AP.

PROFESSIONALS

2022

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[EMPLOYEE BENEFIT GUIDE]

Making the most of your employee benefits.

WELCOME!

AP Professional's goal is to provide you and your family with the most effective, cost-efficient and comprehensive benefits. These programs are reviewed annually to ensure they are in-line with the current trends and remain in compliance with government regulations such as the Health Care Reform legislation. As we enter a new plan year, you'll see a continued dedication to offering a wide array of benefit choices so you can make the best decisions to suit your needs and those of your family.

This guide contains a brief summary of the benefit plans offered. It is not the complete summary plan description. Please read this guide carefully so that you may make informed enrollment decisions. Additional enrollment and benefit information may be requested directly from the insurance carrier.

INITIAL ELIGIBILITY PERIOD

The initial eligibility period begins the day you become benefit eligible (per your employer's eligibility guidelines) and ends 30 days from that date. If your enrollment is not completed on or before the end of your initial eligibility period:

- You will have to wait until the next Open Enrollment period to change your benefit elections (unless there is a qualifying event outlined below).
- You will be automatically enrolled in the core benefit plans that are paid in full by your employer.

OPEN ENROLLMENT

Open Enrollment is the window of opportunity to review your benefit enrollments and determine if you want to make any changes for the following plan year. It is important to remind you that decisions made during Open Enrollment are generally binding for the entire plan year and cannot be changed until next year's Open Enrollment unless there is a qualified change in status.

QUALIFIED CHANGE IN STATUS INCLUDE

- Marriage
- Divorce
- Legal separation
- Domestic partnership status change
- Birth or adoption of a child
- Legal guardianship
- Involuntary loss of coverage
- National support notice
- Change in child's dependent status
- Death of spouse, child or other qualified dependent
- Change in residence due to an employment transfer for you or your spouse
- Commencement or termination of adoption proceedings
- Change in spouse's benefits or employment status

Requests for a qualifying event must be received within 30 days of the event date. The change will be added to your coverage as of the date of the event. If you submit a qualifying event more than 30 days after the event, the change is subject to carrier approval.

We encourage you to take advantage of all of your available resources and work toward improving your overall health, making this year your healthiest ever.

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MEDICAL COVERAGE

BCBS of WNY – PPO 6317 HDHP Medical Plan

MEDICAL COVERAGE OVERVIEW

BlueCross BlueShield of Western New York

BCBS of WNY PPO 6317 HDHP medical coverage provides in-network and out-of-network benefits. Members are encouraged to receive care from participating plan providers, except in the case of a life or limb-threatening emergency.

BCBS of WNY	PPO 6317 HDHP	
	In-Network	Out-of-Network
General Plan Information		
Deductible	Individual: $2,000 Family: $4,000	Individual: $3,000 Family: $6,000
Coinsurance	N/A	30% coinsurance after deductible
Out-of-Pocket Maximum	Individual: $5,000 Family: $10,000	Unlimited
Dependent Coverage		
Dependent Age Limit	To age 26	
Prescription Coverage		
Prescription Drugs	$5 / $50 / $75	Not covered
Mail Order	N/A	Not covered
Preventive Services		
Routine Well Baby & Child Care **Routine Adult Annual Physical** **Immunizations** **Routine OBGYN Exam & Pap Test** **Routine Mammography** **Prostate & Colon Cancer Screenings**	Covered in full (see benefit summary for list)	30% coinsurance after deductible (some services may not be covered)
Physician Services		
Primary Office Visit	$30 copay after deductible	30% coinsurance after deductible
Specialist Office Visit	$30 copay after deductible	30% coinsurance after deductible
Hospital Services		
Inpatient Hospital (per admission)	$0 copay after deductible $0 copay for Maternity Admissions	30% coinsurance after deductible
Outpatient Surgical Procedure	$150 copay after deductible	30% coinsurance after deductible
Emergency Services		
Emergency Room (waived if admitted)	$150 copay after deductible	30% coinsurance after deductible
Urgent Care Center	$35 copay after deductible	30% coinsurance after deductible

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Nova – HRA

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) OVERVIEW

Nova Health Reimbursement Arrangement (HRA) is an employer funded reimbursement account that is designed to reimburse a portion of incurred qualified medical expenses subject to the deductible. The HRA will reimburse eligible expenses incurred by you and/or your dependents and will be tracked by dollar amount.

Employees who participate in the BCBS of WNY PPO 6317 HDHP plan, will be offered the following for reimbursement:

Medical	HRA Employer Contribution PPO 6317
Individual	$2,000
Family	$4,000

MEDICAL EXPENSES SUBJECT TO THE DEDUCTIBLE

- After visiting a physician or facility a claim is billed by the provider to BCBS of WNY for payment.
  - **PLEASE NOTE**: Your doctor may request payment in advance for services, you may pay out-of-pocket then submit a request for reimbursement to Nova. The amount you pay for at the time of service will count towards your deductible.
- BCBS of WNY processes the claim and applies the contracted, discounted rate to your deductible.
- BCBS of WNY will send you an Explanation of Benefits (EOB) and an electronic claim file to Nova with your deductible information.
- Nova will automatically process your HRA claim(s) based on the BCBS of WNY file data.
- Once you receive your Explanation of Benefits (EOB) from BCBS of WNY, you must complete a claim form and submit to Nova for reimbursement.
- You will be provided an HRA Debit Card offering an easier way to pay for and manage your incurred medical expenses.

PRESCRIPTION COPAYS ARE NOT ELIGIBLE

HRA REIMBURSEMENT

- Always keep a copy of the Explanation of Benefits (EOB) and itemized medical and pharmacy receipts, as Nova reserves the right to substantiate expenses as well as the IRS.
- Once the claim(s) have been processed, you will receive a confirmation from Nova.
- The claim(s) will be paid by Nova for incurred expenses.
- Complete the employee portion of the claim form and include your deductible information.
- Submit copies of all bills, itemized receipts, and/or your Explanation of Benefits (EOB) to Nova for services incurred during the plan year. Your bills, itemized receipts, and EOB's must include the following:

  - Patient Name
  - Provider Name
  - Date of Service
  - Description of Service
  - Total Patient Responsibility
  - Total Cost of the Service

HRA CLAIM RUN-OUT PERIOD

Participants will have 90 days to submit claims for reimbursement for the previous HRA plan year. Ends 03/31/2022.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

FLEXIBLE SPENDING ACCOUNT (FSA)

Nova – Health Care FSA & Dependent Care FSA

FLEXIBLE SPENDING ACCOUNT (FSA) OVERVIEW

Nova Flexible Spending Account (FSA) is an employer-sponsored account that allows you to set aside pre-tax dollars to pay for qualified health or dependent care expenses regardless of whether you are covered by your employer's medical plan. *It is important to plan carefully, as any unused funds over that amount are not returned to the employee per IRS, – "Use It or Lose It" Rule.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Participants may elect to contribute up to $2,850 on a pre-tax basis via payroll deductions throughout the plan year into an FSA. The full amount you select will be available to you on the first day of the plan year to use towards unreimbursed IRS eligible medical expenses (not covered or paid by any insurance) incurred by you, your spouse, and/or dependents.

EXAMPLES OF ELIGIBLE EXPENSES I Medical expenses, such as copays and deductibles for medical, prescription drugs, dental, prescription eye glasses, etc.

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DEPENDENT CARE ACCOUNT (DCA)

Participants may elect to contribute up to $5,000 on a pre-tax basis via payroll deductions throughout the plan year into a DCA. Funds can be used on any child under the age of 13 or any dependent who is physically or mentally unable to care for themselves.

DEPENDENT CARE GUIDELINES

- The care of the dependent must enable you and your spouse to be employed.
- The amount to be reimbursed must not be greater than you or your spouse's income, whichever is less.
- The services may be provided by a daycare facility that cares for 2 or more children simultaneously, the facility must comply with state and local daycare regulations.
- Services must be for the physical care of the child, not for education, meals, etc.; expenses for overnight camps and kindergarten are not eligible for reimbursement.

FSA REIMBURSEMENT

- Always keep a copy of the Explanation of Benefits (EOB) and itemized medical and pharmacy receipts, as reserves the right to substantiate expenses as well as the IRS.
- Participants will be reimbursed by Mandatory Direct Deposit for manual claims or Debit Card for incurred expenses by completing a claim form and submitting it to Nova.

FSA CLAIM RUN-OUT PERIOD

Participants will have until March 31, 2023 to get reimbursed for qualifying claims incurred during the 2022 FSA plan year.

PLEASE NOTE: Once enrolled, you may not change your annual election amount. According to IRS regulations, you may only change your elections at the beginning of each plan year unless you experience a change in your family status.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

QUALIFIED MEDICAL EXPENSES LIST

Flexible Spending Account (FSA)

- Acupuncture
- Alcoholism treatment
- Allergy shots and testing
- Ambulance (ground or air)
- Artificial limbs
- Blind services and equipment
- Car controls for handicapped*
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Crutches, wheelchairs, walkers
- Deaf services -- hearing aid/batteries, hearing aid animal & care, lip reading expenses, modified telephone, etc.
- Dental treatment
- Dentures
- Diagnostic tests
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription)
- Eye examinations and eyeglasses
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices*
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations and surgeries (legal)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Oxygen/oxygen equipment
- Physical exams (except for employment-related physicals)
- Physical therapy
- Psychiatric care, psychologists, psychotherapists
- Radial keratotomy
- Schools (special, relief, or handicapped)
- Sexual dysfunction treatment
- Smoking cessation
- Surgical fees
- Television or telephone for the hearing impaired
- Therapy treatments*
- Transportation (essentially and primarily for medical care; limits apply)
- Vaccinations
- Vitamins*
- Weight loss programs*
- X-rays

if prescribed for a particular ailment or medical condition, provider letter required

Important Notice about Over-the Counter (OTC) Medications

OTC medications require a doctor's prescription to be eligible for reimbursement

For that reason OTC medications cannot be purchased unless dispensed by a pharmacy using the same method as a standard prescription. If a manual claim is submitted for purchase of an OTC medication, both a copy of the prescription and the purchase receipt must be included to receive reimbursement. Non-Medicated OTC products (diabetes test strips, saline solutions, band-aids etc.) do not require a prescription. You can purchase these items and submit the purchase receipt for reimbursement.

ELIGIBLE OVER-THE-COUNTER (OTC) MEDICATIONS & PRODUCTS

COPY OF PRESCRIPTION AS WELL AS DETAILED RECEIPT REQUIRED FOR REIMBURSEMENT:

- Acne medications & treatments
- Allergy & sinus, cold, flu & cough remedies (antihistamines, decongestants, cough syrups, cough drops, nasal sprays, medicated rubs, etc.)
- Antacids & acid controllers (tablets, liquids, capsules)
- Antibiotic & antiseptic sprays, creams & ointments
- Anti-diarrheals
- Anti-fungals
- Anti-gas & stomach remedies
- Anti-itch & insect bite remedies
- Anti-parasitics
- Digestive aids
- Baby care (diaper rash ointments, teething gel, rehydration fluids, etc.)
- Contraceptives (condoms, gels, foams, suppositories, etc.)
- Eczema & psoriasis remedies
- Eye drops, ear drops, nasal sprays
- First aid kits
- Hemorrhoidal preparations
- Hydrogen peroxide, rubbing alcohol
- Laxatives
- Medicated band aids & dressings
- Motion sickness remedies
- Nicotine medications (smoking cessation aids)
- Pain relievers (aspirin, ibuprofen, acetaminophen, naproxen, etc.)
- Sleep aids & sedatives
- Wart removal remedies, corn patches

ELIGIBLE FOR REIMBURSEMENT WITH DETAILED RECEIPT ONLY (NO PRESCRIPTION REQUIRED):

- Breast pumps for nursing mothers
- Braces & supports
- Contact lens solution
- CPAP equipment & supplies
- OTC varieties of Insulin
- Diabetic testing supplies/equipment
- Durable medical equipment (power chairs, walkers, wheelchairs, etc.)
- Home diagnostic (pregnancy tests, ovulation kits, thermometers, blood pressure monitors, etc.)
- Non-medicated band aids, rolled bandages & dressings
- Reading glasses

All OTC items are examples. This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

DENTAL COVERAGE

Guardian – Dental Guard Preferred Plan

DENTAL COVERAGE OVERVIEW

GUARDIAN

Guardian Dental Guard Preferred Plan dental coverage allows you to visit any dentist of your choice but you pay less out-of-pocket when you choose a participating in-network dentist.

Guardian	Dental Guard Preferred Plan	
	In-Network	Out-of-Network
General Plan Information		
Eligibility	All Active Eligible Employees	
Employee Contribution	Contributory – Employer & Employee Paid	
Dependent Age Limit	To age 26	
Cost-Sharing Highlights		
Deductible (per person)	$50	$100
Family Limit	3 per family	
Waived For	Preventive Services	
Annual Maximum	$1,000	
Maximum Rollover		
Rollover Threshold	$500	
Rollover Amount	$250	
Rollover In-Network Amount	$350	
Rollover Account Limit	$1,000	
Preventive Services		
Most routine dental services, including: oral exams, cleanings, x-rays	100% covered	100% covered
Basic Services		
Moderately complex dental services, including: fillings, and simple extractions	100% covered	80% covered
Major Services		
More complex dental services, including: crowns, complex extractions, dentures	60% covered	50% covered
Orthodontia Services		
Covered Dependent Children Only	50% covered	N/A
Lifetime Orthodontia Maximum	$1,000	N/A

PLEASE NOTE: Deductible and Individual Annual Maximum reset on a calendar year basis.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

VISION
Guardian – Davis Vision Network

VISION COVERAGE OVERVIEW

GUARDIAN

Guardian Davis Vision Plan Vision coverage allows you to obtain services in-network and out-of-network, but you pay less out-of-pocket when you choose an in-network vision provider.

Guardian	Davis Vision Network	
	In-Network	Out-of-Network
General Plan Information		
Eligibility	All Active Eligible Employees	
Employee Contribution	Voluntary – 100% Employee Paid	
Dependent Age Limit	To Age 26	
Vision Plan Information		
Eye Examination	$20 copay	Amount over $50 after $20 copay
Materials/Eyewear	$20 copay	$20
Eyeglass Lenses (instead of contacts)		
Single Vision	Covered in full after $20 copay	$48 allowance after $20 copay
Lined Bifocal	Covered in full after $20 copay	$67 allowance after $20 copay
Lined Trifocal	Covered in full after $20 copay	$86 allowance after $20 copay
Lenticular	Covered in full after $20 copay	$126 allowance after $20 copay
Frames		
One Pair of Eyeglass Frames	$135 allowance after $20 copay	$48 allowance after $20 copay
Contact Lenses (instead of eyeglass lenses)		
Elective/Conventional Lenses	$135 allowance	Up to $105 allowance
Medically Necessary	Covered after materials copay	Up to $210 allowance after $20 copay
Frequency		
Vision Exam	Once per Calendar Year	
Frames	Every Other Calendar Year	
Lenses or Contact Lenses	Once per Calendar Year	

PLEASE NOTE: Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered individual must pay the entire discount fee.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Guardian – Base Life/AD&D Plan

LIFE AND AD&D COVERAGE OVERVIEW

Guardian Base Life and Accidental Death & Dismemberment (AD&D) coverage provides crucial financial protection for your family if something were to ever happen to you. Benefits can be used towards income replacement, a mortgage, tuition, outstanding debt, and more allowing you to take care of your loved ones even if you are not there. As an eligible employee, you are automatically enrolled in this plan.

Guardian	Base Life/AD&D Plan
General Plan Information	
Eligibility	All Active Eligible Employees
Employee Contribution	None – 100% Employer Paid
Base Life/AD&D Benefit	
Benefit Amount	100% of earnings to a maximum of $50,000
Guarantee Issue Amount	N/A
Benefit Reduction	
At Age 70	50% Reduction

ADDITIONAL BENEFITS INCLUDED

WAIVER OF PREMIUM

Waives your obligation to pay any further premium in the event you become ill or disabled.

ACCELERATED DEATH BENEFIT

Allows you to receive cash advances in the event you become diagnosed with a terminal illness.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

SUPPLEMENTAL LIFE INSURANCE

Guardian – Supplemental Life

SUPPLEMENTAL LIFE COVERAGE OVERVIEW

GUARDIAN

Guardian Supplemental Life coverage provides crucial financial protection for your family if something were to ever happen to you. Advantage Global Resources gives eligible employees the opportunity to purchase additional Life coverage for yourself, your spouse, and your dependent children. EOI will be required if enrolling outside of initial eligibility.

Guardian	Supplemental Life Plan		
General Plan Information			
Eligibility	All Active Eligible Employees		
Employee Contribution	Voluntary – 100% Employee Paid		
Supplemental Life Benefit	**Employee**	**Spouse**	**Child(ren)**
Benefit Amount	A: $25,000 B: $50,000 C: $75,000 D: $100,000	50% of employee amount up to $50,000	10% of employee amount up to $10,000
Guarantee Issue Amount	Under age 65: N/A Age 65-69: $10,000 Age 70: Any amount requires EOI	Under age 65: $25,000 Over Age 65: $5,000 Spouse coverage terminates at age 70.	N/A
Employee Benefit Reduction			
At Age 70	50% Reduction		

ADDITIONAL BENEFITS INCLUDED

WAIVER OF PREMIUM

Waives your obligation to pay any further premium in the event you become ill or disabled.

ACCELERATED DEATH BENEFIT

Allows you to receive cash advances in the event you become diagnosed with a terminal illness.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

DISABILITY COVERAGE
Guardian – Voluntary Short Term Disability Plan

VOLUNTARY DISABILITY COVERAGE OVERVIEW

GUARDIAN

Guardian Short Term Disability (STD) coverage can help replace a portion of your income during the initial weeks of a disability to help you pay your bills and maintain your current lifestyle. It helps by protecting you and your income if a sickness or accidental injury limits you from working. EOI will be required if enrolling outside of initial eligibility.

Guardian	Short Term Disability (STD) Plan
General Plan Information	
Eligibility	All Active Eligible Employees
Employee Contribution	Voluntary – 100% Employee Paid
Short Term Disability Benefit	
Weekly Benefit Percentage	60% of basic weekly earnings
Weekly Benefit Amount	Up to $1,500 per week
Maximum Benefit Duration	13 Weeks
Benefit Limitations	
Elimination Period	7 Consecutive Days
Pre-Existing Condition	3 Months Look Back; 12 Months Covered
Disability Definition	Own Occupation

EARNINGS DEFINITION | Basic weekly earnings as reported by your employer immediately before the first date your disability begins, excluding commissions, overtime pay, bonuses, or any other special compensations not received as basic salary.

DISABLED DEFINITION | Unable to do the material duties of your job, not performing any work for payment, and under the regular care of a physician.

INJURY | Bodily injury resulting directly from an accident, independent of all other causes. The injury must cause disability which begins while insured.

SICKNESS | Illness or disease causing disability which begins while insured. Sickness includes pregnancy, childbirth, or any complications therefrom.

PRE-EXISTING CONDITION | An injury or sickness, whether diagnosed or misdiagnosed, and any symptoms thereof, for which, in the look back period, you – received medical care/treatment from a doctor, are prescribed/take prescription drugs, or undergo a diagnostic procedure other than routine screening in suspicion of disease processed by a doctor.

OWN OCCUPATION | The occupation, trade, or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

DISABILITY COVERAGE
Guardian – Voluntary Long Term Disability Plan

VOLUNTARY DISABILITY COVERAGE OVERVIEW

GUARDIAN

Guardian Long Term Disability (LTD) coverage can help replace a portion of your income if you were to become disabled for a prolonged period prior to retirement to help you pay your bills and maintain your current lifestyle. EOI will be required if enrolling outside of initial eligibility.

Guardian	Long Term Disability (LTD) Plan
General Plan Information	
Eligibility	All Active Eligible Employees
Employee Contribution	Voluntary – 100% Employee Paid
Long Term Disability Benefit	
Monthly Benefit Percentage	60% of basic monthly earnings
Monthly Benefit Amount	Up to $6,000 per month
Maximum Benefit Duration	To Age 65/ADEA
Additional Benefits	
Social Security Integration	Full Family
Chemical Dependency & Mental/Nervous	24 Months
Survivor Benefit	3 Months
Benefit Limitations	
Elimination Period	90 Consecutive Days
Pre-Existing Condition	3 Months Look Back; 12 Months Covered
Disability Definition	2 Year Own Occupation then Any Occupation

DISABLED DEFINITION | Unable to do the material duties of your job, not performing any work for payment, and under the regular care of a physician.

INJURY | Bodily injury resulting directly from an accident, independent of all other causes. The injury must cause disability which begins while insured.

SICKNESS | Illness or disease causing disability which begins while insured. Sickness includes pregnancy, childbirth, or any complications therefrom.

PRE-EXISTING CONDITION | An injury or sickness, whether diagnosed or misdiagnosed, and any symptoms thereof, for which, in the look back period, you – received medical care/treatment from a doctor, are prescribed/take prescription drugs, or undergo a diagnostic procedure other than routine screening in suspicion of disease processed by a doctor.

2 YEAR OWN OCCUPATION | For the first 24 months of a disability, you are considered disabled if you are unable to perform the material duties of your occupation, trade, or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.

401 (K)
VOYA – 401 (K) Plan

401 (K) COVERAGE OVERVIEW

To help you prepare for the future, AP Professionals sponsors a 401(k) plan as part of its benefits package. As an employee, you may start participating in this plan on the first day of the calendar quarter and after completing 90 days of service. Enrollments will be January 1, April 1, July 1 and October 1.

Plan Type:

VOYA (ING)

Effective Date:

90 days of employment on the following quarter

Benefits You Receive:

By contributing to a 401K traditional plan on a pre-tax basis, you reduce the taxes you pay today and delay paying taxes on the money you save, as well as your account earnings, until you withdraw the money from the plan. You also have the option to contribute to a post-tax Roth plan or you may participate in both a traditional and Roth plan.

Contributions as well as allocations can be changed anytime (even daily).

Maximum Contribution:

For the 2023 calendar year you may contribute anywhere from 1 - 96% for a max of $19,500 for the year.
The 401K Catch up plan for employees age 50 and older allows for an additional $6,500 in contributions for the 2023 calendar year

Employee Cost:

Employee allocated, percentage of pay

EMPLOYEE ASSISTANCE PROGRAM (EAP)

EMPLOYEE ASSISTANCE PROGRAM (EAP) COVERAGE OVERVIEW

GUARDIAN

THE EMPLOYEE ASSISTANCE PROGRAM (EAP) CAN HELP WITH VIRTUALLY EVERY AREA OF LIFE!

Sometimes life takes an unexpected turn, allow the EAP to guide you!

Problems are just a part of everyday life. In additional to the benefits provided under your Guardian Group Insurance coverage, you and your household members now have access to GHN's Employee Assistance Program (EAP) free of charge to help with the everyday challenges of life that may affect your health, family life and desire to excel at work.

BENEFITS YOU RECEIVE:

Consultation & Support

You and the members of your household are entitled to up to 3 consultations with a licensed clinician per incident, per individual, per calendar year. You choose between telephonic consultations, for maximum convenience and anonymity or web-video consultations for convenience with the warmth of a face-to-face conversation. Please call **1-800-386-7055** anytime to speak with a clinician or schedule an appointment.

Work & Life Services

Telephonic consultations are available in the following areas:

Financial Services

Budgeting, credit and financial guidance (investment advice, loans and bill payments not included), retirement planning and assistance with tax issues.

Childcare and Eldercare Assistance

Needs assessment plus referrals to childcare and eldercare providers.

Identity Theft Recovery Services

Information on ID theft prevention, plus an ID theft emergency response kit and help from a fraud resolution specialist if you are victimized.

Legal Services

Consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, estate planning and more.

Daily Living Services

Referrals to consultants and businesses that can help with event planning, transportation services, pet services and more.

ONLINE MEMBER SERVICES:
Email: eapcounselor@ibhcorp.com
Phone: 1 800 386 7055
Available 24 hours a day, 7 days a week*
Web: ibhworklife.com
User name: Matters
Password: wlm70101

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your detailed policy for complete information.

PRICING DETAILS

See below for the cost for each benefit offered, effective January 1, 2022 – December 31, 2022:

MEDICAL	BCBS of WNY Bi- Weekly Cost
Tiers	PPO 6317 HDHP
Single	$ 0.00
Family	$ 0.00

DENTAL	Guardian Bi- Weekly Cost
Tiers	Guardian Dental Guard
Single	$0.00
Family	$27.76

VISION	Guardian Bi-Weekly Cost
Tiers	Davis Vision Network
Single	$2.64
Family	$5.69

SUPPLEMENTAL LIFE INSURANCE

EMPLOYEE, SPOUSE, AND DEPENDENT COVERAGE AVAILABLE

Life/AD&D	Guardian	
Base Life/AD&D	100% Employer Paid	
Supplemental Life	**Supplemental Life – Monthly Cost**	
Age	Per $1,000 Benefit Employee	Per $1,000 Benefit Spouse (based on employee age)
Under 25	$0.070	$0.070
25 – 29	$0.070	$0.070
30 – 34	$0.090	$0.090
35 – 39	$0.120	$0.120
40 – 44	$0.150	$0.150
45 – 49	$0.220	$0.220
50 – 54	$0.360	$0.360
55 – 59	$0.640	$0.640
60 – 64	$0.890	$0.890
65 – 69	$1.640	$1.640
70 – 74	$2.890	$2.890
75 – 79	$6.470	$6.470
80 – 84	$13.240	$13.240
85 – 89	$21.530	$21.530
90 – 94	$33.910	$33.910
95 - 99	$51.770	$51.770
Child(ren)	$0.160/$1,000	

CALCULATING SUPPLEMENTAL LIFE

To calculate your cost per pay period, please use the following for yourself and your spouse (Calculate Spouse Individually):

_____	÷ 1,000 =	_____	x	_____	=	$ _____	x 12 =	_____	÷ 26 =	_____
Benefit Amount				Monthly Life Rate		Monthly Cost		Yearly Cost		Cost Per Pay Period

To calculate your cost per pay period, please use the following for Child(ren):

_____	÷ 1,000 =	_____	x	$0.160	=	$ _____	x 12 =	_____	÷ 26 =	_____
Benefit Amount				Monthly Life		Monthly Cost		Yearly Cost		Cost Per Pay Period

To calculate your total cost for your family per pay period please use the following:

_____	+ _____	+ _____	=	$ _____
Employee Cost Per Pay period	Spouse Cost Per Pay Period (if applicable)	Child(ren) Cost Per Pay Period (if applicable)		Total Cost Per Pay Period

VOLUNTARY DISABILITY OPTIONS

Short Term Disability	Monthly Cost
Age	Per $10 Benefit
Under 25	$0.350
25 – 29	$0.460
30 – 34	$0.610
35 – 39	$0.460
40 – 44	$0.390
45 – 49	$0.410
50 – 54	$0.480
55 – 59	$0.590
60 – 99	$0.870

Long Term Disability	Monthly Cost
Age	Per $100 Benefit
Under 25	$0.140
25 – 29	$0.150
30 – 34	$0.190
35 – 39	$0.270
40 – 44	$0.420
45 – 49	$0.720
50 – 54	$1.050
55 – 59	$1.180
60 – 99	$0.830

CALCULATING SHORT TERM DISABILITY

To calculate your monthly cost, please use the following:

	÷ 52 =		x .6 =		÷ 10 =		x $		x12= $		÷ 26 =	
Your Annual Earnings		Your Weekly Earnings		Weekly Benefit				Monthly Cost		Yearly Cost		Cost Per Pay Period

CALCULATING LONG TERM DISABILITY

To calculate your monthly cost, please use the following:

	÷ 12 =		÷ 100 =		x		= $		x12=		÷26=	
Your Annual Earnings Maximum		Your Monthly Earnings				Monthly Rate		Monthly Cost		Yearly Cost		Cost Per Pay Period

SPECIAL ENROLLMENT RIGHTS NOTICE

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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT ENROLLMENT (WHCRA) ENROLLMENT NOTICE

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

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

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

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT (NMHPA) 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).

TO REQUEST NOTICES OR MORE INFORMATION

To request a copy of the General Notices or more information, please contact:

Human Resources Director:
Tracy Allen
716.866.6425
tracy@theadvantage.com

General Notice of COBRA Continuation Coverage Rights

** 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 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;
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: Tracy Allen, HR Director by mail or email at the addresses below.

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 medical insurance coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Benefits eligible for continuation under COBRA rules include health insurance, Health Reimbursement Accounts, dental, vision, and Flexible Spending Accounts. 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. You must provide this notice to: Tracy Allen HR Director, by mail or email at the addresses below. To avoid a potential lapse in coverage, please remit confirmation of Social Security Disability Determination within 30 days or receipt.

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 Director:
Tracy Allen
716.866.6425
tracy@theadvantage.com

Important Notice from Advantage Global Resources 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 Advantage Global Resources 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. Advantage Global Resources has determined that the prescription drug coverage offered by the all BCBS PPO and the Platinum Standard health plans are, 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 Advantage Global Resources coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Advantage Global Resources coverage, be aware that you and your dependents will be able to get this coverage back by re-enrolling during a subsequent open enrollment or within 30 days of a qualifying event.

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 Advantage Global Resources 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 Advantage Global Resources 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).

Human Resources Director:
Tracy Allen
716.866.6425
tracy@theadvantage.com

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. 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.asp x	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/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov 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: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.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: http://dhcfp.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 July 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

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)

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary 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 Benefits Summary and the 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 this summary, contact Human Resources.

BCBS OF WNY

Monday – Friday: 8:00 am – 7:00 pm
TOLL FREE 1.800.544.BLUE (2583) LOCAL 716.884.2800
HEALTH ADVOCATE 1.800.359.5465 (24 HOUR LINE)
PHARMACY SERVICES 1.800.939.3761
CustomerService@bcbswny.com
bcbswny.com

GUARDIAN

DENTAL 1.800.541.7846
VISION 1.877.393.7363
TERM LIFE & AD&D 1.800.525.4542
NYS DISABILITY 1.888.278.4542
SHORT TERM DISABILITY 1.800.268.2525
LONG TERM DISABILITY 1.800.538.4583
EMPLOYEE ASSISTANCE PROGRAM 1.800.386.7055
GuardianAnytime.com

NOVA

HRA/FSA ADMINISTRATION
TOLL FREE 1.800.264.9115
LOCAL 716.505.8509
novahealthcare.com

VOYA

401(K)
PHONE 1.800.584.6001
www.voya.com

Annual Vacation, Holiday, & Sick Days

PTO / Vacation Days (10 per year)*

Accrual begins after 60 days of employment, earned at the rate of 1 day per end of month (for a total of 10 days per year).

Vacation Days are only tracked in-house, not in AP Connects or Paycom.

Holidays (10 per year)

Holiday pay is available immediately upon employment. AP Professionals has six scheduled holidays:

1. New Years Day
2. Memorial Day
3. 4th of July
4. Labor Day
5. Thanksgiving Day
6. Christmas Day

The remaining four days are floating days to be used according to the client's holidays:

Examples: MLK Day, Presidents Day, Columbus Day, Day after Thanksgiving

Sick Days (5 per year, 40 hours total). These days are available immediately upon hire.

* Maximum cap, 150 hours