Transitional Lenses	20% off
Anti-reflective Coating	20% off
Scratch Resistance	Included on all lenses
Correction Surgery	
LASIK	15% off
Refractive	15% off
Annual Premium	Not applicable

[1] *Cannot be combined with any other insurance or vision discount plan.*

Flexible Spending Accounts

Inspira Health Network can help you create accounts to pay for eligible medical or daycare expenses. You fund Flexible Spending Accounts (FSAs) by setting aside part of your pay—before taxes—through payroll deduction. If you can estimate your expenses for the coming year, this can be a good way to save on your taxes each year.

How FSAs work

There are two kinds of FSAs:

- **Health Care FSA**
- **Dependent Care FSA (daycare expenses)**

Each pay period, your money accumulates in any FSAs you elect. You can use these FSA funds to pay for eligible expenses throughout the year using an FSA debit card, just like any other bank account. In the case of a Health Care FSA, you can use your funds at any time throughout the year; for a Dependent Care FSA, you may only use funds you have already set aside.

How much money should you put into an FSA each pay period?

That depends on your expenses. The best way to estimate your expenses for the year is by looking over the eligible expenses you incurred over the past few years. Divide your expected expenses by the number of pay periods in the year. Consider contributing this amount each pay period to an FSA. Estimate carefully: unused funds are lost at the end of the year. You have until June 15 to incur expenses using funds remaining in your FSAs from the previous year, and you can file for reimbursement for those expenses until June 30.

HSA Plan Enrollees: the Limited Use Medical FSA

Due to federal guidelines, participants in the HSA Plan are not eligible to enroll in both a traditional Health Care FSA and an HSA. However, enrollees in the HSA Plan may open a Limited Use Medical FSA (as well as a Dependent Care FSA).

Initially, you may use a Limited Use Medical FSA for eligible dental and vision care expenses only. Once you reach your deductible, you may use the FSA to cover medical expenses, as well. You must submit documentation that states your annual deductible has been met.

To participate in an FSA, you must renew your election before the start of each plan year (April 1).

FSA Tax Savings Example

By anticipating your family's medical and dependent care costs, you can use FSAs to lower your taxable income. Your lower taxes translate to more spendable income. Here's an example:

	If You Participate in FSAs	If You Don't Participate
Annual Salary (before taxes)	**$24,000**	**$24,000**
Less Health Care FSA Contribution	-$1,500	$0
Less Dependent Care FSA Contribution	-$4,000	$0
Taxable Income	**$18,500**	**$24,000**
Less Federal Income & Social Security Taxes	-$4,070	-$5,280
Take Home Pay	**$14,430**	**$18,720**
Less Health Care Expenses	$0*	-$1,500
Less Dependent Care Expenses	$0*	-$4,000
Spendable Income	**$14,430**	**$13,220**
Increase in Spendable Income	**$1,210**	**$0**

** You are reimbursed for these expenses from your Flexible Spending Accounts.*

Estimate Your Annual Health Care FSA Contributions

A Health Care FSA helps you save money on a pre-tax basis for any IRS-allowed health expenses not paid by your health plan. These expenses can include deductibles, copayments, coinsurance payments, uninsured dental expenses, qualified over-the-counter products, vision care expenses (e.g., eyeglasses or contact lenses), hearing care expenses (e.g., a hearing exam or a hearing aid), and orthodontia expenses.

Deductibles and/or copayments	$ _____
Over-the-counter products (band-aids, contact lens solution, etc.)	$ _____
Non-reimbursed physician, dental, prescription services	$ _____
Vision services and eyewear	$ _____
Prescription copayments	$ _____
Total Estimated Health Care Expenses	**$** _____

The maximum annual amount you can deposit into a Health Care FSA is $2,650.

Estimate Your Annual Dependent Care FSA Contributions

A Dependent Care FSA helps you set aside money on a pre-tax basis for daycare expenses for your child or disabled parent or spouse. This benefit may only be used to pay for dependent care expenses that allow you and your spouse to work, seek employment, or attend school on a full-time basis.

Generally, expenses will qualify for reimbursement if they are the result of care for:

- Your children, under the age of 13, for whom you are entitled to a personal exemption on your Federal income tax return; and
- Your spouse or other dependents, including parents, who are physically or mentally incapable of self-care.

Dependent care provider inside and outside the home	$ _____
Elder care center	$ _____
Nursery school or daycare center	$ _____
Total Estimated Dependent Care Expenses	**$** _____

The maximum annual amount you can deposit into a Dependent Care FSA is $5,000.

FSA Reimbursement Deadlines

- **You have until June 15 to use any FSA funds** remaining from the previous year. Any money not spent will be lost.
- **You have until June 30 to file for reimbursement** from FSA funds from the previous year. After this date you may only be reimbursed from the current year's FSA funds.

Benny™ Prepaid Benefits Card

Your Benny card makes using your FSA dollars easy. By using your card at eligible providers and merchants, you are immediately reimbursed for qualified health care and dependent care expenses.

HOW IT WORKS

You will automatically receive two cards when you enroll in a Health Care or Dependent Care FSA. You can request additional or replacement cards for $5 each.

When you use your Benny card, funds are deducted directly from your account. Purchases that exceed your available funds are partially reimbursed. When this happens, you will have to use another form of payment for the remaining balance.

Your Benny card is similar to a credit card: during payment, always select "Credit" and sign for purchases. Your card does not require a PIN, and you cannot withdraw cash. If a merchant or provider does not accept Visa®, you will need to use another form of payment and submit a claim for reimbursement.

ALWAYS SAVE YOUR RECEIPTS

Save your receipts for eligible health care and dependent care expenses, even when using your Benny card. While pharmacies and other merchants can automatically verify many eligible purchases, health care providers usually cannot. For this reason, we recommend you keep receipts for all FSA transactions, including doctor's office copays.

HELPFUL HINTS

Please keep the following items in mind when using your Benny card:

- You can use your card to be reimbursed from your current FSA benefit during the Year-End Grace Period.
- Through **www.myFlexDollars.com** and the myFlexDollars Mobile App, you are provided with instant access to real-time account information.
- You keep the same debit card each plan year.

Submitting Claims

When not using your Benny Prepaid Benefits Card, you must submit a claim in order to be reimbursed for qualifying expenses.

- Submit a claim online at **www.myFlexDollars.com**
- Complete an FSA Reimbursement Claim Form and submit it to Baker Tilly Vantagen by fax at 1-866-406-0946, or by mail to 1200 Abington Executive Park, Clarks Summit, PA 18411.

You must include bills or receipts when you submit claims. The documentation you provide must include the following information at a minimum:

- The name of the provider or place where product was purchased;
- The service or product purchased;
- The date(s) the service or product was purchased;
- The Rx number for prescription drugs;
- The amount you paid out-of-pocket;
- The name of the person receiving the service or product; and
- The name, address, Social Security number or Tax ID number of any dependent care service provider (Dependent Care FSA claims only).

Canceled checks and/or credit card receipts cannot be used as documentation for these expenses. Claim forms are available at **www.myFlexDollars.com**, by calling 1-800-307-0230, or by visiting your local Human Resources Department.

CLAIM PAYOUT SCHEDULE

Claims are paid out on a weekly basis on Tuesdays for any claims submitted by noon on the previous Thursday. Claims received after this deadline will be processed on the following payout cycle.

DIRECT DEPOSIT OPTION

To directly deposit claim reimbursements into your bank account, you can sign up for direct deposit online at **www.myFlexDollars.com**. You can also have reimbursements sent to directly to a provider when submitting a claim for reimbursement.

What's Reimbursable? Health Care FSA Examples:

- Expenses incurred for hospital care.
- Physician's fees, copays, coinsurance, and deductibles.
- Physician-prescribed over-the-counter drugs.
- Laboratory and clinical costs for services ordered by a physician, such as x-rays.
- Dental or orthodontic treatment.
- Vision care costs including eyeglasses or contact lenses and supplies, doctor's fees, and LASIK/radial keratotomy surgery.
- Nursing care, such as boarding and lodging.
- Ambulance services and other travel-related costs for the purpose of obtaining necessary medical care.
- Medicines prescribed for a specific medical purpose, including insulin and birth control pills.
- Medically necessary supplies and equipment such as artificial limbs and teeth, crutches, wigs, wheelchairs, hearing aids, support hosiery, heating devices, orthopedic shoes, and abdominal or back support devices.
- Medically necessary therapies such as chiropractic, psychiatric, acupuncture, therapy sessions, hydrotherapy, physical therapy, diathermy, sterilization, vasectomy, whirlpool baths, and convalescent care.
- Well-baby care, including 50% of the expense for Lamaze classes relating to childbirth preparation.
- Seeing eye dog/cost of a guide incurred by blind persons.
- Alcoholics Anonymous expenses essential for mental health.
- Weight Watchers or smoking cessation expenses essential for health of heart disease patients.
- Costs of stays in mental health institutions.
- Expenses of kidney donor.
- Special school tuition for mentally/physically handicapped children.

What's Reimbursable? Dependent Care FSA Examples:

- Services provided: (a) inside or outside of your home by anyone other than your spouse, another one of your dependents or one of your children under 19 years of age, (b) by a child care center, or (c) by a housekeeper whose services include dependent care.
- Services provided by a dependent care center that meets local regulations, cares for more than six non-residents and receives a fee for such services, whether or not for-profit, but only if the care is for a dependent under age 13 or an eligible dependent who regularly spends at least eight hours a day in your home.
- Services provided outside of your home, such as day camp (if both parents work), preschool tuition or other outside dependent/child care services, such as before and after-school programs.
- Care for dependents who live with you at least eight hours a day and who are mentally and physically incapable of caring for themselves and who depend on you for over half of their support.
- Schooling costs for children not yet in kindergarten when they participate in an after-school daycare program at the same school (only the after-school program cost is reimbursable).
- Summer day camp (when both parents work).
- Expenses for a dependent daycare center (must meet all state and local licensing requirements).

Life Insurance

Basic Group Term Life Insurance

Inspira Health Network provides all eligible employees with Basic Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance in an amount equal to 2x annual base salary (not to exceed the plan's benefit maximum). This coverage is 100% company-paid.

You must name a beneficiary—the person or persons who will receive your life insurance benefit in the event of your death. If you do not name a beneficiary, then the benefit will be paid to your estate.

YOUR GROUP LIFE INSURANCE IS PORTABLE

You may elect portable life insurance coverage when:

- Your employment ends; or
- You have a change in eligibility.

The portable life insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan. You must apply for portable coverage and pay the first premium directly to the insurance company within 31 days after the date:

- Your coverage ends; or
- You begin working less than the minimum number of hours required in this plan

Supplemental Group Term Life Insurance

You may purchase Supplemental Life Insurance within 31 days of your initial eligibility. Coverage is available for yourself, your spouse, and/or your dependent children.

Coverage is guaranteed issue (no medical Evidence of Insurability necessary) if you enroll during your initial eligibility period for the following amounts:

- **Employee:** Increments of $10,000, max of $100,000
- **Spouse:** Increments of $10,000, max of $100,000
- **Dependent:** Increments of $2,500, max of $10,000

You must enroll in Supplemental Life Insurance in order to enroll your spouse or dependents.

EVIDENCE OF INSURABILITY

Evidence of Insurability (EOI) is required if you apply as a new employee, within 31 days of eligibility for any amount over $100,000 in coverage (to a maximum of $500,000 for employees). EOI is also required on all amounts if you apply for coverage more than 31 days from your date of eligibility.

Life insurance purchase amounts requiring EOI do not become effective (and therefore are not deducted from your pay) until approved.

This is a term insurance product: rates will increase as your age increases.

Permanent Life Insurance

Permanent Life Insurance is an individual life insurance policy that can also build cash value you can utilize while you are still living. At an affordable premium, you can have the added financial protection you and your family may need during times of uncertainty.

PLAN FEATURES

- You can purchase coverage for yourself, your spouse, and your children.
- No physical exams are required to apply for coverage up to a certain amount during an enrollment period.
- As the policy builds cash value, you can eventually use it to make premium payments or to pay urgent expenses while you are still living.
- You can take your policy with you if you leave the company or retire.
- Permanent Life Insurance never expires. You keep the policy as long as you make the payments, which means the premiums will not go up. (Initial cost varies based on age, coverage level and tobacco use.)

Disability Coverage

The disability benefits through Inspira Health Network can provide you with income replacement if you cannot work due to a non-work-related injury or illness.

Voluntary Short-Term Disability Insurance

Most employees under age 70 can enroll in Voluntary Short-Term Disability Insurance. For New Jersey residents, you may elect a benefit amount of up to 40% of your annual income. For residents of Pennsylvania and Delaware, you may elect benefit amounts up to 60% of your annual income. Benefits become payable after seven consecutive days of illness or off-the-job injury and continue for a maximum duration of 26 weeks.

You become eligible to enroll in this benefit on your date of hire.

Basic Long-Term Disability Insurance

Inspira Health Network provides all full- and part-time employees with Basic Long-Term Disability Insurance at no cost. After 180 days of disability due the same illness or injury, you may apply for Long-Term Disability benefits. If approved, you can receive 50% of your annual salary up to a maximum of $2,500 per month. Benefits are generally payable for up to 24 months for each disabling illness or injury.

After 24 months, you may still be considered disabled if (solely due to the same illness or injury) you are unable to perform your current or equivalent job and are unable to earn 60% or more of your indexed earnings. To be eligible to receive Long-Term Disability benefits for a longer period of time, you must provide proof of earnings and continued disability.

Supplemental Long-Term Disability Insurance

You may purchase Supplemental Long-Term Disability coverage to increase the benefit amount you receive in the event of an extended illness or injury that prevents you from working. If elected, you will be eligible for a disability benefit of 60% of your annual salary, to a maximum of $10,000 per month. Additional features include continuation of benefit coverage upon termination of employment, and waiver of premiums after the elimination period.

Employees who enroll in this benefit after their initial eligibility period will be required to provide Evidence of Insurability.

Pre-Existing Conditions:

Benefits are not payable for medical conditions for which you incurred expenses or services (or for which a reasonable person would have consulted a physician) up to three months prior to enrolling in insurance for Long-Term Disability and 12 months for Short-Term Disability.

Benefits are not payable for any disability resulting from a pre-existing condition, unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

Please Note:

These benefits are portable: should you retire or leave Inspira Health Network, you can take your Voluntary Short-Term Disability Policy and/or Supplemental Long-Term Disability Policy with you and choose from a number of convenient payment plans.

Critical Illness Insurance

Out-of-pocket costs of a serious illness can be catastrophic, even if you have medical insurance. Critical Illness Insurance pays a lump sum benefit directly to you if you are diagnosed with a covered condition. You use this money however you choose—deductibles and coinsurance, expenses your family incurs to be by your side, or simply to replace your lost earnings from being out of work.

You choose the benefit amount when you enroll—from $10,000 up to $50,000 (in $5,000 increments). The premium you pay is based on the benefit amount you choose and whether or not you use tobacco.

COVERED ILLNESSES INCLUDE:

- Heart Attack
- Stroke
- Major Organ Transplant
- End Stage Renal (Kidney) Failure
- Cancer
- Carcinoma in Situ*
- Coronary Artery Bypass Surgery*

**The coverage pays 25% of the face amount of the policy once per lifetime for coronary artery bypass surgery and carcinoma in situ.*

PLAN FEATURES

- You do not have to be terminally ill to receive benefits.
- Coverage options are available for your spouse and children as riders to your coverage.
- A Wellness Benefit is included, which pays a benefit once per calendar year to the insured individual if a covered health screening test is performed (blood tests, stress tests, colonoscopies, chest X-rays, mammograms, etc.).**
- Coverage is portable—you can take your policy with you if you change jobs or retire.

Visit the enrollment website or speak with a benefits counselor for help calculating the cost of the benefit, which will vary depending upon your age, tobacco use, and the amount of coverage you elect.

***Wellness Benefit may not be available in all states.*

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

Critical Illness Insurance is Employee-Paid

Critical Illness Insurance is entirely employee-paid. If you enroll, you are covered directly through the vendor, and your benefits are not managed or sponsored by Inspira Health Network.

No Health Questions or Exams are Necessary to qualify for these plans during enrollment periods.
The voluntary benefits on these pages complement your medical plan, helping you cover out-of-pocket expenses, such as deductibles, co-insurance, and other ancillary costs that typical medical plans don't cover. With each of these plans, you can cover your spouse, as well.

Accident Insurance

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact, which is often substantial. Voluntary Accident Insurance can help cover the out-of-pocket medical expenses and extra bills that can follow an accident.

The total benefit you receive is based on the type of injury, its severity, and the medical services you received in treatment and recovery.

The plan pays benefits for a variety of injuries and accident-related expenses, including:

- Hospitalization
- Emergency room treatment
- Physical therapy
- Fractures
- Transportation
- Dislocations

PLAN FEATURES

- Benefits are paid for accidents that occur on and off the job.
- You can also elect to cover your spouse and children.
- There are no health questions or physical exams required.
- Coverage is individually owned, which means you can take your policy with you if you change jobs or retire.

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

Voluntary Benefits are Employee-Paid

The Voluntary Benefits on this page are entirely employee-paid. If you enroll, you are covered directly through the vendor, and your benefits are not managed or sponsored by Inspira Health Network.

Already Have Coverage?

These benefits replace the plans offered by Inspira Health Network in previous years. If you are already enrolled in Critical Illness or Accident coverage, you must re-enroll in the new plans to continue to use payroll deduction.

If you would like to keep any existing coverage, you will need to set up separate billing with the carrier.

Hospital Indemnity

Hospital Indemnity Insurance pays a benefit, in addition to the coverage from your medical plan, when you are hospitalized or need in-hospital surgery or intensive care as the result of an accident or sickness.

Benefits are paid directly to you, and you can use the money however you choose to help pay medical bills or cover everyday living expenses. The plan includes a $1,000 admission benefit, which is paid directly to you.

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

Legal Insurance

Legal Insurance provides you with telephone and office consultations for an unlimited number of personal legal matters with a network attorney of your choice. During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options, and recommend a course of action. Legal services are generally paid in full if you select a network provider, but some plan benefits are available for out-of-network providers.

Covered services include:

- Document review
- Name changes
- Estate administration
- Document preparation
- Lawyer office work
- Adoptions
- Administrative hearings
- Real estate transfers
- Debt collection defense

Identity Theft Protection

InfoArmor's PrivacyArmor is a monitoring solution that protects you from the hassles of identity theft. By proactively seeking out fraud at the source, when thieves first use personal information, InfoArmor is able to detect fraud sooner, to reduce damages.

We start by employing patented technology used by top financial institutions and banks to monitor applications for misuse of participants' information. The InfoArmor solution also includes monitoring High Risk Transactions, such as unauthorized account access, fund transfers, and password resets to detect fraud sooner.

If InfoArmor detects fraud or unusual activity indicative of fraud, you will be the first to know. Rest assured, when there is a situation that needs attention, a Privacy Advocate will help do the work to resolve it, start to finish, all on your behalf.

Voluntary Benefits are Employee-Paid

The Voluntary Benefits on this page are entirely employee-paid. If you enroll, you are covered directly through the vendor, and your benefits are not managed or sponsored by Inspira Health Network.

Additional Services

In addition to basic and voluntary benefits, Inspira Health Network offers a variety of programs and discounted services that all employees can take advantage of.

Employee Assistance Program

The Employee Assistance Program (EAP) is a benefit available to all employees, regardless of status, that provides confidential counseling services to help manage the stress and strain of balancing personal needs and work responsibilities. This program can assist with issues such as relationship problems, substance abuse, stress, grief, emotional difficulties, and much more.

CAREBRIDGE

The Carebridge EAP provides help with personal and family issues through telephonic or face-to-face consultations, assistance, and resources, available 24 hours a day, seven days a week. In addition to its EAP, Carebridge makes available to all employees its Work-Life Services Program to assist with managing child care, elder care, college planning, parenting, adoption, time management, financial and retirement planning, and much more.

Call 1-800-437-0911 to get started with Carebridge, or visit **www.myliferesource.com** (access code: AGCA8).

Fitness Connection Discounts

Inspira Health Network offers employee membership discounts to Fitness Connection through payroll deductions.

Credit Union

Several credit unions are available to employees. Credit unions offer its members holiday/vacation clubs, special discounts on area attractions, low interest credit cards, loans, IRAs, and more.

Direct Deposit

Inspira Health Network offers employees the option of using direct deposit for payroll. This is a safe, simple, secure, and convenient way to have your money deposited into your account by 9 a.m. on payday.

Intra-Inspira Health Network Facility Travel Reimbursement

Travel reimbursement is offered to those employees who travel between campuses during their work schedule.

Working Advantage

Log on to **www.workingadvantage.com** for discounts on movie tickets, theme park admissions, cell phones, auto insurance, wholesale clubs, and more. Inspira Health Network employees may also take advantage of discounted bus trips to cultural events throughout the tri-state area, including seasonal activities, theatrical shows, etc.

Tax Sheltered Annuity/403(b)

This voluntary program allows employees to save for retirement with pre- and post-tax (Roth) income through a convenient payroll deduction. Certain Hospital employees are eligible for an employer contribution match. For more information on the 403(b) plan, please contact Inspira's HR Service Center.

Tuition Assistance

Tuition reimbursement is available to certain Hospital employees after three months of employment. Expenses for course work related to a degree are covered up to $5,000 for full-time employees and $2,500 for part-time employees. Expenses for a work-related certification are reimbursable up to $3,000 for full-time employees and $1,500 for part-time employees. RNs in the bargaining unit should refer to their contract for details regarding tuition eligibility.

For information on these programs and services, please contact Inspira's HR Service Center at 1-856-641-MYHR.

Your Plan Rights

Inspira Health Network is required to provide you certain protections administered by the Internal Revenue Service and the United States Department of Labor. This Flexible Benefit Plan is classified by the Department of Labor as a "welfare plan" and by the IRS as a "specified fringe benefit plan" under IRC s.6039(D). This Plan is also governed by Internal Revenue Code Section 125. Plan participants are entitled to certain protections and directions for recourse in the event of mistreatment by the Plan, its sponsor or administrator. Since these protections are essentially the same as federal law, this Statement of Rights is published here for your information.

The Employer Identification Number (EIN) assigned to Inspira Health Network is 21-0634484. You should refer to this number in any correspondence about the plan.

Statement of Plan Rights

Inspira Health Network is designated as the Administrator in connection with claims processed under the Plan. Such claim matters may be served by directing the process to the Plan Administrator at Inspira Health Network, 333 Irving Avenue, Bridgeton, NJ 08302.

The Internal Revenue Code and specific Department of Labor Regulations were enacted to help assure that all employer-sponsored group benefit programs conform to standards set by Congress. An employee who is a participant in the Flexible Benefits Plan is entitled to certain rights and protections under federal law, which provides that all participants will be entitled to (1) examine, without charge, at the Human Resources Office, all Plan documents and copies of all Plan documents and other Plan information upon written request to the Human Resources Office, subject to a reasonable charge for the copies; and (2) receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. Plan records are kept on a plan-year basis.

In addition to creating rights for Plan participants, federal law imposes duties upon those responsible for the operation of the Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of participants and beneficiaries. If a claim for a benefit under a Plan is denied in whole or part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under federal law, there are steps an employee covered under a Plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require Inspira Health Network to provide the materials and pay that person up to $110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the control of Inspira Health Network. If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if an employee covered under a Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the claimant is successful, the court may order the Employer to pay these costs and fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If an employee covered under a Plan has any questions about the Plan, the employee should contact the Human Resources Department. If an employee has any questions about this statement of the employee's rights under federal law, the employee should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Important Laws & Notices

Women's Health and Cancer Rights Act (WHCRA)

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact Kim Schwindt at Schwindtk@ihn.org for more information.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Notice of Availability of Privacy Practices

Inspira Health Network maintains a Notice of Privacy Practices that provides information to individuals whose Protected Health Information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Kim Schwindt at Schwindtk@ihn.org.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Kim Schwindt at Schwindtk@ihn.org.

Medicare Part D Notice

IMPORTANT NOTICE FROM INSPIRA HEALTH NETWORK ABOUT 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 Inspira Health Network 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. Inspira Health Network has determined that the prescription drug coverage offered by the Inspira Health Network Prescription 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 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 Inspira Health Network coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Inspira Health Network 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 Inspira Health Network 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 Inspira Health Network 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: April 1, 2018
Name of Entity/Sender: Inspira Health Network
Contact Position/Office: Kim Schwindt
Address: 333 Irving Avenue, Bridgeton, NJ 08302
Phone Number: 856-575-4615

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, 2018. Contact your State for more information on eligibility.

ALABAMA, Medicaid
myalhipp.com
1-855-692-5447

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

ARKANSAS, Medicaid
myarhipp.com/
1-855-MyARHIPP (855-692-7447)

COLORADO
Health First Colorado (Colorado's Medicaid Program) &
Child Health Plan Plus (CHP+)
Medicaid www.healthfirstcolorado.com
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
1-800-359-1991/ State Relay 711

FLORIDA, Medicaid
flmedicaidtplrecovery.com/hipp
1-877-357-3268

GEORGIA, Medicaid
dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
1-404-656-4507

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

IOWA, Medicaid
dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
1-888-346-9562

KANSAS, Medicaid
www.kdheks.gov/hcf/
1-785-296-3512

KENTUCKY, Medicaid
chfs.ky.gov/dms/default.htm
1-800-635-2570

LOUISIANA, Medicaid
dhh.louisiana.gov/index.cfm/subhome/1/n/331
1-888-695-2447

MAINE, Medicaid
maine.gov/dhhs/ofi/public-assistance/index.html
1-800-442-6003 TTY: Maine relay 711

MASSACHUSETTS, Medicaid and CHIP
mass.gov/eohhs/gov/departments/masshealth/
1-800-862-4840

MINNESOTA, Medicaid
mn.gov/dhs/people-we-serve/seniors/health-care/
health-care-programs/programs-and-services/medi-
cal-assistance.jsp
1-800-657-3739

MISSOURI, Medicaid
www.dss.mo.gov/mhd/participants/pages/hipp.htm
573-751-2005

MONTANA, Medicaid
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084

NEBRASKA, Medicaid
www.ACCESSNebraska.ne.gov
855-632-7633 Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA, Medicaid
dhcfp.nv.gov
1-800-992-0900

NEW HAMPSHIRE, Medicaid
www.dhhs.nh.gov/ombp/nhhpp
603-271-5218
Hotline: NH Medicaid Service Center- 1-888-901-4999

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

NEW YORK, Medicaid
www.health.ny.gov/health_care/medicaid/
1-800-541-2831

NORTH CAROLINA, Medicaid
dma.ncdhhs.gov/
919-855-4100

NORTH DAKOTA, Medicaid
www.nd.gov/dhs/services/medicalserv/medicaid/
1-844-854-4825

OKLAHOMA, Medicaid and CHIP
www.insureoklahoma.org
1-888-365-3742

OREGON, Medicaid
healthcare.oregon.gov/Pages/index.aspx
www.oregonhealthcare.gov/index-es.html
1-800-699-9075

PENNSYLVANIA, Medicaid
www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
1-800-692-7462

RHODE ISLAND, Medicaid
www.eohhs.ri.gov/
855-697-4347

SOUTH CAROLINA, Medicaid
www.scdhhs.gov
1-888-549-0820

SOUTH DAKOTA Medicaid
dss.sd.gov
1-888-828-0059

TEXAS, Medicaid
gethipptexas.com/
1-800-440-0493

UTAH, Medicaid and CHIP
Medicaid: https://medicaid.utah.gov/
CHIP: health.utah.gov/chip
1-877-543-7669

VERMONT, Medicaid
www.greenmountaincare.org/
1-800-250-8427

VIRGINIA, Medicaid and CHIP
Medicaid or CHIP:
www.coverva.org/programs_premium_assistance.cfm
Medicaid: 1-800-432-5924
CHIP: 1-855-242-8282

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

WEST VIRGINIA, Medicaid
mywvhipp.com/
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN, Medicaid and CHIP
www.dhs.wisconsin.gov/publications/p1/p10095.pdf
1-800-362-3002

WYOMING, Medicaid
wyequalitycare.acs-inc.com/
307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, 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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

INTRODUCTION

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 Baker Tilly at 1200 Abington Executive Park, Clarks Summit, PA 18411, Email: COBRA@bakertilly.com Phone: 1-800-307-0230.

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, Medicaid, 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.

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.

Plan contact information

Kim Schwindt
Director HR Operations Inspira Health Network
333 Irving Avenue
Bridgeton, NJ 08302
Email: schwindtk@ihn.org
Phone: 856-575-4615

Nondiscrimination Notice

Inspira Health Network complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Inspira Health Network does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Inspira Health Network:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Kim Schwindt.

If you believe that Inspira Health Network has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Kim Schwindt, Director HR Operations, 333 Irving Avenue, Bridgeton, NJ 08302, 856-575-4615, Schwindtk@ihn.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kim Schwindt, Director HR Operations is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-856-575-4615.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-856-575-4615。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-856-575-4615 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-856-575-4615.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-856-575-4615.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-856-575-4615.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-856-575-4615.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-856-575-4615.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-856-575-4615.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-856-575-4615.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-856-575-4615.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-856-575-4615 पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-856-575-4615.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-856-575-4615.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-856-575-4615.

Contact Information

Questions Regarding	Contact	Phone Number	Online/Address
Enrollment	Enrollment Center	Annual enrollment: 1-800-868-0798 Newly eligible: 1-866-402-9863	www.myinspirabenefits.org
General Eligibility, deductions, plan options, life event changes, COBRA	Baker Tilly Vantagen Employee Service Center	T: 1-800-307-0230 F: 1-866-406-6946	www.myinspirabenefits.org 1200 Abington Executive Park Clarks Summit, PA 18411
Medical Benefits	Horizon	1-833-876-3827	www.horizonblue.com www.horizonblue.com/Inspira
Prescription Benefits	CVS Caremark	General Inquiries: 1-800-966-5772 Specialty Pharmacy: 1-800-237-2767	www.caremark.com
Dental Benefits	Horizon Healthcare Dental Services, Inc.	1-800-4-DENTAL	www.horizonblue.com
Vision Benefits UnitedHealthcare Vision Plan	UnitedHealthcare	Customer Service: 1-800-638-3120 Provider Locator: 1-800-839-3242	www.myuhcvision.com
Preferred Vision Plan	Eye Institute of South Jersey	1-856-205-1100	
Flexible Spending Accounts	myFlexDollars	1-800-307-0230	www.myFlexDollars.com
Basic Life/AD&D Insurance	Inspira's HR Service Center	1-856-641-MYHR	NA
Permanent Life Insurance	Transamerica	1-888-763-7474	www.transamericabenefits.com
Voluntary Short-Term Disability Insurance	Unum	1-866-679-3054	www.unum.com
Basic and Supplemental Long-Term Disability Insurance	Cigna	1-800-362-4462 1-866-562-8421	www.cigna.com/customer-forms
Accident, Critical Illness, and Hospital Indemnity Insurance	MetLife	1-800-438-6388	www.metlife.com/mybenefits
Legal Services	MetLife	1-800-438-6388	www.metlife.com/mybenefits
Identity Theft Protection	InfoArmor	1-800-789-2720	www.myprivacyarmor.com
Employee Assistance Program	Carebridge	1-800-437-0911	www.myliferesource.com Access Code: AGCA8
AAA Membership	AAA	1-855-772-5551	www.aaa.com
Working Advantage Program	Working Advantage	1-800-565-3712	www.workingadvantage.com
Personal Health Nurse	Health Connection	1-856-641-6724	NA

For questions regarding your benefit plans, contact the HR Service Center: 1-856-641-6947 or ext. 1MYHR.

Decision Guide

You've reviewed your benefit options in this guide and made your choices. Take a moment before you enroll and review the decisions below.

DECISION 1: ELECT YOUR MEDICAL, DENTAL, AND VISION BENEFITS

Have you considered what levels of coverage are best for you? Think about the expenses you and your family had in the past year. Do you need higher levels of protection? Do your doctors participate in your plans of choice? Does your spouse have available coverage? You might be better off waiving one or more of these coverages and picking them up under your spouse's plan.

DECISION 2: WHO WILL BE COVERED UNDER YOUR BENEFITS?

You may only cover eligible dependents under the Inspira Health Network benefit plans, as explained on pages 1-2 of this Guidebook. You will need to submit proof of dependent status for each dependent that you enroll in coverage (e.g., a marriage certificate, birth certificate, etc.). Your dependent(s) will not be covered until you provide proof of dependent status. (You do not need to provide dependent documentation for dependents previously covered under your plan.)

DECISION 3: MAKE YOUR LIFE INSURANCE BENEFIT ELECTIONS

How much money would your family need to cover your financial obligations if something should happen to you? Think of things like rent or mortgage payments, college tuition, and regular day-to-day living expenses. How much coverage do you have elsewhere? Consider all the sources of life insurance protection you have available.

DECISION 4: WHO WILL BE YOUR BENEFICIARIES?

You will need to designate any beneficiaries for your Life and AD&D Insurance benefits. It is important to keep your beneficiary designation as up-to-date as possible. Should something happen to you, your benefits will be paid to the most recent beneficiary(ies) on file.

DECISION 5: WHAT OTHER BENEFIT OPTIONS DO YOU NEED?

Think about the value of enrolling in the Critical Illness, Permanent Life, Personal Accident, Hospital Indemnity, Legal Insurance, and Identity Protection plans.

Also consider the pre-tax benefits associated with using a Health Care or Dependent Care FSA to pay for your ongoing expenses not covered by insurance. While using an FSA can help your household bottom line, it does require careful advanced planning.

DECISION 6: DOUBLE-CHECK YOUR BENEFIT ELECTIONS

Once you have made your benefit elections, but before you hit "submit," double-check the choices you've made. Do they accurately reflect the benefit options that you want through the upcoming plan year?

ACTION: SUBMIT YOUR BENEFITS ENROLLMENT

We offer an eco-friendly process with paperless benefits enrollment. Submit all of your benefit elections online at **www.myinspirabenefits.org**.

ACTION: CONFIRM YOUR BENEFITS

Once your online enrollment is complete, a confirmation statement will automatically be generated. Check your confirmation statement for accuracy. If any corrections are necessary, follow the instructions listed in the statement.

Enrollment Questions

If you have any questions regarding your benefits and/or need assistance during the Annual Benefits Enrollment period, you can call the enrollment center at 1-800-868-0798. For enrollment as a new hire or newly eligible employee, please call 1-866-402-9863. For mid-year benefit changes due to life events, please call 1-800-307-0230.

Inspira Health Network Human Resources
333 Irving Avenue, Bridgeton, NJ 08302