Phoenix House
Rising Above Addiction

2017 Benefits Guide
Opening Remarks
Our mission is to protect and support individuals, families, and communities affected by substance abuse and dependence. Our unique and holistic approach has helped thousands of people – making us the nation’s leading provider of alcohol and drug abuse treatment and prevention services. We are proud that our employees share our vision and passion – and we recognize that you are an important part of the team!

We hold ourselves to a high standard when it comes to delivering health benefits to our employees. We offer a wide range of employee benefits, from the standard medical and prescription benefits, to pension benefits, to employee recognition opportunities.

This guide is designed to assist you in making benefit choices and provide details about other benefit opportunities. It provides key information on the various aspects of the health plans and helps you sort through your options.

Please review the material, discuss it with your family, and make an informed choice when selecting coverage. Changes are only allowed during the next open enrollment season or if you experience a “Qualifying Life Event.”

Phoenix House reserves the right to change the benefits package and/or our pay practices, or any components thereof, at its discretion at any time. Detailed descriptions of each plan are contained in the official plan texts, insurance contracts and trust agreements, which are the legal documents that govern the operation of the plans, the rights of employees to benefits, and the calculation and payment of benefits. In the event of a conflict between the official plan documents and the summaries contained herein, the applicable plan texts, insurance contracts and/or trust agreements will govern.

If you have questions, please contact the ADP Benefits Service Center at 1 855 809 8200.
How to Enroll in Benefits

Before you can enroll in benefits, you will need to register on the ADP Portal.

To Register: Go to https://workforcenow.adp.com. Click on “REGISTER HERE”.

Step 1: Enter the registration code: A registration code is provided to you when you are hired.

Step 2: Enter the required information and click “CONFIRM”

Step 3-7: Verify Identity, create User ID and password to complete registration and select security questions and answers.

Now you are ready to enroll!

Enter your information at “User Login”

All new hires have 90 DAYS to complete their enrollment!

Step 1: To enroll in a benefit plan, add dependents and assign beneficiaries as a new hire, click on “START THIS ENROLLMENT”.

If Dependents need to be added, select “ADD DEPENDENT/BENEFICIARY”. If no dependents need to be added, skip to Step 2.
How to Enroll, continued...

Step 2: Select “Walk me Through My Benefit Options” and click “CONTINUE”.

Step 3: Select desired plans, then click “ENROLL IN THIS PLAN”. Repeat steps for all applicable plans.

Step 4: Click on “REVIEW & COMPLETE” when ALL desired benefits have been selected.

Step 5: Review your selected benefits for accuracy. If finished, click on “COMPLETE ENROLLMENT” or, to change benefit selections, click on “RETURN TO CHOOSE PLANS”.

Step 6: Once your enrollment is complete, a green banner will appear indicating your changes have been submitted. Click on the “View/Print Benefits Statement” link to print your Benefits Statement.
Benefits and Eligibility

New Hires Have 90 Days To Enroll!
If you do not submit your elections within 90 days from your date of hire, you and/or your eligible dependent(s) will not be enrolled in benefits.

- You will be required to enter dependent dates of birth and social security numbers.
- You will be required to claim your Tobacco-Free Incentive.

You will not be able to make plan changes or enroll your dependent(s) until the next Annual Enrollment period, unless you experience a Qualifying Life Event during the year.

Benefit Coverage by Hours Worked

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>SCHEDULED TO WORK PART TIME</th>
<th>SCHEDULED TO WORK PART TIME</th>
<th>SCHEDULED TO WORK FULL TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>under 30 hours per week</td>
<td>30 hours or more per week</td>
<td></td>
</tr>
<tr>
<td>Medical – UHC &amp; Express Scripts</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dental</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Vision</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Short-Term Disability</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>401(b) – Company Contributions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-elective Safe Harbor and Match</td>
<td>Yes¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>403(b) – Voluntary Contributions</td>
<td>Yes¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EAP – Life Assistance Program</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Secure Travel</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuition Reimbursement</td>
<td>No</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>QTE Plan</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Veterinary Insurance</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Insurance</td>
<td>No</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Excellence Award Program</td>
<td>No</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Service Award Program</td>
<td>No</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Cobra Continuation</td>
<td>No</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Travel Accident Insurance</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1. Eligibility exclusions apply as per the plan document.
2. Reimbursement limits are one-half the limits set for full-time employees.

Employee Eligibility
Different benefits are available to you based on your work schedule (part- or full-time) and your length of employment. Use the chart below to review eligibility and available benefits.

Eligibility in Massachusetts
Medical and Prescription Drug Coverage is available to full- and part-time employees who work 64 hours or more per month and have been employed for 90 days. All other benefits are subject to the eligibility rules below.
**Plan Year**

Your benefit elections for the current plan year will be effective **from January 1 to December 31, 2017.**

When you enroll in the plan, benefits become available on your effective date until you make a change during open enrollment or after experiencing a qualified life event.

**Flexible Spending Accounts** are in effect only to the end of the plan year (Dec. 31). You must re-enroll in these accounts prior to the beginning of each plan year.

### Benefits Coverage by Eligibility Date

<table>
<thead>
<tr>
<th><strong>PARTICIPATION ELIGIBILITY</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Rx - UHC &amp; Express Scripts</td>
<td>Effective on 90th Day of Employment</td>
</tr>
<tr>
<td>Dental</td>
<td>Effective on 90th Day of Employment</td>
</tr>
<tr>
<td>Vision</td>
<td>Effective Date of Hire</td>
</tr>
<tr>
<td>Flexible Spending Account</td>
<td>Effective Date of Hire</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>Effective Date of Hire</td>
</tr>
<tr>
<td>STD &amp; LTD</td>
<td>Effective on 90th Day of Employment  (employees covered under NY, RI and CA statutory plans are not subject to the 90 day wait for short-term disability coverage)</td>
</tr>
<tr>
<td>Employee Assistance</td>
<td>Effective Date of Hire</td>
</tr>
<tr>
<td>Transportation Expense</td>
<td>Effective Date of Hire</td>
</tr>
<tr>
<td>Legal</td>
<td>Effective Date of Hire</td>
</tr>
<tr>
<td>Veterinary</td>
<td>Effective Date of Hire</td>
</tr>
<tr>
<td>403(b) Retirement Plan</td>
<td>Voluntary contributions – Effective Date of Hire Company contributions – The month following 1 year of service (providing you worked 1000 hours)</td>
</tr>
</tbody>
</table>
Dependent Eligibility

You may enroll eligible family members for coverage as outlined below. Benefits for covered dependents begin on the same date(s) as coverage for the employee. Dependents are defined as the following:

- Your legal spouse
- Your civil union partner
- Your domestic partner ONLY IF coverage is required by law of the state in which you reside.

- Dependent Children:
  
  **Medical & Prescription Drug Coverage:** Until the end of the year in which the dependent child turns 26 years of age.

  **Dental Coverage:** Until the end of the year in which the dependent child turns 19 years of age, or 23 years of age if the child is a full-time student. Dental coverage is available in FL, MA and TX until the end of the calendar year of the dependent’s 25th birthday.

  **Vision Coverage:** Until the end of the year in which the dependent child reaches 19 years of age, or 23 years of age if the child is a full-time student.

- Unmarried children age 26 or older who are physically or mentally incapacitated (if such incapacitation occurs before the age of 26), are not capable of self-support, and are dependent on you for support. (Physician verification will be required on an annual basis and acceptance of documentation is at Phoenix House’s sole discretion.)

Newborn or newly adopted child

If you are adding coverage for a newborn or newly adopted child during the year, you must record the change through the ADP Portal within 31 days of the event, otherwise you must wait until the next open enrollment period. See the section titled “Benefit Changes During the Year” for more details.

Domestic Partners

In order to enroll a dependent as a domestic partner, domestic partner coverage must be required by law of the state in which you reside. The employee must also complete and sign the “Declaration of Domestic Partnership”. The Declaration can be found on the ADP Portal.

The certificate or signed Declaration and the supporting documents requested in the Declaration must be faxed to ADP at 855 238 9071 or emailed to phoenixhousebenefits@adp.com.

Taxability of Domestic Partner and Civil Union Partner benefits

Federal law in effect at the time of this publication requires the taxation of health coverage for domestic partners and civil union partners who are not also qualified tax dependents under IRC Section 152. This means that if your domestic partner or civil union partner is not a tax-qualified dependent, you will pay imputed income taxes based on the value of the insurance provided to your domestic partner or civil union partner. You will also be required to pay a portion of your contribution on an after-tax basis. In the event your dependent is tax-qualified, you will need to provide this information to the ADP Benefits Service Center, otherwise imputed income taxes and after-tax contributions will apply. The rules for tax qualification of dependents are complex. Please refer to a tax professional if you have questions regarding this requirement.
Benefit Changes During the Year

A “Qualifying Life Event” is an opportunity to change benefits!

A “qualifying life event” describes a major life change, such as a marriage or birth of a child that enables you to change your current benefits elections without having to wait until the next open enrollment period. These life events are good opportunities to review current benefits, compare them to new needs, and decide on adjustments.

Procedure for Changes

If you experience one of the events listed in the chart below and want to make changes, you must record the change through the ADP Portal within 31 days of the event. In addition, you must provide proof of the change, such as a marriage certificate, birth certificate, divorce decree or verification of student status. Please review the table for qualified life events and corresponding required documentation.

Changes are effective on the date updated within the ADP Employee portal, with the exception of birth or adoption, which is effective on the day that the qualifying event occurs.

Benefit Changes and Required Documentation

<table>
<thead>
<tr>
<th>QUALIFYING LIFE EVENTS</th>
<th>REQUIRED SUPPORTING DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADDING COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Marriage/Civil Union</td>
<td>A copy of a marriage/civil union certificate.</td>
</tr>
<tr>
<td>Birth</td>
<td>Copies of birth certificate(s) for biological child(ren).</td>
</tr>
<tr>
<td>Adoption</td>
<td>If you are the legal guardian or adopted parent of a covered dependent child: A copy of the legal document awarding you custody, or the adoption certification.</td>
</tr>
<tr>
<td>Stepchild</td>
<td>If you have a step child dependent on you for support: A copy of the tax return listing the child as your dependent.</td>
</tr>
<tr>
<td>Disabled Dependent 26 or Older (unmarried)</td>
<td>If you have an unmarried child age 26 or older who is a disabled dependent, as defined in the medical plan document: Disability certification from a physician. Proof of disability must be submitted before the day they reach age 26.</td>
</tr>
<tr>
<td>Loss of Coverage</td>
<td>Documentation reflecting loss of other coverage</td>
</tr>
<tr>
<td>Judgement, Decree or Court Order</td>
<td>Copy of legal document mandating coverage</td>
</tr>
<tr>
<td><strong>REMOVING COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Gaining Coverage Elsewhere</td>
<td>Proof of new coverage elsewhere on company letterhead.</td>
</tr>
<tr>
<td>Death of a Spouse or Dependent</td>
<td>A copy of the death certificate.</td>
</tr>
<tr>
<td>Divorce or Legal Separation</td>
<td>A copy of divorce or legal separation papers.</td>
</tr>
<tr>
<td>Removing a Dependent</td>
<td>Provide proof of the dependent’s new coverage.</td>
</tr>
<tr>
<td>Enrollment in Marketplace Exchange</td>
<td>Copy of enrollment confirmation</td>
</tr>
<tr>
<td>Reduction in Hours of Service</td>
<td>Provide proof of status change</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
</tr>
<tr>
<td>Name Change</td>
<td>A copy of your new Social Security card to your Regional Human Resources Representative.</td>
</tr>
</tbody>
</table>
Medical Benefits

Medical: United Healthcare

United Healthcare Overview
Phoenix House offers two United Healthcare medical plans - an EPO (Exclusive Provider Organization) and a POS (Point of Service).

Eligibility
Medical coverage is available to full-time employees and to part-time employees who work 30 hours or more per week on a regularly scheduled basis following 90 days of employment. For those working in Massachusetts, coverage is available to full-time employees and to part-time employees who work 64 hours or more per month following 90 days of employment.

United Healthcare Coverage
Phoenix House pays for the majority of your healthcare benefits, but you contribute a small portion through premiums, deductibles and co-insurance.

Health Plan Services and Coverage
The information below outlines other costs you are responsible for. This includes the deductible, co-pays and co-insurance for specific services.

- Deductible: The fixed amount you pay before insurance benefits start.
- Co-insurance: The percentage of the total medical bill that you are responsible for (after meeting your deductible).
- Co-pay (or Co-payment or Office Visit Co-pay): A fixed dollar amount that you pay for an in-network office visit or for a prescription drug.

Please note that not all available services are listed. For more details, please refer to the Plan documents.

Choosing in-network or out-of-network medical services
In-network health care includes services performed by a provider, such as a doctor or hospital, that has been selected as part of the UHC Choice Network (Choice Plus network for plans with out-of-network benefits) to provide care to members at a reduced cost.

At Phoenix House, we continuously strive to provide competitive and affordable benefits while protecting the plan from unnecessary expenses. OON providers will only be reimbursed based on a percentage of what Medicare would pay the same provider.

Non-network outpatient dialysis, and non-network surgical and non-surgical treatment of obesity (e.g. gastric bypass, lap band surgery) is not covered. These services will continue to be covered in-network. OON care is significantly more expensive than in-network care, and encouraging in-network care through plan design makes the plan more affordable for employees and Phoenix House.

United Healthcare: EPO
The EPO plan offers comprehensive coverage for in-network benefits. You’ll pay lower premiums on the EPO plan.

United Healthcare: POS
The greatest advantage of the POS plan is flexibility: it offers coverage for services received both in- and out-of-network (OON). However, employee premiums are higher than on the EPO plan.
What does this mean for you?

- If you seek care from an OON provider or facility and it is in one of the excluded categories, you are responsible for 100% of the charges you incur. These services are covered in-network only, and any OON charges will not apply to your annual out-of-pocket maximum.

- When you seek care from an OON provider or facility that is not in an excluded category, you are responsible for your deductible and co-insurance.

- The plan will reimburse the OON provider based on 140% of the rate Medicare would pay for the same services.

- If the OON provider decides this does not cover your care, you may be responsible for paying the remainder of your medical bill. This is called “balance billing.” These expenses could be substantial and do not apply to your annual out-of-pocket maximum.

What can you do to avoid unexpected out of pocket costs?

- **Use in-network providers**, who have agreed to accept our rates!

- If your doctor refers you to another provider, lab, or facility, make sure they are in-network.

- Be an educated consumer; use the resources available to you to estimate your costs:
  - [www.myuhc.com](http://www.myuhc.com)
  - [www.fairhealthconsumer.org](http://www.fairhealthconsumer.org)
  - Contact UHC member services at the number listed on your ID card and request a cost estimate in advance of any OON treatment you are considering.

Pre-Certification is required under both plans

Medical pre-certification is required for both the EPO and PPO plans.

- If an employee receives services from an In-Network Provider:
  - The provider is responsible for notifying United Healthcare

- If an employee receives services from a Non-Network Provider, the employee must contact UHC Member Services prior to obtaining the following services:
  - Inpatient Hospital Admission
  - Home Health Care Services
  - DME/Prosthetics in excess of $1,000
  - Transplant Services

- For both Network and Non-Network Mental Health/Chemical Dependency related services, an employee must contact United Behavioral Health at the toll free number listed on the ID Card

- **Emergency Room Services and Emergency Admissions** (either in-network or out-of-network):
  - An employee must notify Medical Management within 48 hours after receiving care in Emergency Room (via the toll free number on the back of the ID Card.)

- If you use Non-Network Providers, the amount UHC will reimburse is based on a percentage of the rate Medicare would pay for the same services. Your provider may balance bill you for amounts above what is reimbursed by UHC; any balance billed amounts do not accumulate toward your deductibles and/or out-of-pocket maximums.
United Healthcare

The EPO Plan (Exclusive Provider Organization)
[Designed for employees who always stay in-network.]

UNITED HEALTHCARE EPO

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Co-pay</td>
<td>$30 PCP/Specialist</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Deductible (single/family)</td>
<td>$1,500/$3,000</td>
<td>$2,000/$4,000</td>
</tr>
<tr>
<td>Co-Insurance Employee</td>
<td>15% after deductible</td>
<td>40%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (single/family)</td>
<td>$3,000/$6,000 incl. deductible</td>
<td>$6,000/$12,000 after deductible</td>
</tr>
<tr>
<td>Lifetime Plan Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Hospital Admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-insurance – Employee</td>
<td>15% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>ER Co-pay (waived if admitted)</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Referral Needed for Specialist</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

The POS Plan (Point of Service)
[Designed for employees that need/want both in-network and out-of-network benefits.]

UNITED HEALTHCARE POS

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Co-pay</td>
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<tr>
<td>ER Co-pay (waived if admitted)</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Referral Needed for Specialist</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Pre-certification

Pre-certification is the process of confirming eligibility and collecting information prior to inpatient admissions (overnight hospital stays) and selected ambulatory services.

In most cases, it is your responsibility to call before these services are received. In some cases the provider or supplier of services needs to call. Use UHC’s Medical Management Program for help in the pre-certification process. Pre-certification is NOT required for the treatment of an “emergency condition” but you must notify Medical Management within 48 hours after receiving care in Emergency Room (via the toll-free number on the back of an ID Card).
Women’s Preventive Health Services And Contraception

Certain women’s preventive health services and contraceptive methods are offered at no cost to you:

- Well women visits
- HPV testing
- Screening and counseling for interpersonal and domestic violence
- Screening for gestational diabetes
- Breastfeeding support, counseling, and supplies
- Counseling for sexually transmitted infections
- Counseling and screening for HIV
- Female contraceptive methods and counseling
- Implantable devices
- Barrier devices
- Elective sterilization
- Generic hormonal and emergency contraceptive drugs which require a prescription

*Note: Some of the services/contraceptive methods above may have frequency and age limits.*
Eligibility

With enrollment in either the United Healthcare EPO or POS Plan, you are automatically enrolled in prescription drug benefits through Express Scripts where you can choose from a nationwide network of over 60,000 participating pharmacies. Prescription drug coverage for dependent children is available under the prescription plan until the end of the year in which the dependent child reaches 26 years of age, regardless of student status.

Phoenix House pays for the majority of your prescription benefits and you contribute a small portion (premiums), via bi-weekly payroll deductions. Please refer to the enclosed literature for information on the costs of coverage.

Prescription coverage cannot be taken separately from medical coverage. Thus, if an employee does not elect medical coverage, the employee cannot elect prescription coverage and conversely, if the employee elects medical coverage, the employee must elect prescription coverage.

Note: Employees receive a medical ID card from United Healthcare for doctor/hospital coverage and a separate card from Express Scripts for prescription coverage.

If you have any questions, visit www.express-scripts.com or call Express Scripts Member Services toll-free at 1 866 727 5867.

The Express Scripts Formulary

The Express Scripts drug formulary is a list of FDA-approved prescription drugs that our plans cover, which have been reviewed by physicians and clinical pharmacists for their quality and effectiveness.

The formulary allows you and your physician to choose from a wide variety of prescription medications, and pay only a co-insurance of 20%. You pay 100% of the discounted price for brand-name drugs that are not on the Express Scripts formulary.

Out-of-Pocket Maximums

Your prescription costs are protected by an out-of-pocket (OOP) maximum that applies to prescription drugs. Once you meet your prescription drug OOP maximum, you no longer have to pay for drugs for the remainder of the plan year. (This maximum does not include non-covered drugs, mandatory generic penalties, or drugs obtained though non-network pharmacies).

The annual prescription drug out-of-pocket maximum is $3,600 for individuals and $7,200 for families.

<table>
<thead>
<tr>
<th>COSTS</th>
<th>TIER</th>
<th>DRUG CATEGORY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>($) least expensive Tier 1 Generic</td>
<td>Medications that are generic and will almost always be your least expensive alternative.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>($$) mid-range Tier 2 Formulary</td>
<td>A brand-name medication that has been reviewed by physicians and clinical pharmacists for quality and effectiveness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>($$$) more expensive than those in Tier 2 Tier 3 Non-Formulary</td>
<td>A brand-name medication not on the Express Scripts formulary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>($$$) Requires an enhanced level of service Tier 4 Specialty</td>
<td>Specialty medications are drugs that are used to treat complex conditions, such as certain types of cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether they’re administered by a health care professional, self-injected or taken by mouth, specialty medications require an enhanced level of service.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Specialty Medications

All specialty medications must be filled through Accredo, Express Scripts’s specialty pharmacy. These medications are not covered under the United Healthcare plan and must be obtained through Accredo. Specialty medications obtained through Accredo are subject to the Tier 4 cost share structure, as outlined below.

Specialty medications are drugs that are used to treat complex conditions, such as certain types of cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether they’re administered by a health care professional, self-injected or taken by mouth, specialty medications require an enhanced level of service.

Please visit www.express-scripts.com or call Express Scripts Member Services toll-free at 1 866 727 5867 for questions regarding specialty medications.

The Secret to Saving on Medications

Mail order saves you money and trips to the pharmacy! You can order a 90-day supply of your prescription medication, often at a significantly discounted price. In some cases, it can save you hundreds of dollars on some medications over the course of a year. You also get free shipping on your order.

Visit www.express-scripts.com to order prescriptions or for more information.

Generic Medications

A generic medication typically costs a lot less than its brand-name counterpart.

Essentially, a generic drug is a copy of a brand-name drug. It has the same active ingredients, dosage, quality, and strength. Remember to ask your doctor whether generic equivalents are available for your medication.

Note: If you purchase a brand-name medication when a generic medication is available, you will pay the difference between the cost of the brand drug and the generic co-pay. Diabetic supplies require a $5 co-payment at both mail and retail.

Smart Healthcare Decisions for Saving Money

- See In-Network Doctors
- Use generic drugs and mail-order
- Consider a Flexible Spending Account (FSA)
- Seek preventive care
- Take advantage of the health care “freebies” such as checkups and screenings and flu shots.

Paying for Medications: Co-pays and Co-insurance

<table>
<thead>
<tr>
<th>DRUG CATEGORY</th>
<th>PARTICIPATING RETAIL PHARMACIES (UP TO A 30-DAY SUPPLY)</th>
<th>MAIL-ORDER PHARMACY (UP TO A 90-DAY SUPPLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Generic</td>
<td>$10</td>
<td>$30</td>
</tr>
<tr>
<td>Tier 2 - Formulary</td>
<td>20% co-insurance, minimum $30</td>
<td>20% co-insurance, minimum $90</td>
</tr>
<tr>
<td>Tier 3 - Non-Formulary</td>
<td>100% co-insurance</td>
<td>100% co-insurance</td>
</tr>
<tr>
<td>Tier 4 - Specialty</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>
Employee Contributions

Premiums

Your share of the cost of coverage under a health plan is called a premium. Deductions are taken on a pre-tax basis (except for Domestic Partners) and salary banded, which means that costs are equitably distributed according to employee salary levels. Additionally, employee contributions are made through convenient payroll deductions every pay period.

UHC EPO Plan Premiums Per Pay Deductions

<table>
<thead>
<tr>
<th>SALARY RANGE</th>
<th>EMPLOYEE</th>
<th>EMPLOYEE + CHILD(REN)</th>
<th>EMPLOYEE + SPOUSE/DOMESTIC PARTNER</th>
<th>FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $25,000</td>
<td>$65</td>
<td>$100</td>
<td>$138</td>
<td>$165</td>
</tr>
<tr>
<td>$25,000 - $34,999</td>
<td>$77</td>
<td>$124</td>
<td>$164</td>
<td>$201</td>
</tr>
<tr>
<td>$35,000 - $49,999</td>
<td>$97</td>
<td>$164</td>
<td>$208</td>
<td>$260</td>
</tr>
<tr>
<td>$50,000 - $74,999</td>
<td>$113</td>
<td>$197</td>
<td>$243</td>
<td>$310</td>
</tr>
<tr>
<td>$75,000 and Over</td>
<td>$126</td>
<td>$221</td>
<td>$272</td>
<td>$347</td>
</tr>
</tbody>
</table>

UHC POS Plan Premiums Per Pay Deductions

<table>
<thead>
<tr>
<th>SALARY RANGE</th>
<th>EMPLOYEE</th>
<th>EMPLOYEE + CHILD(REN)</th>
<th>EMPLOYEE + SPOUSE/DOMESTIC PARTNER</th>
<th>FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $25,000</td>
<td>$83</td>
<td>$131</td>
<td>$175</td>
<td>$219</td>
</tr>
<tr>
<td>$25,000 - $34,999</td>
<td>$98</td>
<td>$161</td>
<td>$208</td>
<td>$265</td>
</tr>
<tr>
<td>$35,000 - $49,999</td>
<td>$126</td>
<td>$216</td>
<td>$268</td>
<td>$348</td>
</tr>
<tr>
<td>$50,000 - $74,999</td>
<td>$142</td>
<td>$248</td>
<td>$304</td>
<td>$396</td>
</tr>
<tr>
<td>$75,000 and Over</td>
<td>$155</td>
<td>$275</td>
<td>$334</td>
<td>$436</td>
</tr>
</tbody>
</table>

Express Scripts Prescription Plan Per Pay Deductions

<table>
<thead>
<tr>
<th>EMPLOYEE COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>
Tobacco-free Incentive

We are experts in the field of overcoming addiction and role models for our patients and communities. When people visit our rehabilitation facilities, they should gain a sense of encouragement to follow healthy guidelines.

All of our facilities are tobacco-free.

As a way to further encourage a tobacco-free environment, employees who have been tobacco-free for the past 12 months, or are enrolled in a tobacco cessation program, are eligible to receive an incentive towards the cost of their medical premiums. The incentive will apply to employees and spouses, if the spouse is covered on the medical plan.

Incentive

If you participate in a Phoenix House medical plan, you may claim your tobacco-free incentive on our online portal at https://workforcenow.adp.com. You will be required to attest that you are either tobacco-free and have been for the past 12 months, or are enrolled in a cessation program.

If you are also covering your spouse or domestic partner, you are required to attest that they also have been tobacco-free for the past 12 months, or are enrolled in a cessation program.

Those enrolled in a cessation program are required to upload proof of enrollment.

If you do not claim your incentive during the enrollment period, you will not be eligible to claim it until the next open enrollment period. Your attestation for this period is in effect until 12/31/17.

The incentive amounts are as follows:
Employee: $30 per pay period
Employee and Spouse/Partner: $60 per pay period

Using your Flexible Spending Account (FSA) for Cessation Products and Services

Employees who participate in the Phoenix House Healthcare Flexible Spending Account can obtain reimbursement for over-the-counter smoking/tobacco/nicotine cessation aids such as gums/patches/etc. with a doctor’s prescription. In addition, the cost of participation in any smoking cessation program, if recommended by your physician, is eligible for reimbursement under the FSA.
Dental Benefits

Delta Dental Overview

Phoenix House offers you a flexible dental plan through Delta Dental. You may receive care from any licensed dentist – but you'll save money by choosing a dentist within the Delta network. Dental health is an important part of your regular health care and we encourage you to take advantage of the benefits. If you choose not to participate, please make sure you have adequate coverage from other sources.

Eligibility

Dental coverage is available to full-time employees and part-time employees who work 30 hours or more per week on a regularly scheduled basis following 90 days of employment. Dental coverage is also available for dependent children until the end of the year in which the dependent child turns 19 years of age, or 23 if the child is a full-time student.

Dental coverage is available in FL, MA and TX until the end of the calendar year of the dependent's 25th birthday.

Some of the services covered by the dental plan are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental PPO Dentists*</th>
<th>Delta Dental Premier Dentists*</th>
<th>Out of Network Non-Participating Dentists*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$50/$150</td>
<td>$50/$150</td>
<td>$50/$150</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Preventive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Exam &amp; teeth cleaning: Twice per year</td>
<td>100%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>X-rays: Bitewings twice per year; full mouth series every 2 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings: Amalgam, Silicate &amp; Acrylic</td>
<td>80%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Root canal therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral surgery: extractions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Anesthesia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridge Installation</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Dentures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlays, Onlays, Crowns and Posts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia Lifetime Limit</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Waive Deductible for Preventive</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

* For Delta Dental PPO dentists, percentages are based on PPO Allowed Amount, which is the lesser of the dentist’s submitted fee or the PPO Maximum Allowance. For Premier and non-participating dentists, percentages are based on the Premier Allowed amount, which is the lesser of the dentist’s submitted fee or the Premier Maximum Plan Allowance.

Premiums

Employees share in the cost of dental coverage. The amount of the employee's dental premium deduction depends on the type of coverage the employee chooses and who is covered. Employee premium deductions are taken on a pre-tax basis, except in the case of domestic partners.

Delta Dental Plan Premiums Per Pay Period

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Employee + Spouse/Domestic Partner</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$14.45</td>
<td>$40.36</td>
<td>$40.36</td>
</tr>
</tbody>
</table>

A list of in-network providers can be found at [www.deltadentalins.com](http://www.deltadentalins.com) or by calling 1 800 932 0783.
Vision Benefits

Eligibility

Upon employment, vision coverage is available to full-time employees and part-time employees who work 30 hours or more per week on a regularly scheduled basis. Coverage becomes effective upon completion of enrollment.

Vision coverage is available for dependent children until the end of the year in which the child reaches 19 years of age, or 23 if the child is a full-time student.

Vision Overview

Phoenix House offers two different vision plans through VSP, Vision Plan A and Vision Plan C. Under both plans, office visits incur a $5.00 co-pay at the time of service and all vision services must be acquired through providers affiliated with the VSP network.

Please note, you will not receive an ID card from VSP. ID cards are not required to receive vision services.

Vision Plan A

Provides for an eye exam every 12 months and spectacle lenses (and frames) or contact lenses every 24 months.

Vision Plan C

Provides for an eye exam every 12 months and spectacle lenses (and frames) or contact lenses every 12 months. In addition, coverage for tinted or photo chromic spectacle lenses is included.

VSP vision care gives you access to a wide range of in-network professionals, including some of the top optical retailers. You receive discounted costs for routine exams and prescription eyewear such as glasses and contact lenses. A list of in-network physicians/providers and plan information can be obtained at www.vsp.com or by calling 1 800 877 7195.

Vision Services

<table>
<thead>
<tr>
<th>Vision Service</th>
<th>Vision Plan A</th>
<th>Vision Plan C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Co-pay</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>12 months</td>
<td>12 months</td>
</tr>
<tr>
<td>Eyeglass Lenses and Frames or Contact Lenses</td>
<td>24 months</td>
<td>12 months</td>
</tr>
</tbody>
</table>

Premiums

Employees share in the cost of vision coverage. Employee cost depends on the plan the employee chooses and who is covered. Employee premium deductions are taken on a pre-tax basis, except in the case of domestic partners.

Vision Service Plan Premiums Per Pay Period

<table>
<thead>
<tr>
<th>Premium Type</th>
<th>Vision Plan A</th>
<th>Vision Plan C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$3.40</td>
<td>$5.31</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$5.33</td>
<td>$8.33</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$5.44</td>
<td>$8.50</td>
</tr>
<tr>
<td>Family</td>
<td>$8.77</td>
<td>$13.71</td>
</tr>
</tbody>
</table>
Flexible Spending Accounts

About Flexible Spending Accounts
A Flexible Spending Account (FSA) allows you to set aside money on a pre-tax basis, to use for eligible health care and/or dependent care expenses. Your elections are deducted from your paycheck on a bi-weekly basis before Federal, State and Social Security taxes are applied to your earnings. This means that your taxable income is lower and you save a substantial amount of money!

To view a list of eligible expenses and for more information, visit myspendingaccount.adp.com.

Eligibility and Enrollment
The FSA Plan Year for this period runs from January 1 through December 31. According to the IRS’s “use-it-or-lose-it” rule, if you do not use all the money in your FSA for expenses incurred during the plan year, you will forfeit the unused balance. Your unused balance cannot be carried over into the next year.

Do not contribute more than you expect to spend during the year. Our plan offers a 2.5 month grace period, extending your time frame to incur claims to March 15, 2018.

All full-time employees and part-time employees who work 30 hours or more per week on a regularly scheduled basis are eligible to enroll in an FSA upon employment. Phoenix House offers two types of FSAs:

• Health Care Flexible Spending Account
• Dependent Care Flexible Spending Account

Annual Elections
The amount employees may elect to place into a Flexible Spending Account is listed in the chart below:

<table>
<thead>
<tr>
<th>HEALTHCARE FSA</th>
<th>DEPENDENT CARE FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Annual Election</td>
<td>$2,600</td>
</tr>
<tr>
<td>Minimum Annual Election</td>
<td>$130</td>
</tr>
<tr>
<td>$5,000: if single or married filing jointly; or $2,500: if married and filing single</td>
<td></td>
</tr>
</tbody>
</table>

Examples of eligible expenses

- Medical, dental, and vision deductibles
- Orthodontia
- Medical, prescription, dental, and vision co-pays and co-insurance
- Laser eye surgery
- Over-the-counter medications that are prescribed by a doctor
- Child care at day camp, nursery school or a private sitter (caregiver must provide a valid tax ID or Social Security number)
- Expenses for preschool and afterschool child care
- Eldercare for an incapacitated adult who lives with you at least eight hours per day

Deductions towards your elected amount will be taken from your paycheck every bi-weekly pay period.
Depending on your elections, this means that $5 - $192.30 will be taken out per paycheck, per FSA account.

Health Care FSA
A Health Care FSA pays for qualified health care expenses not covered or reimbursed by your health insurance plans. When you enroll in a healthcare FSA, you automatically receive an ADP Health Care Account Visa® Debit Card in the mail. Just like your bank debit card is linked to your checking account, your FSA Card is directly linked to your FSA account. This gives you immediate access to your healthcare FSA funds to pay for eligible purchases.

Dependent Care FSA
A Dependent Care FSA may be used for eligible day-care expenses incurred. Your child and/or dependent care expenses must be for the care of one or more qualified dependent(s). Your qualified dependent(s) for a Dependent Care FSA may include:

• Your child(ren) under age 13.
• Dependents of any age who are mentally or physically incapable of caring for themselves, and whom you claim as a dependent on your federal income tax return.

There is no debit card with the dependent care account. You must fax, email or submit online a reimbursement request along with the receipt for the expense.

You can submit a claim via fax at 1 866 392 4090 or 1 678 762 5900, online at myspendingaccount.adp.com, or mail your forms to: ADP Claims Processing, PO Box 1853, Alpharetta, GA 30023-1853

Please Note: You must use all the money in the account during the plan year; you cannot roll unused amounts over to the following year.
Eligibility

Upon employment, employees are eligible to participate in the ADP Commuter Benefits program. Participation in the program allows you to set aside money on a pre-tax basis to use for certain eligible transportation expenses to and from work. Employees participating in the Commuter Program have the option to obtain a Commuter Check® MasterCard® that works like a debit card and allows participants access to funds scheduled through payroll deductions.

Effective January 1, 2017 the transit and parking pre-tax maximums are:

- Transit Limit: $255 per month
- Parking Limit: $255 per month

Visit myspendingaccount.adp.com for more information.

Enrollment is a 2 Step Process!

Step 1: Select your Payroll Deductions

- Point to the Benefits tab on the home screen, and select “Review/Change Benefits”.
- Select “Walk me through this process”.
- Choose “Commuter Plans” and select ADP Transit and/or ADP Parking and follow the remaining steps to complete Step 1 of your Commuter Benefit enrollment.

Step 2: Select your Commuter Benefit Product

- Go to myspendingaccount.adp.com (first time users must register).
- Under Participant Login, type in your Username and Password and click “Login”.
- Click the “Commuter Benefits” tab where you will see a summary of your balance.
- Click “Continue” to go to the Online Ordering Platform.
- Click “Place an Order” on the menu bar and select your desired option (Transit, Vanpool, Parking).
- Select the commuter product you would like to order.
- Follow the steps to complete your order.

For assistance with the ordering platform, contact the ADP Commuter Benefit Customer Service at 1 800 654 6695.
Life Insurance

Life insurance eases the financial burden placed upon family members in the event of your premature death. Knowing that your family will be taken care of brings peace of mind and contributes to you and your family's overall well-being, which is why Phoenix House provides basic life insurance benefits to eligible employees at no cost.

Basic Life Insurance: Eligibility and Benefits

Life insurance coverage is available to full-time employees and part-time employees who work 30 hours or more per week on a regularly scheduled basis following 90 days of employment. For basic life insurance, evidence of insurability is not required.

Basic life insurance coverage is provided at no cost to the employee. The amount of company-paid basic life insurance an employee receives is equal to the lesser of one times the employee's annual salary rounded to the next higher $1,000, if not already a multiple thereof, or $800,000.

Voluntary Life Insurance: Eligibility, Benefits and Cost

Employees may elect voluntary additional life insurance equal to one, two, three or four times their salary rounded to the next higher $1,000, if not already a multiple thereof. ANY request for life insurance equal to three or four times salary; any request for life insurance above $300,000; or any request to increase the amount of the employee's voluntary life insurance multiple after the initial enrollment eligibility date will require evidence of insurability.

- Guaranteed issue amount (at the time of initial eligibility): The lesser of either two times annual compensation or $300,000.
- Maximum available benefit (with employee’s evidence of insurability approved by Sun Life): The lesser of either four (4) times annual compensation or $500,000.

The cost of the voluntary coverage depends on the employee's age, and the cost is paid by the employee through pre-tax payroll deductions.

Understanding Imputed Income

Federal regulations require you to pay imputed income tax on the value of company-provided basic group term life insurance in excess of $50,000. This means that the value of your basic group term life insurance over $50,000 will be taxed based on the IRS imputed income tax table and included as taxable income on your W-2 form at the end of the year.

Costs of Voluntary Life Insurance

<table>
<thead>
<tr>
<th>AGE</th>
<th>PER PAY COST PER $1,000 OF COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.0277</td>
</tr>
<tr>
<td>25 to 29</td>
<td>$0.0277</td>
</tr>
<tr>
<td>30 to 34</td>
<td>$0.0369</td>
</tr>
<tr>
<td>35 to 39</td>
<td>$0.0462</td>
</tr>
<tr>
<td>40 to 44</td>
<td>$0.0646</td>
</tr>
<tr>
<td>45 to 49</td>
<td>$0.0969</td>
</tr>
<tr>
<td>50 to 54</td>
<td>$0.1662</td>
</tr>
<tr>
<td>55 to 59</td>
<td>$0.2769</td>
</tr>
<tr>
<td>60 to 64</td>
<td>$0.4246</td>
</tr>
<tr>
<td>65 to 69</td>
<td>$0.8169</td>
</tr>
<tr>
<td>70 and older</td>
<td>$1.3246</td>
</tr>
</tbody>
</table>

HOW TO CALCULATE COST OF VOLUNTARY LIFE INSURANCE

EXAMPLE:
A. List your salary $28,680
B. Round up “A” to next highest $1,000 $29,000
C. Amount of additional insurance you want to acquire (1, 2, 3, or 4 times salary) 2
D. Multiply “B” by “C” (i.e., 29,000 times 2) $58,000
E. Divide “D” by $1,000 58

To finish: Multiply “E” by cost shown above that corresponds to your age – i.e., if you are 35 cost is .0462 per pay – thus: 58 x $.0462 equals $2.68 per pay period

The amount of life insurance provided to an employee (both company paid and voluntary) is reduced to 50% of the life insurance benefit at age 70; to 35% at age 75; and to 25% at age 80. The life insurance policy also has a total and permanent disability provision that enables disabled employees who are not eligible for waiver of premium due to age (over age 60) to continue some life insurance coverage.
The plan includes a Life Assist benefit that provides a lump sum payment of half the death benefit to a maximum of $100,000 to a covered individual who is terminally ill, and whose life expectancy is six months or less.

Life insurance amounts over $50,000 (both company paid and voluntary) are taxable as imputed income in accordance with IRS regulations given that basic is provided at no cost and voluntary is paid out of pre-tax dollars.

Remember to Designate a Beneficiary!
Designating a beneficiary is very important. When you enroll in Life Insurance benefits, you must name at least one beneficiary to receive the benefits of your life insurance after death. Employees should complete the Beneficiary Information in the ADP Portal and update annually during Open Enrollment.

If more than one beneficiary is named and you do not designate their order or share of benefits, the beneficiaries will share equally. You may change your beneficiaries and their amounts at any time by updating your designation(s) in the ADP Portal. It is important to keep your designation(s) current.

Beneficiary designation in some states may be governed by local community property law, including California, Virginia, and Texas, and may require that the spouse be selected as the primary beneficiary. If an employee in one of these states would like to designate someone other than the spouse as the primary beneficiary, please consult local community property laws.

Short Term Disability (STD)
Disability benefits offer you financial support when you’re sick, injured and unable to work and earn an income.

Short Term Disability (except RI)
Eligibility
Short term disability coverage is available to full-time employees and part-time employees who work 30 hours or more per week on a regularly scheduled basis following 90 days of employment.

Benefits
The Short Term Disability Plan provides an employee with coverage equal to 60% of basic monthly earnings, minus other Federal/state disability payments, up to a maximum of $350/week.

Details
Short Term Disability is provided at no cost to the employee for off-the-job injuries/illnesses. Employees are eligible to receive short term disability payments after all accrued sick leave has been exhausted or the employee has been off from work due to an illness for seven consecutive days, whichever comes last. Benefits may continue up to a maximum of 6 months.

Short Term Disability in New York
Eligibility
Full-time employees in NY are eligible for NY DBL (Disability Benefits Law) coverage after four consecutive weeks of work. Part-time employees in NY are eligible for DBL coverage after the 25th day of employment.

For additional details about the New York coverage, employees should call the ADP benefits service center at 1 855 809 8200 or email phoenixhousebenefits@adp.com.

Benefits
The waiting period is 7 days with benefits starting on the 8th day. Benefits are 50% of weekly wages to a maximum of $170 per week. If you receive NY DBL and STD at the same time, your maximum total weekly benefit is $350/week. You may be covered for up to 26 weeks.

Short Term Disability in Rhode Island
Eligibility
You are entitled to benefits if you are an insured Rhode Island worker that experiences wage losses resulting from a non-work related illness or injury. To be eligible, an individual must meet certain earnings requirements and be medically certified by a physician as unable to work.

Benefits
The specific number of weeks covered and the amount of coverage is determined by the state.

Details
Short Term Disability Insurance is provided by Rhode Island Temporary Disability Insurance (TDI). The TDI program is state-mandated and funded through employee payroll deductions. The required TDI deductions from the employee’s pay begin immediately upon employment. The specific number of weeks covered and the amount of coverage is determined by the state. If you have questions regarding eligibility for TDI, contact the Rhode Island Department of Labor at 1 401 462 8420.
Long Term Disability (LTD)

Eligibility

Long term disability coverage is available to full-time employees and part-time employees who work 30 hours or more per week on a regularly scheduled basis following 90 days of employment.

Coverage begins after six months of continuous total disability. After six months, you are considered disabled if you are unable to perform the material and substantial duties of your regular occupation and have at least a 20% loss of income. After 24 months, you will still be considered disabled if you are unable to perform the material and substantial duties of your occupation or a gainful occupation that you are reasonably suited for by education, training, or experience whereby you can earn at least 40% of your pre-disability income.

LTD Benefits

Long Term Disability Insurance is provided at no cost to the employee for off-the-job injuries/illnesses. The LTD Insurance provides an employee with coverage equal to 40% of basic monthly earnings, minus other disability income benefits from any source, to a maximum of $4,000 per month. Executive and Vice Presidents receive coverage equal to 60% of basic monthly earnings, minus other disability income benefits from any source, to a maximum of $11,000.

Workers’ Compensation

Upon employment, Phoenix House provides worker’s compensation coverage for wage protection and medical costs for on-the-job injuries and illnesses in accordance with state regulations and worker’s compensation plan provisions. Unless forbidden by state regulations, employees who are disabled and unable to work due to a work related injury are required to apply any accrued sick leave, vacation leave and personal days (in that order) towards their time out. California employees can only use up to 33% of their accrued sick or vacation hours.

Company provided benefits will continue while the employee is on workers’ compensation (subject to the limitations noted in the next paragraph) so long as the employee continues to pay the required monthly employee co-pays on or before the 30th of the month following the month for which workers’ compensation coverage begins.

Please note: During the time that an employee is on workers’ compensation, the company will, from time to time, engage in an interactive communication process with the employee, the employee’s healthcare provider, and the workers’ compensation insurance provider to determine in what ways, if any, that Phoenix House can accommodate/facilitate the employee’s return to work.

If at the end of four (4) months of workers’ compensation coverage it is determined that Phoenix House is unable to accommodate the employee’s return to work and/or the employee does not participate in the interactive communication process and/or the employee fails to provide requested medical information to Phoenix House and/or the workers’ compensation insurance carrier in a timely manner, the employee’s employment with Phoenix House will be terminated, except when such termination runs counter to State regulations.

Upon termination of employment, the employee will be offered the opportunity to continue medical, dental, vision and FSA coverage under COBRA if the employee had said coverage prior to the worker’s compensation leave. Also included in the COBRA package will be information on how to convert Life Insurance and Long Term Disability to individual coverage (if the employee was enrolled in these plans prior to worker’s compensation leave).
Legal Insurance

Benefits Overview
The Legal Insurance Plan offered through Phoenix House provides telephone and office consultations with in-network attorneys for a wide variety of matters including estate planning, real estate, family law, traffic offenses, civil law defense, financial issues, immigration.

Legal areas excluded from coverage are criminal, employment law matters, and matters involving Phoenix House.

Participants have the option of choosing in-network or out-of-network attorneys for service. When using an out-of-network attorney, the covered employee will receive reimbursement from the Hyatt Legal Plan according to an established fee schedule.

Eligibility
Legal insurance coverage is available upon employment to full-time employees and part-time employees who work 30 hours or more per week. Coverage becomes effective upon enrollment.

Employee Deduction
The employee cost for the Legal Plan is $7.62 per pay period (after tax) to cover the employee and all dependents.

To identify specific services covered and identify the in-network attorneys:

- Go to “http://www.legalplans.com”
- Go to the “Employees/Members” section
- Click the link “enter here”
- Under the “Thinking about Enrolling” section enter the access code METLAW
Phoenix House
403(b) Retirement Plan

Benefits
Phoenix House provides employees with the 403(b) Plan as a way to save towards retirement. Employees are eligible to make voluntary pre-tax contributions into the 403(b) Plan from the first day of employment. The maximum amount that an employee may voluntarily contribute to the 403(b) Plan for 2017 is $18,000 ($24,000 if the employee is age 50 or over during the year). Contribution limits are subject to change each year, as determined by the IRS.

All voluntary contributions are pre-tax contributions and thus, are not subject to Federal, state or local taxes. However, voluntary contributions are subject to Social Security taxes. Contributions are subject to taxation only when withdrawn. In addition, employees are eligible to roll over qualified 401(a), 401(k), and 403(b) funds from other employers into the 403(b) Plan at any time after employment with Phoenix House.

Enrolling
To enroll and make voluntary contributions to the 403(b) Plan, or to obtain information on investment options, call Transamerica Retirement Solutions at 1 800 755 5801.

Company Contributions
Eligible employees may receive Phoenix House contributions, the non-elective Safe Harbor and Match, after completion of the 403(b) Plan’s eligibility requirements of one Year of Service with at least 1,000 hours worked during the employee’s initial anniversary year. If the 1,000 hours worked requirement is not met during the initial anniversary year, the hours worked requirement will be determined during subsequent calendar years.

Once the eligibility requirement is met and the employee has entered the Plan, the amount contributed by Phoenix House is determined as follows:

- Phoenix House will make annual non-elective SAFE HARBOR employer contributions equal to 3.5% of each participant’s compensation on behalf of all current and future participants
- Phoenix House will make annual matching contributions of 50% of each participant’s salary deferral contributions of up to 5% of the participant’s eligible compensation. The maximum matching contribution for any given year will therefore be 2.5% of each participant’s compensation.

Vesting Schedule
To be vested means that you have non-forfeitable ownership of your account balance.

- You are always 100% vested in the contributions you make to your account.
- Phoenix House Safe Harbor non-elective employer contributions will be fully (i.e. 100%) vested at all times
- Phoenix House Match employer contributions will be fully vested after you have attained three Years of Service. Service from your date of hire is considered.

The 403(b) Plan offers employees a variety of different investment options for both employee and Phoenix House contributions. Information about the various investment options can be accessed via the Transamerica website at www.trsretire.com.
In accordance with 403(b) Plan provisions, employees can take loans from employee contributions and vested employer contributions. Loans can be made for up to 50% of the vested contribution balance, with $1,000 being the minimum loan and $50,000 being the maximum loan (other loan provisions may apply). If an employee fails to repay the loan in accordance with the terms of the loan, the unpaid balance will be considered a default and will be subject to all applicable taxes and penalties. Hardship withdrawals are available from employee voluntary contributions in accordance with strict IRS guidelines and are subject to all applicable taxes and penalties.

The 403(b) Plan offers benefits to beneficiaries, in case something happens to the employee. In order to ensure that beneficiaries have access to benefits available to them, employees must complete the Beneficiary Information portion of the 403(b) Plan enrollment. Beneficiary information should be updated as needed. Beneficiary designation in some states may be governed by local community property law, including California and Texas, and generally require that the spouse be selected as the primary beneficiary. If an employee in one of these states would like to designate someone other than the spouse as the primary beneficiary, please consult local community property laws and/or call Transamerica Retirement Solutions at 1 800 755 5801 for assistance.

Upon termination of employment, vested balances in the employee’s 403(b) Plan account can be rolled over into other types of pension accounts such as a 403(b), 401(k), or IRA, etc. without any taxes or penalties; alternatively, the employee can withdraw the balance subject to IRS regulations and all applicable taxes and penalties. If the terminated employee does not provide an election, the account may be handled as follows:

- If the former employee’s vested account balance is under $1,000, and absent an election by the employee, the employee will be sent a check by Transamerica for the balance of the account.
- If the former employee’s vested account balance is more than $1,000 but less than $5,000, and absent an election by the employee, the balance will be rolled over to a Transamerica IRA, and they will not remain in the Phoenix House 403(b) Plan.
- If the former employee’s vested account balance is $5,000 or more, the employee can leave the funds in the Phoenix House 403(b) Plan account; can roll the funds over into other types of pension accounts such as a 403(b), 401(k), or IRA, etc. without any taxes or early withdrawal penalties; or can withdraw the funds subject to IRS regulations and all applicable taxes and penalties.
LifeCare® Employee Assistance Program

Upon employment, Phoenix House employees can take advantage of a confidential employee assistance program called LifeCare® at no cost to the employee. LifeCare® provides employees with completely confidential, third-party assistance for a variety of work, home, personal or family issues including parenting and child care, education, senior care, financial and legal problems, emotional support, depression and stress management. To register for LifeCare benefits through the ADP portal, enter your email address, create a password and answer a security question. To reach a LifeCare® specialist, call 800 697 7315 (or TDD/TTY 800 873 1322).

Assist America® Travel Assistance

Upon employment, employees can utilize Assist America® Emergency Travel Assistance, provided at no cost to the employee. The program provides travel assistance if the employee has a medical emergency while traveling abroad or more than 100 miles from home. Assist America® will help the employee arrange for 24-hour multilingual service, medical consultation and evaluation, emergency medical evacuation, emergency Rx services, care for minor children, and more. While there is no charge for Assist America® services, employees may incur costs for the actual services provided by third-party providers identified by Assist America®. To learn more, visit www.assistamerica.com.

Wellness Tools & Resources

There are no shortcuts to getting healthy. Here at Phoenix House, we provide you with the resources you need to reach your goals and make lasting changes. Take advantage of these free apps and member discounts offered with your medical plan.

Myuhc.com is your everyday resource for:

- **Health Discounts Program:** save money on vision care, dental care, long-term care, chiropractic and massage therapy and more. Get discounts on fitness clubs, Jenny Craig®, Nutrisystem®, and others.
- **Health Education Webinars:** get tips on how to keep you and your family healthy with these online seminars.
- **Healthy Mind Healthy Body® Newsletter:** this monthly e-newsletter can be customized with topics that are most relevant to you. Register at www.uhc.com/myhealthnews.
- **myHealthcare Cost Estimator:** use this tool to estimate costs, view prices among providers, and compare network physicians in your area.
- **myClaims Manager:** you can view and manage your claims and even pay your health care providers online for out-of-pocket expenses.

**Health4Me™ Mobile App**

Download the Health4Me app today! You can find providers, view claims, or speak directly with a health care professional. Available from Apple’s iTunes App Store or Google Play for Android.
Veterinary Insurance

Eligibility
You may obtain veterinary/pet insurance through VPI with a discounted rate. The Pet Insurance plan is not subject to eligibility rules so employees can enroll at any time throughout the year and new employees are eligible for coverage immediately upon employment.

Benefits
The VPI policy covers thousands of medical problems and conditions related to accidents or illnesses for dogs, cats, birds, ferrets, rabbits, reptiles and other exotic pets. Employees have the freedom to visit any licensed veterinarian.

Enrolling
Employees can enroll directly with VPI. Once enrolled, VPI will direct bill employees for coverage; payroll deductions are not available for this benefit. There are two ways for employees to learn more about what pet insurance covers and/or to obtain a free quote:

• Call 1 877 PETS VPI (1 877 738 7874). Mention Phoenix House as the employer.
• Visit the VPI Phoenix House website at www.petinsurance.com/affiliates/PhoenixHouse_npr

Tuition Assistance

Eligibility
Full-time employees that have completed at least six months of service are eligible for pre-approved tuition reimbursement beginning the first full semester.

Benefits
Courses through an accredited college or university:
Tuition reimbursement benefits are $2,000 per semester, up to a maximum of $4,000 per calendar year (50% for eligible part-time employees). Tuition reimbursement will only be made on actual amounts the employee paid out-of-pocket for a course.

To receive reimbursement:
• Courses must be taken at an accredited college or university
• The course of study is in a field related to the employee’s current job and/or is for a degree relevant to the needs of conditions including colds or flu, headaches, sore throat, and fever. You pay a portion of the service costs according to your medical plan. To register or learn more, login to myuhc.com.

Plum Benefits
For deals on entertainment, travel, and other exclusive employee discounts, log on to www.plumbenefits.com. (code phf718). Plum Benefits is a great way to purchase reduced-price tickets to theme parks, shows, movie theatres, and resorts.

NurselineSM
Speak with a registered nurse, 24/7 when you need help choosing care, managing a chronic condition, understanding treatment options, and more. Call the Customer Care number on the back of your ID card or visit myuhc.com.

Virtual Visits
Access care when you need it from the comfort of home. A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Doctors can diagnose and treat a variety of non-emergency medical

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Speak with a registered nurse, 24/7 when you need help choosing care, managing a chronic condition, understanding treatment options, and more. Call the Customer Care number on the back of your ID card or visit myuhc.com.
Employee Service Awards

Service Award Program

The Employee Service Award Program provides recognition for the contribution and outstanding service that employees make to Phoenix House. The Service Award Program commemorates every five years of service with a unique Phoenix House lapel or shirt/blouse logo pin that identifies their latest service milestone.

<table>
<thead>
<tr>
<th>NUMBER OF SERVICE YEARS</th>
<th>UNIQUE PHOENIX HOUSE PIN</th>
<th>ADDITIONAL RECOGNITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 years</td>
<td>pin with one ruby</td>
<td>Eligible to choose an award from a selection of gifts designed especially for that anniversary</td>
</tr>
<tr>
<td>10 years</td>
<td>pin with two rubies</td>
<td></td>
</tr>
<tr>
<td>15 years</td>
<td>pin with three rubies</td>
<td></td>
</tr>
<tr>
<td>20 years</td>
<td>pin with one diamond</td>
<td>Eligible to select a gift from a gift catalogue and will also receive an anniversary award/gift chosen by Senior Management. In addition to the gift, each employee receives a certificate recognizing her/his years of service to Phoenix House.</td>
</tr>
<tr>
<td>25 years</td>
<td>pin with two diamonds</td>
<td></td>
</tr>
<tr>
<td>30 years</td>
<td>pin with three diamonds</td>
<td></td>
</tr>
</tbody>
</table>

Business Travel Accident Insurance

Upon employment, Business Travel Accidental Death and Dismemberment insurance is provided at no cost to the employee. The amount of insurance an employee receives is equal to two times the employee’s annual salary, up to a maximum of $500,000.

This coverage provides 24-hour accident insurance when the employee is traveling on authorized Phoenix House business. It does not cover travel to and from work; any unauthorized travel, or any travel that is personal in nature.
Continuation of Coverage (COBRA)

Eligibility

Employees enrolled in the medical, pharmacy, dental, vision and/or FSA plans provided by Phoenix House are eligible for COBRA continuation coverage. If you experience an event that normally results in loss of the previously mentioned coverage, you may be eligible to continue receiving benefits for up to 18 months if you meet one of the following conditions:

- The death of the employee who was the primary account holder
- Termination of employment (other than by reason of the employee’s gross misconduct) or reduction in hours
- The divorce or legal separation of the employee
- A dependent child ceases to be a dependent under the terms of the plan
- Newborn and newly adopted children of a COBRA beneficiary become eligible for continuation coverage at the time of their birth or adoption

If you meet the eligibility requirements, you will be sent a notice for COBRA options within 60 days of your loss of coverage.

Also included in the COBRA package will be information on how to convert Life Insurance and Long Term Disability to individual coverage (if the employee was enrolled in these plans prior to termination).

Continuation Coverage Cost

If you choose to continue coverage under COBRA, you are responsible to pay the full cost of coverage and an administrative fee. You must make your first payment for coverage no later than forty-five (45) days after the date of your election. If you do not make your first payment for continuation coverage in full, no later than forty-five (45) days after the date of your election, you will lose all continuation coverage rights under the plan. After you make your first payment, monthly payments are due each month that continuation coverage is available and requested.

Change of Status under active COBRA Coverage

If you are already receiving benefits from COBRA and you experience a life-status change, you must notify the employer in writing within sixty (60) days of the event. Coverage will be affected and determined by your new status, with deductions adjusted accordingly.

Qualifying Life-Event Changes Include:

- Death of employee
- Divorce of employee
- Legal separation of employee
- Child’s loss of “dependent” status

COBRA and Domestic Partnerships

A change in domestic partner status is not a COBRA qualified event and thus, domestic partners are not eligible for COBRA continuation coverage. However, the addition or termination of a domestic partner relationship will be considered a qualifying event for the purpose of employee benefit changes.

Covered Dependents

Covered dependents may also be eligible for this coverage if the employee loses eligibility status under the group plan, the employee becomes deceased, or if the dependent is no longer an eligible dependent. It is the employee’s responsibility to notify the Phoenix House Benefits Department when there is a change in dependent eligibility for any Phoenix House benefit plan.
Important Laws and Notices

Newborn & Mothers’ Health Protection Act
Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician’s assistant) after consultation with the mother, discharges the mother or newborn earlier.

Plans and issuers may not select the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

Women’s Health & Cancer Rights Act
On October 21, 1988, the Women’s Health and Cancer Rights Act became effective. This law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies.

As the Act requires, we have included this notification to inform you about the law’s provisions. The law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and co-insurance provisions that apply for the mastectomy.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)
HIPAA requires that you be informed of your Special Enrollment rights when you and/or your eligible dependents decline health care coverage during the initial enrollment period.

If you are declining coverage for yourself or your dependents (including your spouse) and you are not currently covered under a medical plan, you will be considered a late applicant.

HIPAA allows a late applicant to enter a medical plan only during an open enrollment period.

The Plan will use Protected Health Information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended. The plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Plan Sponsor hereby certifies that in accordance with HIPAA, access to PHI information may be given only to the Plan Sponsor and staff of the Plan Sponsor who receive protected health information related to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business in carrying out Plan administration functions that the Plan Sponsor performs for the Plan. If the Plan Sponsor and said staff do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. With an authorization, the Plan will disclose PHI for the purposes granted, and to the parties specified in the authorization.

Mental Health Parity of 2010
Taking an active, involved approach to caring for your mental and emotional health can help you lead a healthier, more balanced life. Effective January 1, 2010, the Paul Wellstone and Pete Domenici Health Parity and Addiction Equity Act removed any visit limits for the following:

- Mental Health Outpatient
- Mental Health Inpatient
- Alcohol and Substance Abuse Outpatient
- Alcohol and Substance Abuse Inpatient stays for detoxification and rehabilitation
Premium Assistance Under Medicaid & 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, 2016. You should contact your State for further information on eligibility.

ALABAMA – MEDICAID
Website: myalhipp.com/
Phone: 855 692 5447

ALASKA – MEDICAID
The AK Health Insurance Premium Payment
Website: http://myakhipp.com/
Email: CustomerService@MyAKHIPP.com
Phone: 1 866 251 4861

Medicaid Eligibility
Website: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

COLORADO – MEDICAID
Medicaid Website: www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1 800 221-3943

FLORIDA – MEDICAID
Website: http://fmedicaidtplrecovery.com/hipp
Phone: 877 357 3268

GEORGIA – MEDICAID
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404 656 4507

INDIANA – MEDICAID
Healthy Indiana Plan for low-income adults 19-64
Website: www.hip.in.gov
Phone: 877 438 4479

All other Medicaid:
Website: www.indianamedicaid.com
Phone: 1 800 403 0864

IOWA – MEDICAID
Website: dhs.state.ia.us/hipp/
Phone: 888 346 9562

KANSAS – MEDICAID
Website: kdheks.gov/hcf/
Phone: 785 296 3512

KENTUCKY – MEDICAID
Website: chfs.ky.gov/dms/default.htm
Phone: 800 635 2570

LOUISIANA – MEDICAID
Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888 695 2447

MAINE – MEDICAID
Website: www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800 442 6003 TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP
Website: www.mass.gov/MassHealth
Phone: 800 462 1120

MINNESOTA – MEDICAID
Website: http://mn.gov/dhs/ma/
Phone: 800 657 3739

MISSOURI – MEDICAID
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573 751 2005

MONTANA – MEDICAID
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800 694 3084
NEBRASKA – MEDICAID
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 855 632 7633

NEVADA – MEDICAID
Medicaid Website: dwss.nv.gov/
Medicaid Phone: 800 992 0900

NEW HAMPSHIRE – MEDICAID
Website: dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603 271 5218

NEW JERSEY – MEDICAID AND CHIP
Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609 631 2392
CHIP Website: njfamilycare.org/index.html
CHIP Phone: 800 701 0710

NEW YORK – MEDICAID
Website: nyhealth.gov/health_care/medicaid/
Phone: 800 541 2831

NORTH CAROLINA – MEDICAID
Website: ncdhhs.gov/dma
Phone: 919 855 4100

NORTH DAKOTA – MEDICAID
Website: nd.gov/dhs/services/medicalserv/medicaid/
Phone: 800 755 2604

OKLAHOMA – MEDICAID AND CHIP
Website: insureoklahoma.org
Phone: 888 365 3742

OREGON – MEDICAID AND CHIP
Website: oregonhealthykids.gov
hijossaludablesoregon.gov
Phone: 800 699 9075

PENNSYLVANIA – MEDICAID
Website: dhs.state.pa.us/hipp
Phone: 800 692 7462

RHODE ISLAND – MEDICAID
Website: eohhs.ri.gov
Phone: 401 462 5300

SOUTH CAROLINA – MEDICAID
Website: scdhhs.gov
Phone: 888 549 0820

SOUTH DAKOTA – MEDICAID
Website: dss.sd.gov
Phone: 888 828 0059

TEXAS – MEDICAID
Website: gethipptexas.com
Phone: 800 440 0493

UTAH – MEDICAID AND CHIP
Medicaid: health.utah.gov/medicaid
CHIP: health.utah.gov/chip
Phone: 877 543 7669

VERMONT – MEDICAID
Website: greenmountaincare.org/
Phone: 800 250 8427

VIRGINIA – MEDICAID AND CHIP
Website: coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800 432 5924
CHIP Phone: 855 242 8282

WASHINGTON – MEDICAID
Website: hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 800 562 3022 ext. 15473

WEST VIRGINIA – MEDICAID
Website: dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 877 598 5820, HMS Third Party Liability

WISCONSIN – MEDICAID
Website: dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800 362 3002

WYOMING – MEDICAID
Website: wyequalitycare.acs-inc.com
Phone: 307 777 7531

To see if any more States have added a premium assistance program since July 31, 2016 or for more information on special enrollment rights, you can contact either:

U.S. DEPARTMENT OF LABOR
Employee Benefits Security Administration
Website: dol.gov/ebsa
Phone: 866 444 EBSA (3272)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Website: cms.hhs.gov
Phone: 877 267 2323, Menu Option 4, Ext. 61565
# Contact Information

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADP Benefits Service Center</td>
<td>Number: 1 855 809 8200</td>
</tr>
<tr>
<td>Enrolling in Benefits</td>
<td>Email: <a href="mailto:phoenixhousebenefits@adp.com">phoenixhousebenefits@adp.com</a></td>
</tr>
<tr>
<td>Medical: UnitedHealthcare</td>
<td>Website: workforcenow.adp.com</td>
</tr>
<tr>
<td></td>
<td>Number: Varies by State – please refer to medical ID card.</td>
</tr>
<tr>
<td>Prescriptions: Express Scripts</td>
<td>Website: <a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
</tr>
<tr>
<td>Dental: Delta Dental</td>
<td>Number: 1 866 727 5867</td>
</tr>
<tr>
<td>Vision: VSP</td>
<td>Website: <a href="http://www.deltadentalins.com">www.deltadentalins.com</a></td>
</tr>
<tr>
<td></td>
<td>Number: 1 800 932 0783</td>
</tr>
<tr>
<td>Flexible Spending Accounts, Commuter Benefits: ADP</td>
<td>Website: myspendingaccount.adp.com</td>
</tr>
<tr>
<td>Retirement: Transamerica Retirement Solutions</td>
<td>Number: 1 800 755 5801</td>
</tr>
<tr>
<td>VPI Pet Insurance</td>
<td></td>
</tr>
<tr>
<td>LifeCare® Employee Assistance Program</td>
<td>Website: <a href="http://www.petinsurance.com/affiliates/PhoenixHouse_npr">www.petinsurance.com/affiliates/PhoenixHouse_npr</a></td>
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<td></td>
<td>Number: 1 877 PETS VPI (1 877 738 7874)</td>
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<td>Sun Life (Life and Disability Insurance)</td>
<td>Website: workforcenow.adp.com</td>
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<td>Number: 1 800 697 7315</td>
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<td>1 800 873 1322 (TDD/TTY)</td>
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<tr>
<td>Assist America® Emergency Travel Assistance</td>
<td>Website: <a href="http://www.assistamerica.com">www.assistamerica.com</a></td>
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<td>Number: 1 800 872 1414 (within the U.S.)</td>
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<tr>
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<td>1 609 986 1234 (outside the U.S.)</td>
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<tr>
<td>Hyatt Legal Plans</td>
<td>Website: <a href="http://www.legalplans.com">www.legalplans.com</a></td>
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<td>Sentry (Workers Compensation)</td>
<td>Number: 1 800 821 6400</td>
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<tr>
<td>Continuation of Coverage (COBRA)</td>
<td>Number: 1 800 526 2720</td>
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