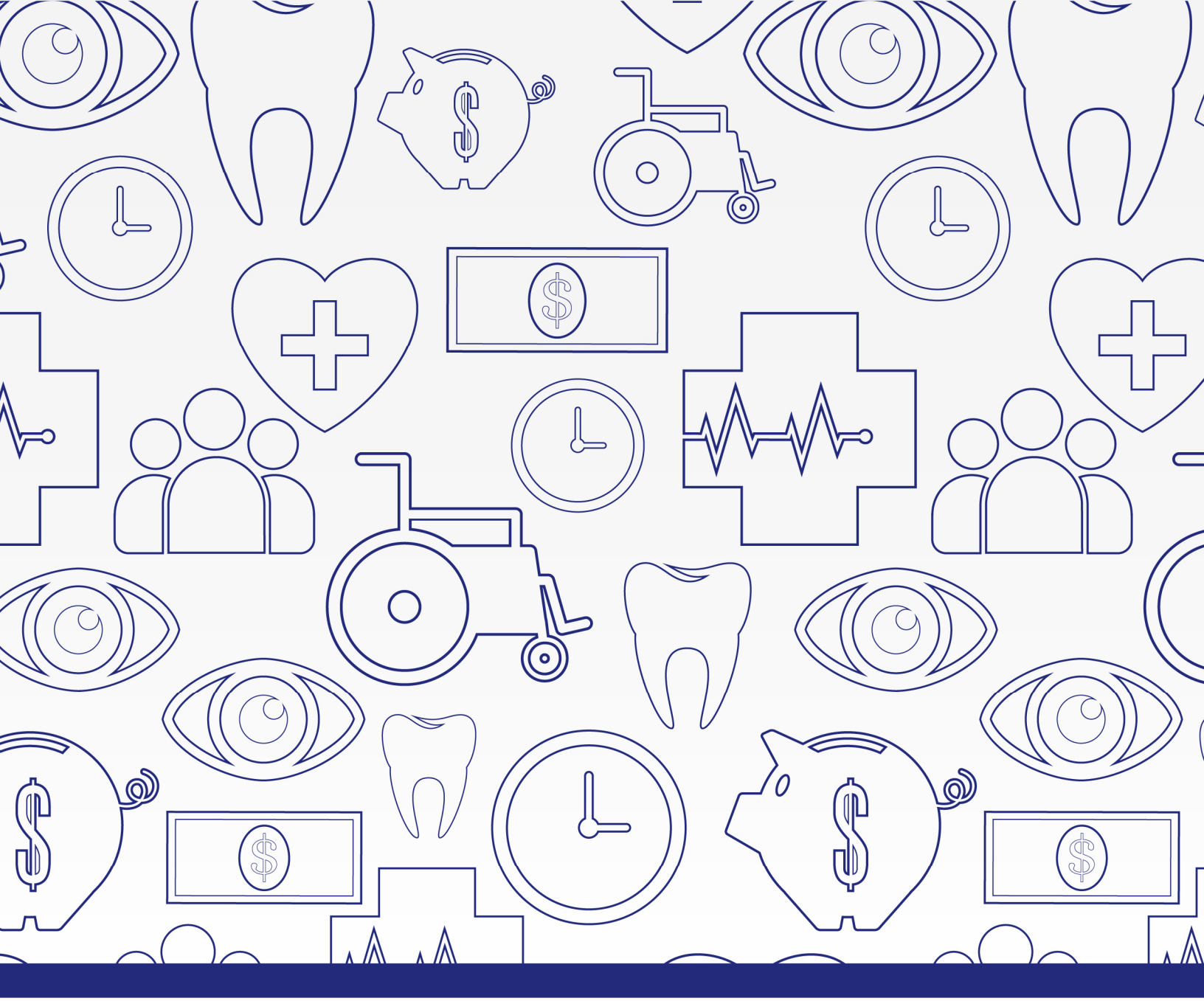

WELCOME TO OPEN ENROLLMENT

Plan Year: 2018

JPW COMPANIES

PICK THE BEST BENEFITS FOR YOU AND YOUR FAMILY.

JPW Companies strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all of the different benefits JPW Companies offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on January 1, 2018. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

TABLE OF CONTENTS

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information, contact Ed LaMott III in Human Resources.

MEDICAL

Provider Name:	Excellus – BlueCross BlueShield of Central New York
Provider Contact Department:	Customer Service Department
Provider Phone Number:	877-757-3850
Provider Web Address:	www.excellusbcbs.com
Pharmacy FLRX Help Desk:	1-800-724-5033
Prime Mail (mail order):	1-866-260-0487

DENTAL

Provider Name:	Excellus – BlueCross BlueShield of Central New York
Provider Contact Department:	Dental Customer Service Department
Provider Phone Number:	800-233-0384
Provider Web Address:	www.excellusbcbs.com

VISION

Provider Name:	EyeMed Vision Care
Provider Phone Number:	888-581-3648
Provider Web Address:	www.eyemedvisioncare.com

NEW YORK STATE DISABILITY / PAID FAMILY LEAVE

Provider Name:	Sun Life Insurance Company
Provider Phone Number:	800-247-6875
Provider Web Address:	www.sunlife.com/us (to file or check on claims)
Fax Number to Fax Claims:	781-304-5599
Address to Mail Claims:	P.O. Box 81915, Wellesley Hills, MA 02481

LIFE & ACCIDENTAL DEATH & DISMEMBERMENT

Provider Name:	Sun Life Insurance Company
Customer Service Phone Number:	800-247-6875
Provider Address:	60 East 42nd Street, Suite 1115, New York, NY 10165

401(K) PROFIT SHARING

Provider Name:	Principal Financial Group
Provider Phone Number:	800-547-7754
Fax Number:	866-704-3481
Provider Web Address:	www.principal.com

WHO IS ELIGIBLE?

If you're a full-time employee at JPW Companies working 40 or more hours per week and you have satisfied your 60 day probationary period, you may be eligible to enroll in the benefits outlined in this guide. In addition, the following family members are eligible for coverage through JPW: Spouse and children to age 26 (married or unmarried) for the medical plan, Spouse and children to age 19 (unmarried) or to age 25 for full time students for the dental plan, and Spouse and unmarried children to age 26 for the vision plan.

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

WHEN TO ENROLL

Open enrollment runs through December 31, 2017. The benefits you choose during open enrollment will become effective on January 1, 2018.

HOW TO MAKE CHANGES

Unless you experience a life-changing qualifying event, you **cannot** make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

WHAT'S NEW FOR 2018

HEALTH INSURANCE – EXCELLUS BCBS

You'll notice several changes to our medical and prescription drug benefits for the upcoming plan year. We are no longer providing the middle plan option, and instead are offering a lower deductible plan which allows you to pay less out of your paycheck for the coverage. In addition, this plan will have a Health Reimbursement Account (HRA) associated with it. This will help reimburse you for out of pocket costs.

The following several charts outline our new benefits that will take effect January 1, 2018. For full details, please refer to the Summary Benefit Descriptions at the end of this guide.

YOUR COST IN 2018

EMPLOYEE WEEKLY DEDUCTIONS			
	Employee Only	Two Person	Employee & Family
PPO I - Copay	$120.66	$334.23	$368.97
HDHP - $1350	$62.34	$184.20	$206.59
HDHP - $5000	$43.37	$108.72	$122.99

For the HDHP - $5000, the company has created an HRA to help fund out of pocket costs. In this case, after an individual has paid $1400, or after a Two Person or Employee & Family has paid $2400 towards their In-Network deductible, JPW will reimburse for the next $1200 of expenses.

	Blue PPO I	
Services	IN-Network	Out-of-Network
Deductible	None	$500 Individual / $1,500 Family
Out-of-Pocket	$4,200 Individual / $12,600 Family	$4,200 Individual / $12,600 Family
Coinsurance	0%	20%
Preventive Care	Covered in Full	Deductible then coinsurance
Office Visit	$15 PCP / $20 Specialist	Deductible then coinsurance
Emergency Room	$50 Copay	$50 Copay
Urgent Care	$25 Copay	Deductible then coinsurance
Inpatient Hospital	$250 Copay	Deductible then coinsurance
Outpatient Surgery	$20 Copay	Deductible then coinsurance
X-Ray and Other Radiology	$20 Copay	Deductible then coinsurance
Diagnostic Lab	Covered in Full	Deductible then coinsurance
Mental / Behavioral / Substance	Outpatient - $20 Copay Inpatient - $250 Copay	Deductible then coinsurance
Prescription Drug		
Tier 1 Generic	$10 Copay	Not Covered
Tier 2 Brand	$30 Copay	Not Covered
Tier 3 Brand	$50 Copay	Not Covered
Mail Order	2 Copays for a 90 day supply	N/A

Weekly Payroll Deductions for 2018	
Employee Only	$120.66
Two Person	$191.52
Family	$368.97

	Signature HDHP - $1350	
Services	**IN-Network**	**Out-of-Network**
Deductible	$1,350 Individual / $2,700 Family	$2,700 Individual / $5,400 Family
Out-of-Pocket	$3,000 Individual / $6,000 Family	$6,000 Individual / $12,000 Family
Coinsurance	20%	40%
Preventive Care	Covered in Full	Deductible then coinsurance
Office Visit	Deductible then coinsurance	Deductible then coinsurance
Emergency Room	Deductible then coinsurance	Deductible then coinsurance
Urgent Care	Deductible then coinsurance	Deductible then coinsurance
Inpatient Hospital	Deductible then coinsurance	Deductible then coinsurance
Outpatient Surgery	Deductible then coinsurance	Deductible then coinsurance
X-Ray and Other Radiology	Deductible then coinsurance	Deductible then coinsurance
Diagnostic Lab	Deductible then coinsurance	Deductible then coinsurance
Mental / Behavioral / Substance	Deductible then coinsurance	Deductible then coinsurance
Prescription Drug – Preventive Drug Not Subject to Deductible		
Tier 1 Generic	$5 after deductible	Not Covered
Tier 2 Brand	$35 after deductible	Not Covered
Tier 3 Brand	$70 after deductible	Not Covered
Mail Order	2 Copays / 90 day supply (after ded)	N/A

Weekly Payroll Deductions for 2018	
Employee Only	$62.34
Two Person	$184.20
Family	$206.59

	Signature HDHP - $5000	
Services	**IN-Network**	**Out-of-Network**
Deductible	$5,000 Individual / $10,000 Family	$10,000 Individual / $20,000 Family
Out-of-Pocket	$6,000 Individual / $12,000 Family	$12,000 Individual / $24,000 Family
Coinsurance	20%	40%
Preventive Care	Covered in Full	Deductible then coinsurance
Office Visit	Deductible then coinsurance	Deductible then coinsurance
Emergency Room	Deductible then coinsurance	Deductible then coinsurance
Urgent Care	Deductible then coinsurance	Deductible then coinsurance
Inpatient Hospital	Deductible then coinsurance	Deductible then coinsurance
Outpatient Surgery	Deductible then coinsurance	Deductible then coinsurance
X-Ray and Other Radiology	Deductible then coinsurance	Deductible then coinsurance
Diagnostic Lab	Deductible then coinsurance	Deductible then coinsurance
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Weekly Payroll Deductions for 2018	
Employee Only	$43.37
Two Person	$108.72
Family	$122.99

What is telemedicine?

24/7/365 on-demand access to U.S. board certified doctors and pediatricians—anytime, anywhere.

Doctors can:

- Diagnose your symptoms
- Prescribe medication* (when appropriate)
- Send the prescription to your nearest pharmacy

Common conditions treated?

General Health

Allergies
Asthma
Bronchitis
Joint Aches
Respiratory Infections
Sinus Infections
...and more!

Pediatric Care**

Cold & Flu
Constipation
Ear Aches
Nausea
Pink Eye
...and more!

ExcellusBCBS.com/Telemedicine
1-866-692-5045

Excellus BlueCross BlueShield | Powered by MDLIVE

*MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. For complete terms of use visit mdlive.com/pages/terms.html

**Parents must be present on each call for children under age 18.

DENTAL INSURANCE – Excellus BCBS

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

The following chart outlines the dental benefits we offer.

TYPE OF SERVICE	AMOUNT YOU PAY
Preventive Services	Exams, cleanings, X-rays — 0%
Deductible	Applies to basic and major services only— Individual : $50 / Family: $150
Basic Services	Fillings, simple extractions — 0% after deductible
Major Services	Oral surgery, root canal, crowns — 50% after deductible
Orthodontia	$1,000 Lifetime Max
Annual Maximum	$1,250
Weekly Payroll Deductions	Employee only—$7.70 Family—$20.21

VISION INSURANCE – EyeMed VisionCare

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

JPW's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. You do have the choice of using a non-participating provider; however, your benefit will be limited. The vision plan is a voluntary plan.

TYPE OF SERVICE	In-Network	Out-of-Network
Vision Exam – Every 12 months	$10 Copay, then covered in full	Up to $50
Lenses – Every 12 months Single Vision, Bifocal, Trifocal, Lenticular	$25 Copay, then covered in full	Up to $50 to $90 depending on lens
Frames – Every 24 months	$0 Copay, then covered up to $150, plus 20% off any out-of-pocket costs	Up to $112.50
Contact Lenses – Every 12 months (in lieu of eyeglasses)	$0 Copay, then covered up to $130, 15% off balance over $130	Up to $130
Medically Necessary Contact Lenses	$0 Copay, then covered up to $130, 15% off balance over $130	Up to $130

Weekly Payroll Deductions for 2018	
Employee Only	$2.32
Employee & Spouse	$4.41
Employee & Child(ren)	$4.64
Family	$6.83

BASIC LIFE INSURANCE

Life insurance can help provide for your loved ones if something where to happen to you. JPW Companies provides full-time employees with $25,000 in group life and accidental death and dismemberment (AD&D) insurance.

JPW pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information.

VOLUNTARY LIFE INSURANCE

While JPW Companies offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, you are responsible for paying the full cost of coverage through weekly payroll deductions. You can purchase coverage for yourself or for your spouse in $25,000 increments. The minimum coverage level is $25,000 and the maximum is $150,000. The chart below outlines the monthly costs of purchasing additional coverage. The voluntary life is guaranteed issue up to $100,000 for those under age 60, $25,000 for those age 60 to 69, $10,000 for ages 70 to 79, and $1,000 for those age 80 or over.

Monthly Cost for Every $1,000 of Employee and Spouse Life Insurance Coverage											
Age	<24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +
Employee Cost:	$0.067	$0.080	$0.107	$0.120	$0.134	$0.200	$0.307	$0.574	$0.881	$1.695	$2.750
Spousal Cost*	$0.048	$0.058	$0.077	$0.087	$0.097	$0.145	$0.222	$0.416	$0.638	$1.228	N/A
Dependent Children	$0.232 per $1,000 unit										

*Spousal costs are based on the EMPLOYEE'S age

Evidence of Insurability (EOI) may be required if electing coverage at any point in time after you were first eligible for coverage. See Human Resources for the required form to be completed.

401(K) AND PROFIT SHARING

JPW Companies offers its eligible employees the opportunity to participate in the Profit Sharing and Retirement Plan (401(K)), which is administered by Principal Financial Group. The plan allows you to decide how much you would like to contribute on a "before-tax" basis. The money contributed may grow through investments in stock, mutual funds, money market funds, savings accounts and other investment vehicles. Contributions and earnings generally are not taxed by the Federal government or by most State governments until they are distributed.

Employees are eligible to actively participate in the plan and receive the Employer contribution on January 1st or July 1st on or after they meet the following criteria:

- Complete one full year of full time employment (1,000 hours or more in their first 12 months of service)
- Are age 21 or older

JPW's 401(k) plan allows you to take your vested balance with you when you leave the company, easing administrative burdens.

Following is JPW's company match and company contribution:

- JPW will pay $0.50 for every hour worked (up to 40 hours per week) into each eligible employee's retirement account, up to an annual maximum of $1,000 regardless of whether the employee contributes to the plan.
- JPW will also match the first 6% of each eligible employee's 401(k) deferral with $0.50 for every dollar, up to an annual maximum of $1,000.

ADDITIONAL BENEFIT OFFERINGS

AFLAC –

Voluntary Cancer, Accident and Supplemental Short Term Disability

JPW Companies offers you the opportunity to purchase an affordable cancer, accident, and short term disability policy through AFLAC New York. The cancer and accident policy premiums are deducted on a pre-tax basis. The policy is portable. If you leave JPW, you can take the policy with you at the exact same cost. The costs for these policies are quoted on an individual basis based on certain variables.

ANNUAL NOTICES

** Continuation Coverage Rights Under 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 [*choose and enter appropriate information:* must pay *or* aren't required to 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;
- 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 Human Resources. Please provide the following documentation if applicable to your qualifying event:

- Marriage license in the event of marriage
- Divorce decree or court documentation of legal separation
- Current address of COBRA eligible participants if different from your own
- Proof of loss of coverage (letter of cancellation from spouse's employer, HIPPA Notice)

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

Human Resources Deparment
Ed LaMott III

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 August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, 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.

OMB Control Number 1210-0137 (expires 12/31/2019)

HIPAA Notice of Privacy Practices – Reminder of Availability

JPW Companies provides benefits through group health plans to its eligible employees and their eligible dependents. By so doing, it creates, receives, uses and maintains health information about plan participants which is protected by federal law (protected health information, or PHI).

The Health Insurance Portability and Accountability Act (HIPAA) requires health plans to provide plan participants and others with a notice of the plan's privacy practices with regard to the health information it creates and maintains in the course of providing benefits (Notice of Privacy Practices). This Notice of Privacy Practices describes the way the plan uses and discloses PHI and is available in Human Resources.

Patient Protection Disclosure under the PPACA

Excellus BCBS generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact **Excellus BCBS** at **1-800-499-1275**.

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

You do not need prior authorization from Excellus BCBS or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact **Excellus BCBS** at **1-800-499-1275**.

New York "Age 29" Dependent Coverage Extension

Summary of Young Adult Option

Chapter 240 of New York Insurance law permits eligible young adults through the age of 29 to continue or obtain coverage through a parent's group policy. Insurers will notify employees of this benefit. Employees or their eligible dependents may then elect the benefit and pay the premium, which cannot be more than 100% of the single premium rate. This benefit, referred to here as the "young adult option", is separate and distinct from the "make-available" requirement. It is called the young adult option benefit because it permits eligible young adults to continue their coverage through a parent's health insurance coverage once they reach the maximum age of dependency under the policy. Young adults may also elect this coverage when they newly meet the eligibility criteria, such as if they lose eligibility for group health insurance coverage.

Summary of Make Available Option

Chapter 240 of New York Insurance law may extend the age of dependency and permit eligible young adults through the age of 29 to remain on a parent's health insurance coverage in the same manner as dependents who are children. The law states insurers that issue a policy or contract that provides coverage for dependent children must make available and, if request by the policyholder/contract holder, extend coverage to qualifying young adults through age 29 as dependents under family coverage. It is called the "make-available" requirement because insurers are required to make it available at the request of the group or individual policyholder/contract holder. Call Excellus BCBS at 1-800-499-1275 Customer Service with any questions.

Special Enrollment Rights

If you are declining enrollment in a JPW Companies medical plan for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after the other coverage ends and provide supporting documentation. 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 in the medical plan, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Note: Please notify Human Resources within 20 days of the qualifying event due to carrier enrollment deadlines.

Women's Health and Cancer Rights Act of 1998

This medical plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymph edema.

Newborns and Mothers Health Protection Act

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

Right of Nursing Mothers to Express Breast Milk

An employer shall provide reasonable unpaid break time or permit an employee to use paid break time or meal time each day to allow an employee to express breast milk for her nursing child for up to three years following child birth. The employer shall make reasonable efforts to provide a room or other location, in close proximity to the work area, where an employee can express milk in privacy. No employer shall discriminate in any way against an employee who chooses to express breast milk in the workplace.

An employee wishing to avail herself of this benefit is required to give her employer advance notice, preferably prior to the employee's return to work following the birth of her child, to allow the employer an opportunity to establish a location and to schedule leave time among multiple employees, if needed.

The New York Commissioner of Labor announced that "reasonable unpaid break time" is "sufficient time to allow the employee to express breast milk," and shall generally be no less than twenty (20) minutes, and generally no more than thirty (30) minutes depending on the proximity of the designated location for expressing breast milk. In most situations, employers are required to provide unpaid break time for the expressing of breast milk at least once every three (3) hours if requested by the employee. At the employee's option, the employer must allow her to work before or after her normal shift (during the employer's normal work hours) to make up for the unpaid break time.

Blood Donation

Section 202-j of the Labor Law mandates that employers provide leave time to employees for the purpose of donating blood. Leave taken by employees for donation leave alternatives shall be paid leave (i.e. blood drive at the employee's place of employment). Employees taking leave for off-premises blood donation shall be permitted at least one leave period per calendar year of three hours duration during the employee's regular work schedule. Leave granted to employees for off-premises blood donation is not required to be paid leave.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call or visit Our website at www.excellusbcbs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network: $500 Individual/$1,000 Two Person/$1,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,200 Individual/$12,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Costs for penalties for failure to obtain preauthorization for services, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay/visit	20% Coinsurance	None
	Specialist visit	$20 Copay/visit	20% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	Adult Physical: 20% Coinsurance Adult Immunizations: Not Covered Well Child Visit: No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per year
If you have a test	Diagnostic test (x-ray, blood work)	$15 PCP; $20 Specialist Copay/visit	20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$20 Copay/visit	20% Coinsurance	Preauthorization Required. If you don't get a preauthorization, benefits will be reduced by 50% up to maximum of $500.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.excellusbcbs.com	Tier 1 (Generic drugs)	$10/prescription retail, $20/ prescription mail order	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription) Preauthorization required. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	$30/prescription retail, $60/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$50/prescription retail, $100/ prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 Copay	20% Coinsurance	None
	Physician/surgeon fees	No Charge	20% Coinsurance	
If you need immediate medical attention	Emergency room care	$50 Copay/visit	$50 Copay/visit	None
	Emergency medical transportation	$20 Copay/visit	$20 Copay/visit Deductible does not apply	None
	Urgent care	$25 Copay/visit	20% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 Copay	20% Coinsurance	Preauthorization Required for out-of-network services only. If you don't get a preauthorization, benefits will be reduced by 50% up to maximum of $500. However, Preauthorization is Not Required for Emergency Admissions
	Physician/surgeon fees	No Charge	20% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copay/visit	20% Coinsurance	None
	Inpatient services	$250 Copay	20% Coinsurance	
If you are pregnant	Office visits	No Charge	20% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	20% Coinsurance	None
	Childbirth/delivery facility services	$250 Copay	20% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	20% Coinsurance	Deductible is limited to $50 Out-of-Network Preauthorization Required. If you don't get a preauthorization, benefits will be reduced by 50% up to maximum of $500.
	Rehabilitation services	$20 Copay/visit	20% Coinsurance	45 Visits per year limit
	Habilitation services	$20 Copay/visit	20% Coinsurance	45 Visits per year limit
	Skilled nursing care	$250 Copay	20% Coinsurance	120 Days per year limit Preauthorization Required Out-of-Network services only. If you don't get a preauthorization, benefits will be reduced by 50% up to maximum of $500.
	Durable medical equipment	20% Coinsurance	20% Coinsurance	None
	Hospice services	No Charge	20% Coinsurance	Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Cosmetic surgery	• Dental care (Adult)
• Dental care (Child)	• Hearing aids	• Long-term care
• Private-duty nursing	• Routine eye care (Adult)	• Routine eye care (Child)
• Weight loss programs		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Chiropractic care	• Infertility treatment
• Non-emergency care when traveling outside the U.S.	• Routine foot care	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next section.––––––––––––––––––

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$250**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$330**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$250**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$930
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$990**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$250**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$170
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$210**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at www.excellusbcbs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,350 Individual/ $2,700 Family; Out-of-Network: $2,700 Individual/ $5,400 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $3,000 Individual/$6,000 Family; Out-of-Network: $6,000 Individual/ $12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Costs for premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	None
	Specialist visit	20% Coinsurance	40% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: 40% Coinsurance Adult Immunizations: 40% Coinsurance Well Child Visit: No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per plan year
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.excellusbcbs.com	Tier 1 (Generic drugs)	$5/prescription retail, $10/ prescription mail order No Charge Members to age 19	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription) Preauthorization required. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	$35/prescription retail, $70/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$70/prescription retail, $140/ prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need mental health,	Outpatient services	20% Coinsurance	40% Coinsurance	None

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
behavioral health, or substance abuse services	Inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	No Charge	40% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	None
	Rehabilitation services	20% Coinsurance	40% Coinsurance	45 visits per plan year limit
	Habilitation services	20% Coinsurance	40% Coinsurance	45 visits per plan year limit
	Skilled nursing care	20% Coinsurance	40% Coinsurance	45 Days per plan year limit
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice services	20% Coinsurance	40% Coinsurance	Family bereavement counseling limited to 5 Visits per plan year
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	40% Coinsurance	1 Exam per contract year
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

- Hearing aids
- Routine eye care (Adult)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

––––––––––––––––––––––*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*––––––––––––––––––

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,350**
Coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$1,650
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,350**
Coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$80
Coinsurance	$1,110
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,600**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,350**
Coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,470**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at www.excellusbcbs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $5,000 Individual/ $10,000 Family; Out-of-Network: $10,000 Individual/ $20,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $6,000 Individual/$12,000 Family; Out-of-Network: $12,000 Individual/ $24,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Costs for premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	None
	Specialist visit	20% Coinsurance	40% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: 40% Coinsurance Adult Immunizations: 40% Coinsurance Well Child Visit: No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per plan year
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.excellusbcbs.com	Tier 1 (Generic drugs)	$5/prescription retail, $10/ prescription mail order No Charge Members to age 19	Not Covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription) Preauthorization required. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	$35/prescription retail, $70/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$70/prescription retail, $140/ prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need mental health,	Outpatient services	20% Coinsurance	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
behavioral health, or substance abuse services	Inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	No Charge	40% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	None
	Rehabilitation services	20% Coinsurance	40% Coinsurance	45 visits per plan year limit
	Habilitation services	20% Coinsurance	40% Coinsurance	45 visits per plan year limit
	Skilled nursing care	20% Coinsurance	40% Coinsurance	45 Days per plan year limit
	Durable medical equipment	20% Coinsurance	40% Coinsurance	
	Hospice services	20% Coinsurance	40% Coinsurance	Family bereavement counseling limited to 5 Visits per plan year
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	40% Coinsurance	1 Exam per contract year
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care

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- Hearing aids
- Routine eye care (Adult)
- Infertility treatment
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This EXAMPLE event includes services like:
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Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,060**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$5,000**
Coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$30
Coinsurance	$420
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,510**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$5,000**
Coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,930
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,930**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Excellus

Dental Blue Options Summary of Benefits

Employer Group name: JPW Riggers

Plan Type: Voluntary
Product Type: Passive PPO (same coinsurance in & out-of-network)

Plan Features

Network: BlueShield local network	Dependent / student age limit: 19/25
Reimbursement In network: Fee Schedule Reimbursement Out-of-network: Average Market Rate (UCR90)	
Annual Plan Deductible: $50 Ind / $150 Fam Deductible applies to: Classes II, IIA and III services	Annual Plan Maximum per member: $1,250 per member Annual Max applies to: Classes II, IIA and III services
Ortho Age Limit: Children to age 19 Lifetime Orthodontia Maximum: $1,000 per member (does not apply toward annual plan maximum)	

Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays: In-Network	Excellus BCBS Pays: Out-of-Network
Class I Preventive & Diagnostic	• Cleanings & exams - twice per calendar year • Fluoride treatments – twice per calendar year to age 16 • Sealants – unrestored 1st and 2nd permanent molars, once every 36 months • Bitewing x-rays – up to 4 every calendar year • Full mouth/Panoramic x-rays – once every 36 months • Diagnostic Photograph/Facial Images – once per calendar year • Space maintainers – up to age 16 • Emergency palliative treatment	100%	100%
Class II Basic Restorative	• Fillings – amalgam & composite; each surface covered once every 12 months • Oral surgery – simple extractions	100%	100%
Class IIA Basic Restorative (12 month waiting period applies for voluntary plans)	• Oral surgery – surgical extractions • Endodontics – root canal treatment • Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months • Periodontal scaling & root planing – once per quadrant every 24 months • Periodontal maintenance following surgery – twice per calendar year	100%	100%

Type of Care	Benefits Included	Excellus BCBS Pays: In-Network	Excellus BCBS Pays: Out-of-Network
Class III Major Restorative (12 month waiting period applies for voluntary plans)	• Fixed prosthetics – bridgework, abutments, pontics • Removable prosthetics – partial / complete dentures • Inlays / onlays / crowns – includes coverage for re-cementation • Relines / rebases – once every 36 months and at least 6 months following initial placement • Above services eligible for replacement every 5 years • Implants – eligible for replacement every 10 years, and subject to alternate benefits provision	50%	50%
Class IV Orthodontia (12 month waiting period applies for voluntary plans)	• Initial banding & monthly follow-up treatment • No more than 1/2 the lifetime maximum can be paid in any calendar year	50%	50%

How to Get The Most From Your Plan

Pre-determination of Benefits
Pre-determination of benefits is recommended for any extensive treatment such as periodontics, orthodontics or prosthetics. A description of planned treatment and expected charges should be sent to the Plan before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be included as Covered Expenses will be determined by your Plan and are subject to the Alternate Benefit provision. When there has not been a predetermination of benefits, your Plan will determine the expenses that will be included as Covered Expenses at the time the claim is received. Predetermination of Benefits does not guarantee payment and expires one year from date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

Alternate Benefits Provision
All covered procedures are subject to an alternate benefit allowance. When there is more than one technology or material type for a dental procedure, the dental plan will reimburse for the procedure which has the lesser allowance. When alternate benefit is enforced, your benefits are not intended to interfere with the treatment plan recommended by the dentist. You and your dentist should discuss which treatment is best suited for you, and may proceed with the original treatment plan regardless of benefit determination. If the more expensive treatment is chosen, you are liable for the balance up to the billed amount.

Participating Dentists
Excellus BlueCross BlueShield offers a broad participating dental network in the Rochester, Syracuse, Utica and surrounding areas.
You have the option of receiving care from a dentist of your choice. However, choosing a participating dentist may result in savings for you because participating dentists agree to accept our Schedule of Allowances as payment in full for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist – that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

Non-participating Dentists
You have the freedom to see any dentist. Non-participating dentists are not obligated to accept our Schedule of Allowances. You will be responsible for balances of non-participating dentists' charges.

Dental Customer Service – for members and dentists
1-800-724-1675
Hours: Monday – Thursday 8:00 am – 5:30 pm
Friday 9:00 am – 5:30 pm

Mailing address for claims
Excellus BCBS
P.O. Box 22999
Rochester, NY 14692

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.