2027

EMPLOYEE BENEFITS GUIDE













SCAN THE QR CODE TO VISIT BENEPORTAL!

Occupational Training Center of Burlington County Strives to offer you and your dependents a competitive and comprehensive benefits package. We encourage you to take the time to review this guide and educate yourself about the benefit options available to you.

OTC SERVICES

ENROLLING IN BENEFITS
What You Need to Know

Welcome to Occupational Training Center! ***Our employees are our most valuable resource. Our goal is to offer a competitive benefit package that allows you to take charge of how you would like to handle your healthcare.***

The benefits you elect during the new hire enrollment period will be effective until December 31, 2027. Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status.

WHAT DO YOU NEED TO DO NOW?

Review all of the enrollment materials and discuss with your family members, if applicable. Be sure to educate yourself about the plan options and choose the best coverage for you and your family.

If you have questions about the benefits available to you or the enrollment process, please contact Human Resources at **HREmail@otcbc.org** or call **609.267.6677**. In addition, the Conner Strong & Buckelew Member Advocacy Team is also available to answer your questions; contact information can be found towards the end of this guide.

HOW DO I ENROLL IN BENEFITS?

If you would like to enroll in medical, dental, or vision benefits, you must submit an enrollment form to Human Resources before the end of your new hire enrollment period.

QUALIFIED STATUS CHANGE

Benefit elections cannot be changed during the plan year unless you or your dependents experiences a qualified change in status. Qualified changes in status include:

- Marriage
- Divorce
- Legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Commencement or termination of adoption proceedings
- Change in spouse's/partner's or dependent child's benefits or employment status

PLEASE NOTE: This is not an exhaustive list of all events that would allow an employee to change elections during the year. If you have questions regarding whether an event would allow you to change your benefit elections mid-year, please contact HR.



DON'T FORGET!

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status.

MEDICAL & PRESCRIPTION DRUG PLAN COMPARISON

Horizon Blue Cross Blue Shield of NJ

Below is a comparison of the three medical plan options available through Horizon Blue Cross Blue Shield of New Jersey. If you would like to enroll in one of the below plans or make changes to your existing coverage, please contact Human Resources for the appropriate forms.

	NEW! OMNIA 13		NEW! OMNIA 4		EPO 4
BENEFIT DESCRIPTION	**TIER 1**	**TIER 2**	**TIER 1**	**TIER 2**	**IN-NETWORK ONLY**
Deductible Individual/Family	$500 / $1,000	$1,250 / $2,500	$500 / $1,000	$2,500 / $5,000	$2,500 / $5,000
Out-of-Pocket Maximum Individual/Family	$3,000 / $6,000	$4,000 / $8,000	$2,500 / $5,000	$4,500 / $9,000	$5,000 / $10,000
Coinsurance (Plan Pays)	90%	80%	90%	60%	50%
Preventive Care Services	100%		100%		100%
PCP Office Visit	$10 copay	$20 copay	$15 copay	$30 copay	$30 copay
Specialist Office Visit	$20 copay	$30 copay	$25 copay	$50 copay	$50 copay
Telemedicine	$5 copay		$5 copay		$15 copay
Diagnostic Laboratory Office Outpatient Facility	100% 90% after deductible	100% 80% after deductible	100% 100%	100% 60% after deductible	100% 50% after deductible
Outpatient X-Ray/Radiology Office Outpatient Facility	100% 90% after deductible	100% 80% after deductible	100% 100%	100% 60% after deductible	100% 50% after deductible
Advanced Imaging (MRI/CT/PET)	90% after deductible	80% after deductible	90% after deductible	60% after deductible	50% after deductible
Emergency Room	$100 copay, then 90% after deductible		$100 copay, then 90% after deductible		$100 copay, then 50%
Inpatient Hospital	90% after deductible	80% after deductible	90% after deductible	60% after deductible	50% after deductible
Outpatient Surgery	90% after deductible	80% after deductible	90% after deductible	60% after deductible	50% after deductible
Mental Health/Substance Abuse - Office	$20 copay	$30 copay	$25 copay	$50 copay	$50 copay
Short-Term Therapies - Office 30 visits per therapy per year	$10 copay	$20 copay	$15 copay	$30 copay	50% after deductible
Durable Medical Equipment	90% after deductible	80% after deductible	90% after deductible	60% after deductible	50% after deductible
Home Health Care	$10 copay	$20 copay	$15 copay	$30 copay	50% after deductible
Skilled Nursing Facility	90% after deductible	80% after deductible	90% after deductible	60% after deductible	50% after deductible
Routine Vision Exam	Adult: Not Covered Pediatric: 1 per year		Adult: Not Covered Pediatric: 1 per year		$50 copay; 1 per year
Vision Hardware	Adult: Not Covered Pediatric: up to $150		Adult: Not Covered Pediatric: up to $150		$100 every 2 years

PLEASE NOTE: Limitations and pre-authorizations may apply for certain benefits; please contact Human Resources for a detailed benefit description or a Summary of Benefit Coverage.

FIND A PROVIDER

Horizon OMNIA Plan

Horizon Omnia Plan is a tiered-network health insurance plan designed to lower monthly premiums and out-of-pocket costs by incentivizing members to use specific high-value healthcare providers.

- **No PCP or Referrals Required:** You do not need to select a Primary Care Physician (PCP) or get a referral to see a specialist.
- **In-Network Only:** There are no out-of-network benefits except for true medical emergencies.
- **Preventive Care:** Routine and preventive services are covered at 100% in-network with no cost-sharing.

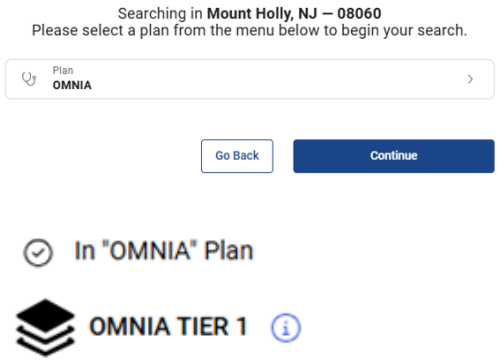
The OMNIA plan uses many of the same providers as the EPO plan, broken out by Tiers; Tier 1 and Tier 2.

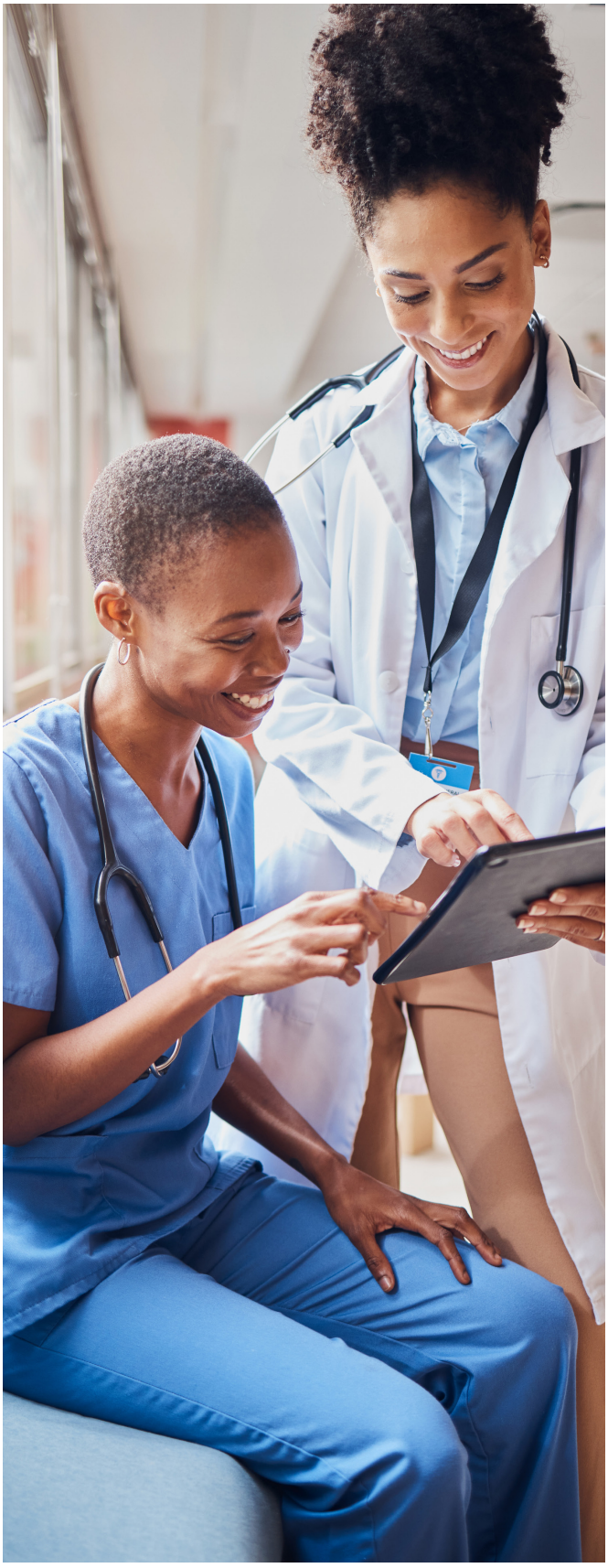
For providers outside of New Jersey, members use the BlueCard benefit, like they do today with the EPO plan. All claims processed under BlueCard will automatically pay at the Tier 2 level with OMNIA.

Members can choose providers from either the Tier 1 or Tier 2 network:

- **OMNIA Tier 1:** Features the lowest out-of-pocket costs (lower copays, coinsurance, and deductibles). Tier 1 providers meet specific quality and cost-efficiency standards.
- **OMNIA Tier 2:** Provides in-network coverage, but with higher cost-sharing responsibilities (higher deductibles and copays) compared to Tier 1

On the Horizon website, members search for participating providers under the **"OMNIA"** plan. The results will show **"Omnia Tier 1"** or **"Omnia Tier 2"** on the right-hand side.





PRESCRIPTION DRUG PLAN OPTIONS

Horizon Blue Cross Blue Shield of NJ

Below are the prescription drug copayments for the OMNIA 13 (NEW) , OMNIA 4 (NEW), and EPO 4 plans.

	OMNIA 13 (NEW), OMNIA 4 (NEW), EPO 4
RETAIL PRESCRIPTIONS (UP TO A 30-DAY SUPPLY)	
Generic	$10
Preferred Brand	$40
Non-Preferred Brand	$75
MAIL ORDER PRESCRIPTION (UP TO A 90-DAY SUPPLY)	
Generic	$25
Preferred Brand	$100
Non-Preferred Brand	$200

PRESCRIPTION PLAN FEATURES

The following features are included with your prescription benefits:

- **DAW1 Program (Dispense as Written):** If the prescriber requests a brand drug when a generic is available, prior authorization will be required and the non-preferred copay is charged.
- **DAW2 Program:** If the member requests a brand drug when a generic equivalent is available, the generic copay PLUS the cost difference between the brand and generic will be assessed.



SAVE ON YOUR PRESCRIPTIONS WITH MAIL ORDER

Using the mail order program for your maintenance medications will save you money. You will receive **up to a 90-day (3-month) supply for 2.5x the retail copay**. In addition to the savings, your prescriptions will be delivered right to your home.

To begin using mail order, simply complete a mail order form at **www.myprime.com** and send along with your prescription(s) written for a 90-day supply of medication.

How Much Can You Save When You Use Mail Order? *Compare for yourself...*

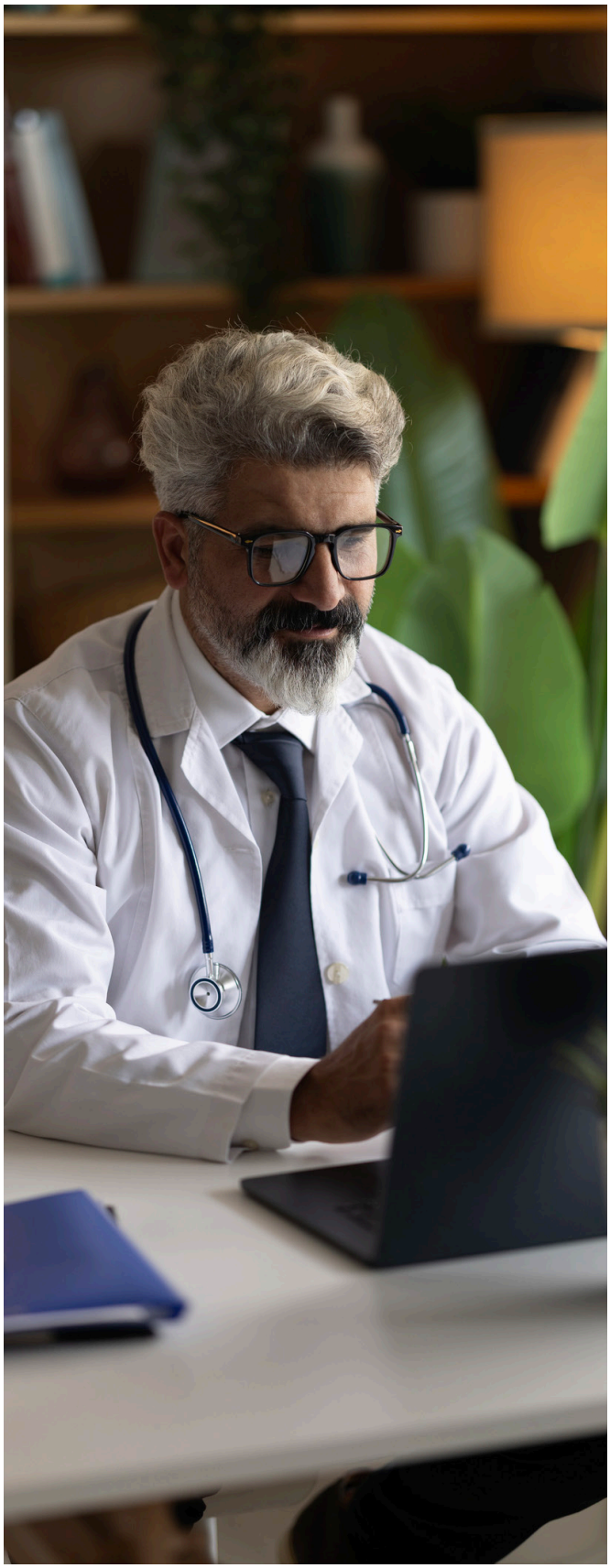
RETAIL PHARMACY	MAIL ORDER	ANNUAL SAVINGS
Preferred Brand-Name Copay **$40**	**Preferred Brand-Name Copay** **$100**	**$80**
Annual Cost *($40 per month x 12 fills)* **$480**	**Annual Cost** *($100 per order x 4 fills per year)* **$400**	

TELEMEDICINE

Horizon CareOnline℠

Need to see a doctor now? Get connected with virtual care 24/7 at only a $15 copay with the EPO 4 and only a $5 copay with the OMNIA plans!

When you need to see a doctor or nurse - anytime day or night - simply sign in to **www.HorizonBlue.com** or the Horizon Blue app. Get 24/7 access to U.S. board-certified doctors and registered nurses via video, phone, or chat from the comfort of your own home.



CONVENIENT VIRTUAL CARE OPTIONS

- **See a Doctor:** Visit with a U.S. board-certified, licensed doctor without an appointment on a computer or mobile device through our telemedicine service, Horizon CareOnline. This option is useful for treating common health problems like fever, colds and flu, sinusitis, skin irritations and rashes, abdominal pain, and more.
- **See a Behavioral Health Specialist:** You can also schedule an appointment with licensed psychiatrists, psychologists, and social workers, from 7:00 am to 11:00 pm, for conditions such as anxiety, attention deficit/hyperactivity disorder (ADHD), bipolar disorder, and depression.
- **Talk to a Nurse:** Get advice and answers to health questions at no cost 24/7, from a register nurse through the Nurse Chat feature.

WHO ARE THE HEALTH CARE PROFESSIONALS?

Urgent medical care services for Horizon CareOnline are provided by U.S. board-certified, licensed doctors who average 15 years of experience in primary/urgent care.

Nurse Chat is staffed by registered nurses who have an average of 15 years of clinical experience and provide physician approved information to guide health care decisions.

REGISTER NOW!

Visit www.HorizonBlue.com or download the Horizon Blue app from the App Store or Google Play.

DENTAL PLAN OPTIONS

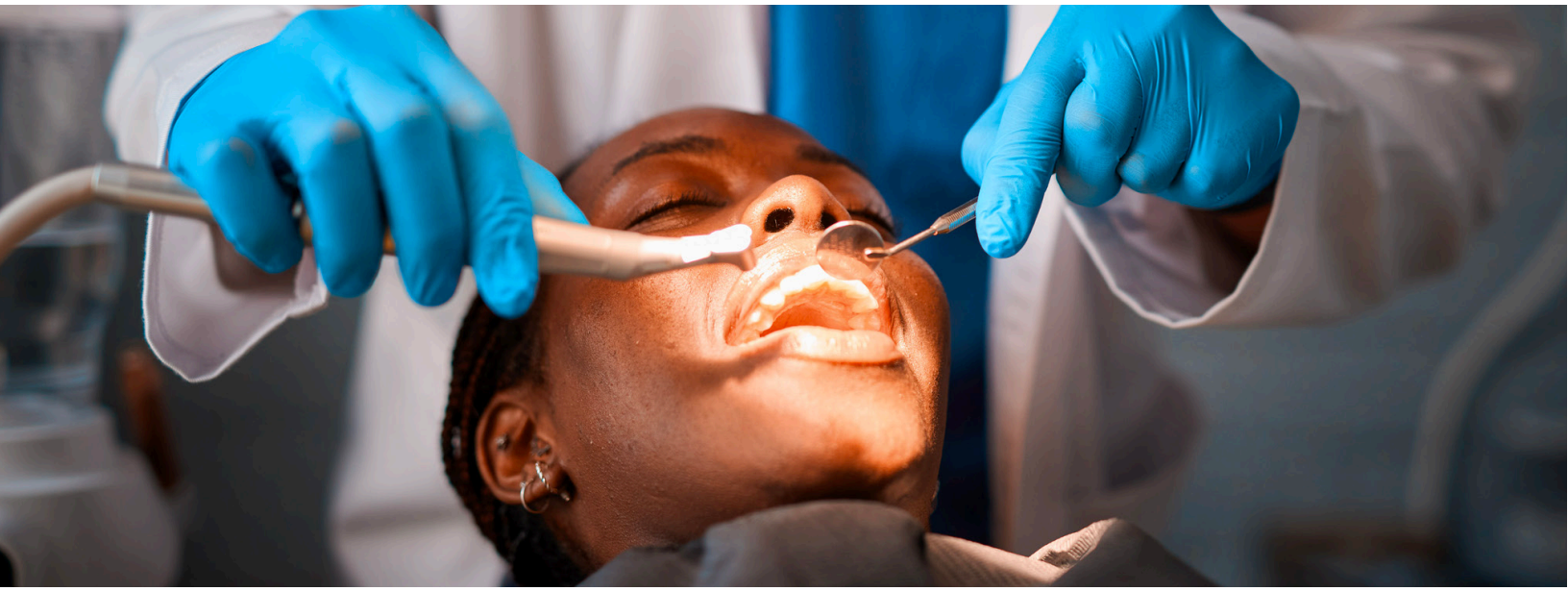
Horizon Blue Cross Blue Shield of NJ

We offer two dental plan options through Horizon Blue Cross Blue Shield of New Jersey, with varying levels of benefits, to help you take good care of your smile. Please contact Human Resources for a complete summary of benefits.

Orthodontic benefits are limited to children under the age of 19 and are not covered under the Dental PPO Access Plan.

	DENTAL PPO ACCESS PLAN*		DENTAL CHOICE DMO PLAN
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Calendar Year Deductible Individual/Family	N/A	N/A	N/A
Calendar Year Maximum (per patient)	N/A	N/A	N/A
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year) Fluoride Treatment (once in a calendar year, children to age 19)	Plan pays 100%*	Plan pays 100%*	Plan pays 100%
Basic Services Fillings, Simple Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	Discounted fee arrangement - see plan summary for detailed information	N/A	Plan pays 100%
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	Discounted fee arrangement - see plan summary for detailed information	N/A	Plan pays 50%
Orthodontia Benefits	Discounted fee arrangement - see plan summary for detailed information	N/A	Plan pays 50%
Orthodontia Lifetime Maximum (per patient)	Discounted fee arrangement - see plan summary for detailed information	N/A	N/A

* When you receive treatment from dentists in the Horizon Dental PPO network, your costs are reduced significantly. When you receive treatment from dentists who do not participate in the network, you may have to pay the provider their usual fees in advance, then file a claim for reimbursement. Horizon BCBSNJ payments are based on the carrier PPO allowance; you are responsible for any charges in excess of these amounts. **There is no out-of-network benefit for major or specialty services.**



EMPLOYEE CONTRIBUTIONS - OTC BURLINGTON

What Will Benefits Cost Me?

Below are the contributions for OTC Burlington effective January 1, 2027.

MEDICAL & PRESCRIPTION DRUG COVERAGE - **OTC BURLINGTON**

TIER	OMNIA 13	OMNIA 4	EPO 4
	Employee Per Pay Contribution	*Employee Per Pay Contribution*	*Employee Per Pay Contribution*
Employee Only	$53.76	$53.14	$46.42
Employee + Child(ren)	$355.50	$321.88	$267.48
2 Adults	$539.05	$487.20	$406.48
Employee + Family	$898.07	$808.34	$672.88

DENTAL COVERAGE - **OTC BURLINGTON**

TIER	DENTAL DMO	DENTAL PPO ACCESS PLAN
	Employee Per Pay Contribution	*Employee Per Pay Contribution*
Employee Only	$0.00	$1.25
Employee + Child(ren)	$6.89	$9.45
2 Adults	$5.93	$6.56
Employee + Family	$12.76	$14.72



EMPLOYEE CONTRIBUTIONS - CNA ABILITY ONE

What Will Benefits Cost Me?

Below are the contributions for CNA Ability One effective January 1, 2027.

MEDICAL & PRESCRIPTION DRUG COVERAGE - **CNA ABILITY ONE**

TIER	OMNIA 13	OMNIA 4	EPO 4
	Employee Per Pay Contribution	*Employee Per Pay Contribution*	*Employee Per Pay Contribution*
Employee Only	$567.09	$512.29	$427.32
Employee + Child(ren)	$892.09	$801.83	$665.62
2 Adults	$1,075.63	$967.16	$804.63
Employee + Family	$1,434.66	$1,288.30	$1,071.03

DENTAL COVERAGE - **CNA ABILITY ONE**

TIER	DENTAL DMO	DENTAL PPO ACCESS PLAN
	Employee Per Pay Contribution	*Employee Per Pay Contribution*
Employee Only	$4.96	$5.69
Employee + Child(ren)	$11.57	$13.89
2 Adults	$10.60	$11.00
Employee + Family	$17.43	$19.17



EMPLOYEE CONTRIBUTIONS - RECYCLING

What Will Benefits Cost Me?

Below are the contributions for Recycling effective January 1, 2027.

If an employee elects not to participate in the health plans offered by the Occupational Training Center of Burlington County (OTC), actual proof of coverage is required and must be forwarded to the attention of Human Resources immediately.

MEDICAL & PRESCRIPTION DRUG COVERAGE - **RECYCLING**

TIER	OMNIA 13	OMNIA 4	EPO 4
	Employee Per Pay Contribution	*Employee Per Pay Contribution*	*Employee Per Pay Contribution*
Employee Only	$81.99	$53.14	$46.42
Employee + Child(ren)	$406.98	$321.88	$267.48
2 Adults	$590.53	$487.20	$406.48
Employee + Family	$949.55	$808.34	$672.88

DENTAL COVERAGE - **RECYCLING**

TIER	DENTAL DMO	DENTAL PPO ACCESS PLAN
	Employee Per Pay Contribution	*Employee Per Pay Contribution*
Employee Only	$0.00	$1.25
Employee + Child(ren)	$6.89	$9.45
2 Adults	$5.93	$6.56
Employee + Family	$12.76	$14.72



VOLUNTARY VISION PLAN

VSP

The voluntary VSP vision plan is 100% employee-paid and can help save you money on eye exams, eyeglasses, and contact lenses. Please contact Human Resources for a complete benefit summary.

To search for a local vision provider, visit www.vsp.com.

VSP VISION PLAN

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Exams	$10 copay then covered in full	Reimbursed up to $45
Frames	$25 copay then covered in full up to $150 retail allowance	Reimbursed up to $70
Lenses		
Single Vision Lenses	Covered in full after $25 copay for standard glass or plastic	Reimbursed up to $30
Bifocal Lenses		Reimbursed up to $50
Trifocal Lenses		Reimbursed up to $65
Lenticular Lenses		Reimbursed up to $100
Contact Lenses (in lieu of eyeglasses)	Up to $130 retail allowance	Elective: Reimbursed up to $105 Necessary: Reimbursed up to $210
Frequency		
Vision Exam	12 months	12 months
Lenses	12 months	12 months
Frames	24 months	24 months

EXTRA SAVINGS

Glasses and Sunglasses

- Extra $20 to spend on featured frame brands. Visit **www.vsp.com/offers** for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

VISION PLAN CONTRIBUTIONS

TIER	VSP VOLUNTARY VISION PLAN *BI-WEEKLY EMPLOYEE COST*
Employee Only	$3.31
2 Adults	$5.29
Employee + Child(ren)	$5.41
Employee + Family	$8.71



FLEXIBLE SPENDING ACCOUNTS

Flex Facts

OTC provides you with the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through the Flexible Spending Accounts (FSA). The FSA plan year runs from January 1st through December 31st of each year.

You must make a new election each plan year, and elections cannot be changed during the year unless you experience a qualified change in status. If you are interested in enrolling in any of the accounts listed, please contact Human Resources.

HEALTHCARE FSA

The Health Care FSA allows you to set aside pre-tax dollars to use for eligible expenses such as office visits and prescription drug copays. You may contribute a maximum of **$3,500** per year.

Eligible expenses include:

- Doctor office copay
- Non-comestic dental procedure (crowns, dentures, orthodontics)
- Prescription contact lenses, glasses, and sunglasses
- LASIK eye surgery

DEPENDENT CARE FSA

The Dependent Care FSA is a great way to pay for dependent care expenses for qualifying dependents with pre-tax dollars. You may set aside a maximum of **$7,500** per year per household, or **$3,750** per year if you are married and filing separately.

Eligible expenses include:

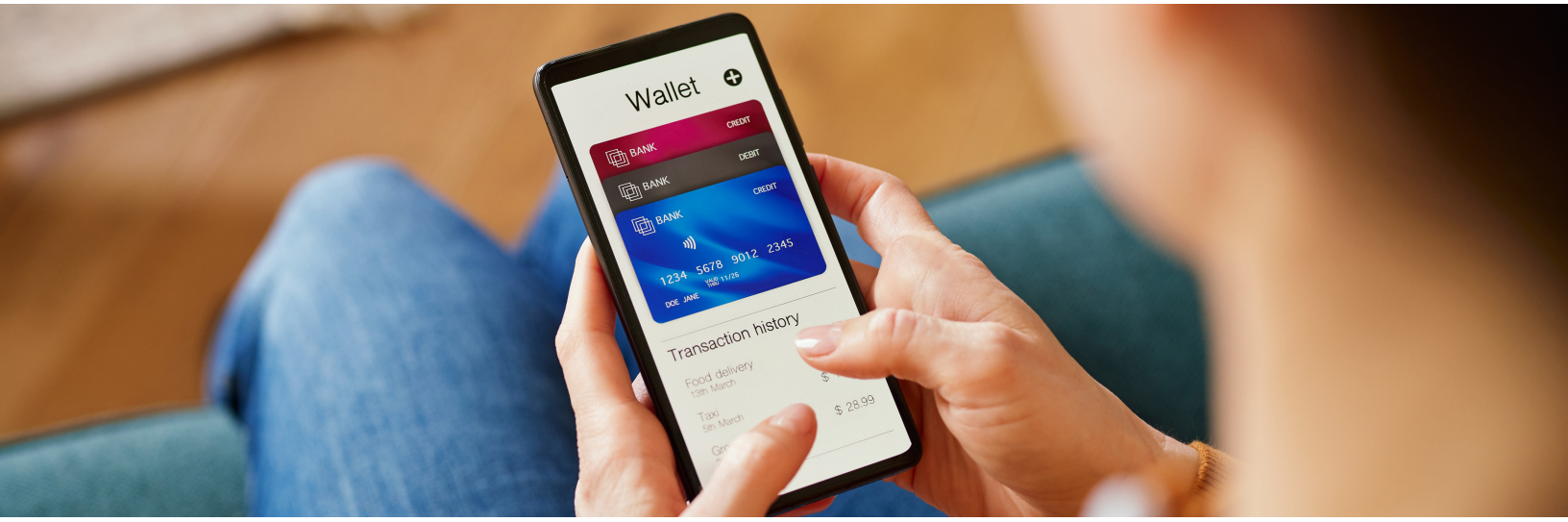
- Au pair
- After school programs
- Baby-sitting/dependent care to allow yuou to work or actively seek employment
- Day camps and preschool
- Adult/eldercare for adult dependents

HOW MUCH SHOULD I CONTRIBUTE?

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period. The maximum you can carry over into the 2028 plan year is $700 for the Healthcare FSA.

GRACE PERIOD

You have 2.5 months after the end of the plan year to incur claims for the Dependent Care FSA. The deadline for the 2027 plan year is March 15, 2028.



COMMUTER BENEFITS

WEX

Commuter benefits allow you to put money from your paycheck aside each month, before taxes are taken out, for qualified mass transit and parking expenses.

CONTRIBUTION LIMITS

The IRS sets the maximum dollar amount you can set aside each month as part of your commuter benefit. The monthly pre-tax contribution limit is:

- **Transit: $350**
- **Parking: $350**

Any money contribute to your transit or parking benefit rolls over every month until it is used or you are no longer eligible.

WHAT DOES IT COVER?

Commuter funds can be used on a variety of transportation and parking expenses that allow you to travel to and from work. Eligible modes of transportation include but are not limited to:

- Train
- Bus
- Ferry
- Vanpool (must seat at least 6 adults)
- Parking or parking near yoru place of employment

View an interactive eligible expenses list at: **wexinc.com/resources/benefits-toolkit/eligible-expenses/**

IRS REGULATIONS

- **Availability of Funds:** Your funds become available as you contribute to the plan, generally within 2-3 days after your payroll contribution.
- **Contribution Changes:** You can adjust the amount you contribute to the plan each month at any time. No qualifying event is needed.
- **Rollovers and Use-or-Lose:** The commuter plan is flexible and your funds will continue to roll over month to month until the funds are used. However, your funds will no longer be available if you terminate employment.



Let's find your best commute. Scan the QR Code for more information!

VOLUNTARY LONG-TERM DISABILITY

Reliance Standard

Long-Term Disability can provide benefits for a disability resulting from a covered injury or sickness. OTC supports payroll contributions for an employee-paid, 100% voluntary, long-term disability benefit which is administered by Reliance Standard.

BENEFITS INCLUDE:

- Monthly Benefit Amount: 60% of covered earnings, up to a maximum benefit of $2,500 per month
- Elimination Period/When Benefit Begins: 180 consecutive days of total disability
- Benefits cover you for two years if you are unable to perform the material duties of your own occupation. If you are unable to perform any occupation, the maximum benefit duration will not extend beyond the longer of Social Security Normal Retirement Age or Duration of Benefits, which is outlined below.

HOW TO CALCULATE PAYROLL DEDUCTIONS

- Enter your annual earnings: _____
- Divide your annual earnings by 12 (monthly earnings). Average monthly income cannot exceed $4,167 _____
- Find your rate from the age table displayed _____
- Multiply the amount on Line 2 by the appropriate rate for your age entered on Line 3 _____
- Divide the amount on Line 4 by 100 and enter the amount on Line 5 to get your monthly payroll deduction _____

AGE AT DISABLEMENT	DURATION OF BENEFITS
61 or less	to age 65
62	3 years
63	3 years
64	2 years
65	2 years
66	1 year
67	1 year
68	1 year
69 or more	1 year

LONG-TERM DISABILITY RATES	
18-24	$0.090
25-29	$0.140
30-34	$0.260
35-39	$0.420
40-44	$0.720
45-49	$0.940
50-54	$1.330
55-59	$1.710
60-64	$1.320
65-69	$0.890
70+	$0.650

BENEFIT RESOURCES

Who to Call When You Have Questions



HUMAN RESOURCES

You may contact Human Resources with any questions regarding your benefits. You can contact the department by phone at **609.267.6677** or by email at **HREmail@otcbc.org**.

BENEFITS MEMBER ADVOCACY CENTER

The Benefits Member Advocacy Center ("Benefits MAC"), provided by our benefits consultant, Conner Strong & Buckelew, allows you to speak to a specially trained and experienced Member Advocate who can assist with benefits claim issues, coverage questions, and enrollment inquires.

You may contact the Member Advocacy Team in any of the following ways:

- **Via phone: 800.563.9929**, Monday - Friday, 8:30 am to 5:00 pm, EST
- **Via the web: www.connerstrong.com/memberadvocacy**
- **Via email: cssteam@connerstrong.com**
- **Via fax: 856.685.2253**

CARRIER CONTACTS

BENEFIT	CARRIER	PHONE NUMBER	WEBSITE
Medical/Prescription Drug	Horizon Blue Cross Blue Shield of New Jersey	800-355-2583	www.horizonblue.com
Dental	Horizon Blue Cross Blue Shield of New Jersey	800-355-2583	www.horizonblue.com
Vision	VSP	800-877-7195	www.vsp.com
Flexible Spending Accounts	Flex Facts	877-943-2287	www.flexfacts.com/services-d/flexible-spending-accounts
Voluntary Long-Term Disability	Reliance Standard	800-351-7500	www.reliancestandard.com
Commuter Benefits	WEX	877-765-8815	www.customer.wexinc.com/contact/benefits

LEGAL NOTICES

Patient Protection and Affordable Care Act

Please Note: The Occupational Training Center medical plans are considered compliant with the Patient Protection and Affordable Care Act.

Occupational Training Center reserves the right to modify, amend, suspend, or terminate any plan, at any time, and for any reason without prior notification. The plans described in this guide are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this guide as accurate as possible. However, should there be a discrepancy between this guide and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern.

Special Enrollment Notice

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, 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 Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [30 days or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage. Coverage will be effective the first of the month following your request for enrollment.

Loss of coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. 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 new dependents. However, you must request enrollment within [30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources.

HIPAA General Notice of Preexisting Condition Exclusion

This plan imposes a preexisting condition exclusion for individuals over age 19. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. Effective January 1, 2011, the preexisting condition exclusion does not apply to an individual who is under age 19, regardless of whether the individual is an employee or a dependent.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to Horizon Blue Cross Blue Shield of NJ.

Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator to (with the assistance of the prior plan administrator or insurer) determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets.

Important Notice From Occupational Training Center 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 the Occupational Training Center Health Benefit Plan 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. Occupational Training Center has determined that the prescription drug coverage offered by the Occupational Training Center Health Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

LEGAL NOTICES

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 Occupational Training Center coverage will not be affected. If you elect Medicare Part D coverage, the Occupational Training Center coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Occupational Training Center coverage, be aware that you and your dependents will not be able to get this coverage back without 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 Occupational Training Center 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 Human Resources.

Please note that you will 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 Occupational Training Center changes. You also may request a copy of this notice at any time.

More Information About Your Options Under Medicare the 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 prescirption 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 users should call 1-800-325-0778.

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

DATE:	November 2026
SENDER:	Occupational Training Center
CONTACT:	Risa Petrie Director of Human Resources
ADDRESS:	2 Manhattan Drive Burlington Township, NJ, 08016
PHONE NUMBER:	O: 609-267-6677 x 144 F: 609-267-6510

Availablilty of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Occupational Training Center offers a series of health coverage options. You should receive a Summary of Benefits and Coverage (SBC) during Open Enrollment. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions or did not receive your SBC.

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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

Illinois – Medicaid
Illinois Medicaid Premium Assistance Information
Medicaid application website: https://abe.illinois.gov
HIPP Hotline Number: 217-524-8268
HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/medicaid/plans-programs/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

LEGAL NOTICES

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://accessnebraska.ne.gov/
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://bms.wv.gov/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2026, 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



This benefit summary provides selected highlights of the employee benefits program at Occupational Training Center. It is not a legal document and shall not be construed as a guaranteed of benefits nor of continued employment at Occupational Training Center. All benefit plans are governed by master policies, contracts, and plan documents. Any discrepencies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts, and plan documents. Occupational Training Center reserves the right to amend, suspend, or terminate any benefit plan in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.