ABBINGTON
Assisted Living

Employee Benefits Enrollment Guide

PLAN YEAR | **2018**

Welcome to Open Enrollment for your 2018 Benefits!

Elections you make now during the open enrollment period will become **effective July 1, 2017**.

Abbington Management Group offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Benefit Contacts			
Horstman Insurance 285 Glenworth Court Powell, OH 43065 614-381-9653			
Aetna (Medical Ins)	**Member Services**	**800-238-6716**	**www.aetna.com**
Anthem (Dental & Life Ins)	**Customer Service**	**877-604-2156**	**www.anthem.com/mydentalvision**
Janet L. Horstman	**Broker/Sales Executive**	**614-381-9653**	**horsehoop@aol.com**
J. Michael Haemmerle	**Abbington Management**	**614-798-5110**	**mike@abbingtononline.com**

DETAILED PLAN INFORMATION AND ANNUAL EMPLOYEE NOTICES CAN BE FOUND ONLINE AT …

https://abbingtononline.com/employee-disclosures/

Who is Eligible?

If you are an employee of an Abbington Assisted Living community, you are eligible if you have been with the company for 90 days **and** you currently work 60 Hours or more every pay period (2 weeks). You and your immediate family members can enroll in the medical and dental plans through Abbington Management Group.

How to Enroll

The first step is to review your current benefit elections. Verify your personal information and make any changes if necessary. Make your benefit elections. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status. Enrollment forms are available from your Executive Director.

When to Enroll

The open enrollment period runs for the month of June each year. The benefits you elect during open enrollment will be effective from January 1, 2018 through December 31, 2018.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in childôs dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in spouseôs benefits or employment status.

What do you need to do in your OPEN ENROLLMENT Period?

- **You must complete an enrollment form if you want to add or change coverage in the medical and dental programs**.
- **The deadline to return your form is December 31, 2017.**

NOTE: After the Open Enrollment Period, you cannot make changes to your coverage during the year unless you experience a change in family status, such as loss or gain of coverage through your spouse, loss of eligibility of a covered dependent, death of your covered spouse or child, birth or adoption of a child, marriage, divorce, or legal separation, and switch from part-time to full-time.

You have **30** days from a change in family status to make changes to your current coverage.

What's New for 2018

Your Medical and Dental Plans with Abbington

Medical – Will be offered through **Aetna effective January 1, 2018 with a calendar year policy year**. Deductibles are also based on the calendar year. If you have satisfied a portion or all of deductible with our previous carrier, you will get credit with our new carrier. Additional forms will need to be completed to get proper credit. Please go to www.aetna.com for a list of network providers. The plan/network is Aetna Open Access Managed Choice POS.

Dental- Will be offered through **Anthem Blue Cross Blue Shield**. The plan/network name is Dental Complete and network providers can be found at www.anthem.com.

Aetna Online Access

Welcome to Aetna Navigator®. ï go to www.aetna.com and Log in to set up your own personal online account. You may have health concerns, personal or family issues, or work-related challenges. Aetna Navigator gives plan members online access to a wide range of health and well-being information.

You can also call one toll-free telephone number available 24 hours a day, 7 days a week. Once your coverage is effective, you may call **1-888-982-3862** for assistance or log in online.

Please feel free to contact any of us and we will be glad to assist you with any questions you may have.

Medical Plan Updates as a result of the Federal Health Care Reform Bill

Health Care Reform 2018

Effective January 1, 2014, the Shared Responsibility provision of the Affordable Care Act will require each individual to have minimum essential health coverage for each month in the calendar year. This means that each individual will need to be enrolled with health benefits in programs such as an Employer-sponsored program, coverage through the individual marketplace, Medicare, Medicaid, Childrenôs Health Insurance Program (CHIP), TRICARE or certain types of Veterans health coverage in order to avoid a penalty. The penalty is the greater of a flat dollar amount or a percentage of income. Beginning January 1st, 2016 and through 2017, the penalty will be the greater of $695 or up to 2.5% of household income.

There also may be coverage available to some of you for your children through the state of Ohio. The program is called Healthy Start and Healthy Families and the phone number is 1-800-324-8680 or you can contact your local county office of Job and Family Services.

Medical and Prescription Drugs

Our medical and prescription drug benefits are changing to Anthem Blue Cross Blue Shield for the plan starting July 1, 2017. All of our plans allow you the freedom to use providers in and out-of-network. However, better benefits are available when you use an In Network Provider. Aetna offers a broad network of providers throughout Ohio and also nationwide.

Services		Aetna Open Access Managed Choice POS	OH OAMC 2000 80/60 RX2	
Deductible (Single/Family)	**In Network** Non Network	$2000/$4000 $4000/$8000	**HRA Plan limits your deductible to $750/$1500**	
Out of Pocket Max (Single/Family) (**Includes Deductible**)	**In Network** Non Network	$5000/$10,000 $10,000/$20,000		
Coinsurance	**In Network** Non Network	80% /20% 60%/40%		
Lifetime Maximum	**In Network** Non Network	Unlimited		
Office Visit Copay	**In Network** Non Network	**$25 PC/$50SP** Deductible & Co-Insurance		
Preventative Care*	**In Network** Non Network	100% Deductible & Co-Insurance		
Pharmacy Retail Pharmacy- Mail Order Specialty Medications	**In Network** **30 Day supply** **90 Day supply**	 $10/$45/$70 $25/$112.50/$175 30% Copay with max of $250.		
Inpatient Hospital	**Network** Non Network	Deductible & Coinsurance Deductible & Coinsurance .		
Emergency Rm Copay	**In Network** Non Network	$200 Deductible & Co-Insurance		
Urgent Care Copay	**In Network** Non Network	$50 Deductible & Co-Insurance		
Outpatient Hospital	**In Network** Non Network	Deductible & Co-Insurance Deductible & Co-Insurance		
Lab & X-Ray	**In Network** Non Network	Deductible & Co-Insurance Deductible & Co-Insurance		

*Preventative Care includes, but not limited to: Yearly exam, Pap Test, Mammogram, PSA, Cholesterol, Colon Caner Screening, Bone Density Test, EKG Chest X-ray, Comprehensive Metabolic Panel, Urinalysis, CBC, and some Immunizations.

Your Cost in 2018

EMPLOYEE PER PAY DEDUCTIONS				
	Single	Employee & Spouse	Employee & Children	Employee & Family
	$42.00	$550.00	$500.00	$600.00

Anthem Dental Complete	In-Network	Non-Network
Deductible	None	None
Diagnostic and Preventive Services ï Includes exams, cleanings, fluoride, space maintainers, x-rays, brush biopsy	100%	100%
Basic Services ï Restoration, emergency treatment, simple extractions, and endodontics	50%	50%
Major Services ï Oral surgery, periodontics, crowns, dentures, and bridges	50%	50%
Annual Maximum	$700	$700
Non-Network Reimbursement	N/A	90th Percentile

There is no contribution for employee, single dental coverage.

Anthem LIFE INSURANCE

All full time employees have an Anthem $25,000 Life and AD&D policy paid by your employer, Abbington.

Required Notifications

Health Care Reform:

Abbington Assisted Living believes this plan is a ñnon-grandfathered health planò under the Patient Protection and Affordable Care Act (the Affordable Care Act).

Lifetime Limit on the dollar value of benefits no longer applies.

Summary of Benefits and Coverage (SBC):

Abbington Assisted Living is required to continue to distribute a new document, called the Summary of Benefits and Coverage (SBC). The purpose of the SBC is to give members information about their health insurance plancs benefits in plain language, so they can make informed choices about their healthcare coverage. This document includes basic coverage information and claim examples, and will be included as an addendum to the Open Enrollment guide this year.

Dependent Age Extension:

A dependent child is eligible for the medical and dental coverage to the end of the month in which they attain age 26 under Federal Law.

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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 American Health Foundation coverage will (or will not) be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current American Health Foundation coverage, be aware that you and your dependents will not be able to get this coverage back until next year's open enrollment.

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 and don't join a American Health Foundation Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month

that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through American Health Foundation changes. You may also request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

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

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