2016

PCHC

PROVIDENCE COMMUNITY HEALTH CENTERS

Employee Benefits Guide

An Overview to your 2016 Health and Welfare, Life, and Retirement Benefits

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Welcome

GUIDE OVERVIEW

The guide is to serve as a general summary of information regarding your benefits as a Providence Community Health Centers (PCHC) employee. Additionally, this booklet is designed to assist you in evaluating your benefit options. The guide is not intended to be all inclusive, however, where applicable and possible, you will have the resources you need to make specific inquiries; whether to the Human Resources department or directly to appropriate Carrier. In the pages to follow, you'll find helpful information about your benefit choices to make informed decisions about your benefit elections

WHATS INCLUDED

Throughout the Guide, you will find high level plan overviews for Health & Welfare, Life & Income Protection, Retirement, Voluntary Benefits Products, and discount programs offered. Within each respective section, you will find important highlights, eligibility information for each product, easy to read charts, and cost/rate information.

ELIGIBILITY AT A GLANCE

PCHC is proud to offer you a competitive benefit package. Benefits are typically available to regular, active employees; but the requirements vary. Please see below for a quick reference on eligibility requirements. You will also find eligibility information under each respective product.

ELIGIBILITY AT A GLANCE

COVERAGE	ELIGIBILITY	PROVIDER
Medical	21 standard hours per week to qualify for Individual Plans 28 standard hours per week to qualify for 2 Person / Family Plans	Blue Cross & Blue Shield of RI
Medical Waiver Credit	21 standard hours per week to qualify for Individual Credit 28 standard hours per week to qualify for 2 Person / Family Credit	PCHC
Dental	All regular employees	Delta Dental of Rhode Island
Vision	All regular employees	VSP
Flexible Spending Account*	All regular employees: *available during open enrollment only	Blue Cross & Blue Shield of RI
Employee Assistance Program	All regular employees	Coastline EAP
Basic Life Insurance & AD&D **Supplemental Life Insurance** **Long Term Disability**	35 Hours per week – company paid	GUARDIAN
Short Term Disability	35 Hours per week – company paid	London Health Administrators
403(B)	All regular employees	New England Pension
Voluntary Products	20 standard hours per week to qualify	Varies
Discounts Products	All regular employees	Varies

Enrollment 101

Enrollment is the process of instructing PCHC to subscribe you and eligible dependents onto the desired plan. You also instruct us to initiate payroll deductions (where applicable) on a weekly basis from your earnings, on either a pre-tax or post-tax basis, depending on the plan.

Because PCHC recognizes that families have different needs for different products, PCHC offers an a-la-carte benefit platform for your Health and Welfare Benefits. This means, for example you may enroll yourself on the medical plan, you and your dependent children on the dental plan, and only you and your spouse on the vision plan. However, you must always be named as the primary subscriber.

An enrollment window is triggered by a Qualifying event and can happen throughout the year. Such events include new hire, moving from a non-eligible to eligible status, or a life event such as marriage, birth, death, etc. The window remains open for 30 days FROM THE DATE OF THE EVENT. Any enrollment changes resulting will be effective the 1st of the month following the date of the event. Once 30 days have passed from the event date you are no longer able to make changes until Open Enrollment. Further details are included in the section "How DO I make Changes"?.

WHERE DO I ENROLL?

While we are making every effort to move to a paperless enrollment, until such time you must complete the necessary paper enrollment form(s) and deliver them to the HR Benefits Coordinator in the Main Office. For your convenience, all necessary forms are located at the end of this Guide. You may also find digital forms by referring to the PCHC Resource Library; which you will fund a shortcut on your HCN desktop for. Lastly, hard copies will always be available to you in the Human Resource Department.

HOW DO I MAKE CHANGES?

There are several factors that allow you to make changes to your benefit elections:

Qualifying Events:

A qualifying event is set forth by the IRS/Sect. 125. It is a IRS regulation that allows employees to make midyear election changes to their pre-taxed deductions when a change in a participant's status occurs. You have ***30 days from the date of your qualified event to make changes to benefit elections***. After 30 days have passed, you will not be allowed to make changes and must wait for open enrollment. Please note that if the enrollment is received after the first of the month when your insurance(s) are effective, but within the 30-day mark, any missed deductions will be captured from your next paycheck. Examples of a qualifying event are as follows:

- ***Marriage*** - you may add your spouse to your coverage(s) within 30 days of the date of marriage. Please provide a copy of your marriage certificate.
- ***Divorce*** – you may remove your ex-spouse from your coverage(s) within 30 days of the date of divorce. Please provide a copy of your final divorce decree.

- ***Birth of a child*** – you may add your newborn to your coverage(s) within 30 days of the date of birth. Please provide a copy of your child's birth certificate.
- ***Adoption, change in legal custody or death of dependent*** - documentation is usually required by the vendor to effect the change to your coverage(s).
- **Employment Status – A Change** in your **employment status** (New Hire, Termination of Employment, Change to and from Benefit Eligible status). Note: A benefit eligible employee that experiences a change in hours but continue to be benefit eligible has **not** experienced a qualifying event.
- **Spouse's employment status** (New Hire, Termination of Employment, Change to and from Benefit Eligible status)
- *You or your dependent become* ***eligible for Medicare or Medicaid*** – you may change the current election for the eligible person only.

Open Enrollment:

This is an annually occurring, companywide event taking place during the last quarter of every year. You will be well informed as to these dates via communication from your Human Resources department and department heads. During this time, you may add, drop, or change your coverage levels and the dependents whom are covered. These changes, however, do not go into effect until January 1st of the upcoming calendar year.

WHEN DO MY BENEFITS GO INTO EFFECT?

The effective date of your benefits varies from product to product and situation; however, newly hired employees as well as active employees who experience a Qualifying Event can look forward to some benefits, such as medical, dental, and vision going into effect on the ***first (1st) of the month following your date of hire or Qualifying Event Date.***

Some benefits are immediate on your date of hire, such as: Direct Deposit and the Employee Assistance Program. For Non-Union employees, paid time begins to accrue on your date of hire; time accrued however will not be available for use until after successful completion of the 90-day probationary period. For Union Employees, paid time off begins to accrue after successful completion of the 90 day probationary period and is available for immediate use up to the amount available in your bank. Others (Basic and Supplemental Life Insurance) go into effect after a *grace period* is met. Your full or part time status or *FLSA status* (Exempt or Nonexempt) can also determine when a benefit becomes available to you. For specific eligibility and grace period requirements, refer to each related chapter in this guide

Current employees who are making benefit elections during open enrollment will have medical, dental, and vision benefit(s) available on ***January 1st of the upcoming calendar year.***

WHO MAY I ENROLL?

We offer your Health Benefits a-la-carte, so you can choose to enroll each dependent onto the respective plan as needed; (i.e . Medical: Employee, spouse and child(ren), Dental: Employee and Spouse, Vision: Employee Only). However, you must always be named as the primary subscriber.

When enrolling dependents onto any Health plan we do require you to submit the appropriate documentation proving your relationship and their eligibility. This documentation shall be submitted in concert with your Enrollment Application.

The following chart includes allowable dependents you may choose to bring onto your medical, dental, vision, and Flexible Spending Accounts (FSA) plans as well as acceptable forms of documentation:

ELIGIBLE DEPENDANTS AND REQUIRED DOCUMENTATION

DEPENDENT	DOCUMENTATION
Spouse: Opposite and Same Gender	Marriage Certificate – Domestic or Foreign are accepted
Spouse: Common Law	Special Rules Apply – See Appendix
Domestic Partner	Special Rules Apply– See Appendix
Children(ren): Natural Born	Birth Certificate – Domestic or Foreign are accepted
Child(ren): Adopted, Court Assigned	Official Documentation assigning you or your spouse guardianship

WHAT ARE MY COSTS?

For eligible programs, you will incur weekly deductions from your paycheck for the portion of your benefits which you have authorized by completing the PCHC Benefits Election Form. Providence Community Health Centers shares the cost of medical coverage with employees. Providence Community Health Centers pays the *entire* cost of Basic Life & AD&D Insurance, Short Term Disability (STD), Long Term Disability (LTD) and Employee Assistance Program.

2016 Health and Welfare Rates Plan	Non-Union Employee Cost			
	Weekly		Monthly	
	28 + Standard Hours	21 - 27 Standard Hours	28 + Standard Hours	21 - 27 Standard Hours
Medical Insurance				
Individual	$11.00		$47.67	
Individual +1	$22.00		$95.33	
Family	$33.00		$143.00	
Medical - Waiver Credit				
Individual	$25.00		$108.33	
Individual +1	$50.00		$216.67	
Family	$75.00		$325.00	
Dental - High Plan				
Individual	$9.42		$40.82	
Individual +1	$18.84		$81.64	
Family	$31.31		$135.67	
Dental - Low Plan				
Individual	$7.31		$31.67	
Individual +1	$14.62		$63.34	
Family	$26.55		$115.03	
Vision				
Individual	$1.87		$8.09	
Individual +1	$2.69		$11.65	
Family	$4.82		$20.89	
Basic Life	$0.00		$0.00	
Supplemental Life	variable - refer to pg 15		variable - refer to pg 15	
Short Term Disability	$0.00		$0.00	
Long Term Disability	$0.00		$0.00	

2016 Health and Welfare Rates Plan	Union Employee Cost			
	Weekly		Monthly	
	28 + Standard Hours	21 - 27 Standard Hours	28 + Standard Hours	21 - 27 Standard Hours
Medical Insurance				
Individual	<50k salary: $15.00 >50k salary: $20.00		<50k salary: $65.00 >50k salary: $86.67	
Family	<50k salary: $25.00 >50k salary: $30.00		<50k salary: $108.33 >50k salary: $130.00	
Medical - Waiver Credit				
Individual	$24.04		$104.17	
Family	$48.08		$208.35	
Dental - High Plan				
Individual	$9.42		$40.82	
Individual +1	$18.84		$81.64	
Family	$31.31		$135.67	
Dental - Low Plan				
Individual	$7.31		$31.67	
Individual +1	$14.62		$63.34	
Family	$26.55		$115.03	
Vision				
Individual	$1.85		$8.04	
Individual +1	$2.69		$11.65	
Family	$4.82		$20.89	
Basic Life	$0.00		$0.00	
Supplemental Life	variable - refer to pg 15		variable - refer to pg 15	
Short Term Disability	$0.00		$0.00	
Long Term Disability	$0.00		$0.00	

Health and Welfare

OVERVIEW

At Providence Community Health Centers, we know that healthcare is very important to our employees! That's why we offer a comprehensive and highly effective health plan at PCHC. The following sections will provide an overview of each plan and offer current eligibility guidelines. On the last page of this Guide, you will find website information so you can take full advantage of your plans offerings. You will also find contact information for each Provider should a service issue arise with your coverage; however only your employer can make changes to your plan so be sure to contact the Human Resources Benefits Department for qualified alterations.

As a reminder, PCHC offers your Health Benefits including in this section a-la-carte, so you can choose to enroll each dependent onto the respective plan as needed; (i.e . Medical: Employee, spouse and child(ren), Dental: Employee and Spouse, Vision: Employee Only). However, you must always be named as the primary subscriber.

Enrollment is not automatic; so you must complete and submit to Human Resources the PCHC Enrollment Form. When enrolling dependents onto any Health plan you are required to submit the appropriate documentation proving your relationship and their eligibility. This documentation shall be submitted in concert with your Enrollment Application.

MEDICAL

The employee's share of the premium is withheld on a pre-tax basis.

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help you pay for coverage. For eligibility information, in Rhode Island, please call 401-462-5300 or **www.dhs.ri.gov**.

Eligibility

You are eligible for coverage under Providence Community Health Centers (PCHC) medical plan if:

- You are a regular; active employee
- Are scheduled 21 standard hours per week to qualify for Individual Plans.
- Are scheduled 28 standard hours per week to qualify for 2 Person / Family Plans

Blue Cross Blue Shield

PCHC has partnered with Blue Cross and Blue Shield of Rhode Island to offer you the Vantage Blue Medical Plan. This provides you and your enrolled dependents National Coverage without the need for referrals from your Primary Care Physician. Dependent children are always covered until the end of the month in which they turn 26 without any other rules or conditions.

In-network coverage has an annual deductible of $5000 for Individual plan and $10,000 for Family plan (2 or more subscribers on a plan). However, to defray the deductible we blanket this plan with a Health Reimbursement Account (HRA) at no additional cost to you. Details are provided below.

The Vantage Blue plan also lets participants visit any health care professional in the network (including specialists) without a referral and without designating a primary care physician (PCP).

The Vantage Blue plan also provides non-network coverage, with somewhat higher deductibles and co-payments. Please be aware however the HRA does not cover any portion of your deductible when out-of-network.

Health Reimbursement Account – (HRA)

Our Medical Insurance plan contains a ***Health Reimbursement Arrangement (HRA)*** which is administrated by Blue Cross & Blue Shield of RI. The HRA feature is funded and paid for by PCHC at no cost to you. This helps control service costs and prevents passing on additional expenses, by way of higher employee contributions, to you. The medical services applicable to the in-network deductible include: inpatient hospitalization, outpatient hospitalization, pre and post-natal care (including birth), obstetrical care, inpatient mental health care, inpatient chemical dependency care, out-patient physical therapy visits, durable medical equipment, and home hospice care.

The HRA will automatically fund, on your behalf the deductible cost for allowable services. You will also find the HRA provides you with partial refunds for services requiring copayments. To further understand how and what the HRA will fund we have included a reference chart at the end of this section.

Please note, the HRA is only applied to in-network services and co-pays; the medical plan will dictate costs for services rendered out of network. Also, the HRA is not available to you under any other insurance program offered by PCHC or any plan which you are enrolled outside of the Company.

How it Works

Show your BCBSRI member ID card when you receive medical services.

• Deductible bill is sent directly to the HRA payment administrator by BCBSRI.

• BCBSRI's HRA administrator pays eligible in-network deductible amount to healthcare provider.

• You are sent a statement if you owe a portion of the deductible to the healthcare provider.

• If you owe a portion of the deductible, pay the healthcare provider the amount stated on the BCBSRI HRA statement with your personal funds.

Medical Waiver for Credit (Opt-Out)

Benefit eligible employees who currently receive medical coverage outside of The Company either through a family member or have their own coverage under another health plan may be eligible to participate in the Hospital's medical waiver (opt-out) program. In lieu of medical coverage, enrolled employees are compensated with normal, reportable earnings each pay period.

Eligibility

You are eligible for to participate under Providence Community Health Centers (PCHC) Medical Waiver for Credit Program:

- You **are** a regular; active employee:
  - **Are** scheduled 21 standard hours per week to qualify for Individual Plans.
  - **Are** scheduled 28 standard hours per week to qualify for 2 Person / Family Plans
- You **are not** covered under another PCHC employee's medical plan
- You **are not** enrolled in a state or federal sponsored plan (MediCaid)

Enrollment

Newly hired employees must:

- Complete enrollment within thirty (30) days of hire by filling out both the PCHC Benefit Enrollment Application and accompanying the Medical Opt Out Application.
- Provide evidence of medical insurance coverage. This is accomplished by providing a photocopy of EACH and EVERY members insurance card or a statement of coverage from the insurance provider.

Current Buy-Out participants must:

- Reenroll during open enrollment by filling out both the PCHC Benefit Enrollment Application and accompanying the Medical Opt Out Application.
- Provide evidence of medical insurance coverage. This is accomplished by providing a photocopy of EACH and EVERY members insurance card or a statement of coverage from the insurance provider.

Employees currently enrolled in PCHC's medical plan can waive medical coverage provided they:

- Have been enrolled in PCHC's medical plans for at least one (1) year,
- Complete enrollment by filling out both the PCHC Benefit Enrollment Application and accompanying the Medical Opt Out Application.
- Provide evidence of medical insurance coverage. This is accomplised by providing a photocopy of EACH and EVERY members insurance card or a statement of coverage from the insurance provider. Please note, state sponsored plans are not eligible)

DENTAL

When you are covered by Delta Dental's PPO Premier program, you have access to the nation's largest network of dentists – over 108,000 dentists nationwide! That's three out of every four dentists in the country.

The employee's share of the premium is withheld on a pre-tax basis.

Eligibility

Regular, active employees can elect an individual, 2 person or Family membership. A standard family membership covers you, your spouse, and/or dependent children until the end of the year in which they turn age 26. Also, handicapped dependent children over age 26 who are mentally or physically incapable of earning their own living can also be covered. *Please note: documentation of the handicap must be sent to Delta Dental for approval.*

Delta Dental Plans

PCHC makes available on a Voluntary basis a Standard and a Premium plan to help meet the different needs of our employees. The Standard plan has an annual deductible of $25 for Individual/$75 for Family. The Premium plan has no annual deductible. Furthermore, the Premium plan offers orthodontic coverage for dependent children up to age of 19. A comparison chart is located at the end of this section for your convenience.

Maximize your coverage with participating dentists. When you go to a participating dentist, show your identification card and discuss your treatment. After your visit, the dentist's office will file a claim and Delta Dental of Rhode Island will pay the dentist for covered services.

Pretreatment Estimates. Whenever your dentist recommends treatment that is expected to cost $300 or more, suggest that the dentist file a pre-treatment estimate with Delta Dental of Rhode Island. Delta Dental will review the treatment plan and let you and your dentist know, in advance, how much will be covered. For services that your dental plan does not cover at 100% (crowns, for example), having a pre-treatment estimate lets you know what your out-of-pocket costs will be.

VISION

Whether it's a day in the life or a day to remember, you'll get the personalized eye care you deserve with VSP. VSP helps millions of people see well, stay healthy and fulfill their potential.

The employee's share of the premium is withheld on a pre-tax basis.

Eligibility

Regular, active employees can elect an individual, 2 person or Family membership. A standard family membership covers you, your spouse, and/or dependent children until the end of the month in which they turn age 26.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) through Blue Cross & Blue Shield of Rhode Island allow you to pay allowable health (medical, dental, and vision) or dependent care expenses on a tax-free or pre-tax basis. Since taxes are not deducted from your contributions, you will pay less in Federal, State, and FICA taxes!

Eligibility

Establishment of your Flexible Spending Account is only available ***during open enrollment*** and is activated on January 1st of the upcoming plan year. FSAs are available to all regular, active employees with a minimum of 17.5 standard hours per week.

FSA Programs

At PCHC, two programs are offered: Health Care and Dependent Care. While you can enroll in each individually you should be aware of the differences prior to making your election

Health Care Accounts:

This option provides you and your dependents the ability to use your earnings on a tax free basis to pay for qualified expenses. Some examples are all co-pays on medical services, including prescription drug copays, prescription glasses and sunglasses, and a lot more. This translates into valuable savings on your yearly income tax.

Dependent Care Accounts

This option, available independent from the HCA provides you the ability to use your earnings on a tax free basis to pay for qualified expenses. The most common expense is day care (at a qualified, licensed institution) for dependent children necessary during your working hours. This translates into valuable savings on your yearly income tax.

Eligible Expenses

Allowable, and non-allowable expenses are determined by the IRS. Below is a quick summary of common eligible expenses and non-eligible expenses. For a complete list of eligible and non-eligible expenses contact the IRS at (800) 829-3676 or visit the IRS website at www.irs.gov and use keyword "Publication 502" or "Publication 503" (Healthcare Spending Accounts or Dependent Care Spending Accounts, respectively). You may also find the information at www.bcbsri.com.

ELIGIBLE MEDICAL FSA EXPENSES		
Ambulance	Contact Lenses	Hospital Services
Artificial Limb or Prosthesis	Deductibles	Physician Fees
Birth Control	Dental Expenses	Prescription Drugs
Braces	Diagnostic / Lab Fees	Smoking Cessation
Chemical Dependency Treatment	Eyeglasses	Transplants
Chiropractors	Eye Surgery	Weight Loss Programs
Copays	Hearing Aids	Prescription Sunglasses
INELIGIBLE MEDICAL FSA EXPENSES		
Cosmetic Surgery	Medicated Shampoo	Tissues
Deodorant	Mouthwash	Teeth Whitening
Electrolysis Hair Removal	Multivitamins	Health Club Dues
ELIGIBLE DEPENDANT FSA EXPENSES		
Child Day Care Programs	Before & After School Programs	Nursery School Programs
Home Care		

Per the 2010 Health Care Reform Act, as of January 1, 2011, ***over-the-counter medicines are not eligible*** for reimbursement by Flexible Spending Accounts unless prescribed by a physician.

Enrollment to FSA's

Healthcare Spending Account:

1. You have 12 months to use your elected annual contribution.
2. Estimate your eligible health expenses for the calendar year.
3. Decide how much you want to contribute. The IRS contribution limit for 2016 is $2,550 annually for employees. Any money under $500 left unused at years' end will be carried over to the following year. Any money over $500 left unused at years' end will be forfeited.
4. Elect your contribution amount. The annual amount you contribute is divided over the number of pay weeks you have (52) and deducted from your pay each period before your taxes are calculated.
5. Plan participants will have the option to receive a Debit Card to facilitate electronic payment for all eligible health care claims. Simply use the Debit Card at your pharmacy or doctor's office the same way you would use your bank issued card. You may also request for reimbursements from your account as you incur eligible expenses as well—forms are available online in the Document Center at www.bcbsri.com or in your Human Resources Office.
6. You can receive reimbursements for the amount of your claim up to your annual contribution election.

Dependent Care Spending Account:

1. You have 12 Months to use your elected annual contribution.
2. Estimate your eligible dependent care expenses for the calendar year.
3. Decide how much you want to contribute. The IRS limit for 2016 is $5,000 annually for employees. Money left unused in your account(s) is forfeited at the end of the plan year.
4. Elect your contribution amount. The annual amount you contribute is divided over the number of pay weeks you have (52) and deducted from your pay each period before your taxes are calculated
5. You can receive reimbursements for the amount of your claim up to the available balance in your account - forms are available online in the Document Center at www.bcbsri.com or in your Human Resources Office. *The remainder of your claim will be automatically reimbursed to you as you make additional contributions to your account.*

Online Tools

BCBSRI's FSA member portal offers easy-to-use tools that will help you maximize your FSA contributions. Below are instructions on how to log in to your FSA portal and descriptions of key features of the website. IF you are enrolled in a medical plan through BCBS you may access those tools by logging into your member page at www.bcbsri.com.

FSA Calculation Worksheet

The worksheet below will help you estimate your healthcare FSA and dependent care FSA contribution amount(s).

Your healthcare FSA annual contribution maximum is $2,550. For dependent care FSA, your annual contribution maximum is $5,000 per family (if you are a head of household or married and file a joint tax return) or $2,500 (if you are married and file a separate tax return).

Healthcare FSA

Annual Medical Expenses:

Deductibles, coinsurance, and co-payments	$_____
Routine physical exams	$_____
Well-baby care	$_____
Hearing exams, hearing aids	$_____
Prescription drugs	$_____
Other eligible expenses	$_____

Dental expenses, such as:

Gold fillings, crowns, fixed bridge or other restorative services	$_____
Treatment exceeding your plan's limits	$_____

Vision care expenses, such as:

Exams	$_____
Eyeglasses, contact lenses	$_____

Other estimated health-related expenses that may exceed your plan's limits

Outpatient psychiatric care	$_____
Therapy	$_____

Estimated Healthcare FSA Contribution:
This is the estimated amount you may want to contribute to your healthcare FSA. This amount cannot exceed the annual Healthcare FSA maximum amount of $2,550 per year.

$_____

Dependent Care FSA

Annual Dependent Daycare Expenses:

Day care center (s) for child care	$_____
In-home care for child care	$_____
Nursery and pre-school	$_____
Before/after school care	$_____
Au pair services	$_____
Summer day camps	$_____
Day care center for elder care	$_____
In-home care for elder care	$_____

Estimated Dependent Care FSA Contribution:
This is the estimated amount you may want to contribute to your dependent care FSA. This amount cannot exceed the annual dependent care FSA maximum amount of $5,000 per year.

$_____

EMPLOYEE ASSISTANCE PROGRAM – NO COST

As part of our commitment to our employees, Providence Community Health Centers offers, at no cost Employee Assistance Programs through Coastline EAP. This service is available to all employees of PCHC & their family, regardless of hours worked.

This confidential, professional resource is available to ALL employees and their family members who may need assistance with any type of personal concern. Counselors are available 24 hours/day, 365 days/year to provide you with an immediate assessment, referral and follow up services.

CONFIDENTIALITY

Coastline EAP maintains strict adherence to State and Federal Laws governing the confidentiality of medical records. All records are kept in locked files in the custody of Coastline EAP and cannot be accessed by employers.

EASY TO USE

Just call 1 800 445-1195 and identify yourself as an employee or family member of a PCHC employee. A counselor will take your call and begin the process.

EAP SERVICES

Coastline EAP consultants have experience assisting with various concerns such as:

- Grief
- Anger
- Stress
- Anxiety
- Addictions
- Depression
- Legal Issues
- Family Matters
- Financial Worries
- Relationship Conflict

TABLE: MEDICAL PLAN COSTS WITH HRA

BlueCross BlueShield Vantage Blue 5000 : Coverage fron 1/1/2016 thru 12/31/2016			
Procedure Description	**BCBS Plan**	**HRA Pays**	**You Pay**
In-Network Annual Deductible: Individual Plan	$ 5,000 Individual $10,000 2+ / Family	$ 5,000 Individual $10,000 2+ / Family	$0
In-Network Coinsurance	0%	0%	0%
In-Network Out-of-pocket maximum: Individual Plan	$6,850	N/A	$6,850
In-Network Out-of-pocket maximum: 2+ / Family Plan	$13,700	N/A	$13,700
Dependent Children	Covered until the end of the month in which they turn 26		
Primary Care or Referrals Necessary?	No		
In-Network Outpatient Preventive and Diagnostic Services			
Preventative Office Visits, Routine GYN, Well Baby Visits	100% Coverage	$0	$0
Preventive Diagnostic X-Rays, Lab Tests, & Imaging	100% Coverage	$0	$0
Adult & Pediatric Preventive Care & Immunizations	100% Coverage	$0	$0
Primary Care Office Visits	$30 Copay	$5 Copay	$25 Copay
Physician/Specialty Care Office Visits	$50 Copay	$10 Copay	$40 Copay
Chiropractic Office Visits	$50 Copay	$10 Copay	$40 Copay
Eye Exams	$50 Copay	$10 Copay	$40 Copay
Outpatient Mental Health & Substance Abuse treatment	$50 Copay	$10 Copay	$40 Copay
Urgent Care (i.e.. Walk-in treatment centers)	$50 Copay	$50 Copay	$0
Ambulance Services	$50 Copay	$0	$50 Copay
Emergency Room (Waived if admitted)	$200 Copay	$125 Copay	$75 Copay
In-Network Prescription Drug			
Generic	$ 10 Copay	$ 0 Copay	$ 10 Copay
Premium Generic	$ 35 Copay	$ 10 Copay	$ 25 Copay
Preferred	$ 60 Copay	$ 20 Copay	$ 40 Copay
Specialty	$100 Copay	$ 30 Copay	$ 70 Copay
In-Network Inpatient Services			
Facility Services	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
In Patient Hospital & Physician Services	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
Maternity-Pre & Post Natal Care	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
Inpatient Mental Health & Substance Abuse	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
In-Network Outpatient Services			
Facility Services	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
Physician/Surgeon Services	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
High-end Radiology Services, Major Diagnostics, and Nuclear Medicine	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
Skilled Nursing, Home Health Care, Including Hospice Care	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
Infertility Services & Infertility Oral & Injectable Drugs	100% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0
Short-term Rehabilitation Therapy (Physical, Occupational, & Speech)	$50 Copay	$10 Copay	$40 Copay
Durable Medical Equipment	80% after Deductible	$5,000 Ind/$10,000 Fam of Deductible	$0 of Ded. + 20% after Ded
Out-of-Network Services*			
Annual Deductible per Individual	$10,000	$0	$10,000
Annual Deductible per Family	$20,000	$0	$20,000
Coinsurance	20%	$0	20%
Out-of-pocket maximum per Individual	$13,700	$0	$13,700
Out-of-pocket maximum per Family	$27,400	$0	$27,400

* This benefit description is not a contract or a complete listing of benefits.

For detailed information, please refer to your subscriber agreement and summary of benefit coverage on your secure member home page on BCBSRI.com or call BCBSRI.

TABLE: DENTAL PLAN REFERENCE TABLE

Delta Dental PPO Plus Premier National : Coverage from 1/1/2016 thru 12/31/2016		
In-Network Benefits	**Low Plan**	**High Plan**
Annual Deductible	$ 25 Individual Plan $ 75 2+ / Family Plan	N/A
Calendar Year Maximum:	$1,500	$2,000
Dependent Children	Dependent Children are covered up until the end of the year that they turn age 26.	Dependent Children are covered up until the end of the year that they turn age 26.
Preventative/Diagnostic		
Oral exam- once per calendar year performed by a general dentist	100%	100%
Cleanings-twice per calendar year	100%	100%
Fluoride treatment-for children under age 19 once per calendar year	100%	100%
Bitewing x-rays-one set per calendar year	100%	100%
Complete x-ray series or panoramic film once every 36 months	100%	100%
Single x-rays as required	100%	100%
Amalgam (silver) fillings, composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays what would have been paid for an amalgam filling. Patient is responsible up to dentist's charge.	100%	100%
Recementing crowns or bridges once every 60 months	100%	100%
Sealants for children under age 18, once per permanent unrestored molar every 24 months	80%*	100%
Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year.	80%*	100%
Repairs to existing partial/complete dentures once per calendar year	80%*	100%
Rebasing/relining of full/partial dentures once every 60 months	80%*	100%
Space maintainers for lost deciduous (baby) teeth, replacement limited to once every 60 months	80%*	100%
Extractions & routine oral surgery when not covered by your medical plan	80%*	100%
General anesthesia or intravenous sedation for complex surgical procedures	80%*	100%
Root canal therapy	80%*	100%
Crowns over natural teeth, build ups, post & cores; replacement limited to once every 60 months	50%*	100%
Periodontal maintenance following active therapy - two per year	50%*	50%
Root planing and scaling once per quadrant every 24 months	50%*	50%
Osseous (bone) surgery once per quadrant every 24 months (bone grafts exc luded)	50%*	50%
Gingivectomies once per site every 24 months	50%*	50%
Soft tissue grafts once per site every 60 months	50%*	50%
Crown lengthening once per site every 60 months	50%*	50%
Guided tissue regeneration and bone replacement graft once per site every 24 months	50%*	50%
Bridges, build ups, post & cores, crowns over implants; replacement limited to once every 60 months	50%*	50%
Partial and complete dentures; replacement limited to once every 60 months	50%*	50%
Surgical placement of endosteal implant, abutment and crown once per tooth site per lifetime.	50%*	50%
Orthodontics:		
Braces and related services for dependent children under the age of 19	N/A	50%
Orthodontic Lifetime Maximum	N/A	$1,500

Pre-Treatment Estimate is recommended for procedures marked with an asterisk (*).
The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%, 80%). Coverage for benefits with time limitations (i.e. 6,12,24,36 or 60 months) is calculated to the exact day.

TABLE VISION PLAN REFERENCE TABLE

VSP CHOICE: COVERAGE FROM 1/1/2016 THRU 12/31/2016			
Benefit	**Description**	**In-Network**	**Frequency**
WellVision Exam		$ 10 copay	Every calendar year
Prescription Glasses:		$ 10 copay	See frame and lenses
Frame	$140 allowance for a wide selection of frames $130 allowance for featured frame brands 20% savings on the amount over your allowance $75 Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements	$ 55 copay $ 95 - $ 105 copay $ 150 - $1 75 copay	Every calendar year
Contacts (instead of glasses)	$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	Up to $60 copay	Every calendar year
Extra Savings - Glasses and Sunglasses	Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
Extra Savings - Retinal Screening	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
Extra Savings - Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

Exam ..... up to $ 45 Lined Bifocal Lenses ..... up to $ 50 Progressive Lenses ..... up to $ 50 Single Vision Lenses ..... up to $ 30
Frame .....up to $ 70 Lined Trifocal Lenses .....up to $ 65 Contacts..... up to $105

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Life and Income Insurance

BASIC LIFE AND AD&D – NO COST

Eligible employees (regular, active employees with at least 35 standard hours per week) receive free life insurance benefits ***paid for by PCHC***. The level of the life insurance coverage is dependent upon your employment at PCHC (Non-Union / Union). Non-Union employees are eligible to receive 2x times their annual salary/rate, in free basic life coverage not to exceed $300,000. Union employees are eligible to receive 1.5 times their annual salary/rate not to exceed $50,000 per the Union contract.

There is no enrollment paperwork; however **we *do require a Beneficiary form be completed***; included within this guide. Eligible employees are automatically enrolled at no cost.

SUPPLEMENTAL LIFE

Introduction

Eligible Employees (regular, active employees with at least 35 standard hours per week) can elect to receive this additional coverage for themselves, their spouse and dependent children. This supplemental insurance is an employee-paid benefit.

Portability

Employees who separate from PCHC have the option to continue this benefit. However, they will no longer fall under PCHC's rate schedule. To carry coverage, you must contact Guardian for the necessary instructions and paperwork.

Available Plans

Employee with Accidental Death and Dismemberment (AD&D): Coverage is available at $ 10,000 increments up to $ 150,000. The amount of insurance reduces 35% at age 65 and 50% at age 70. In conjunction with Supplemental Life Insurance, Accidental Death & Dismemberment (AD&D) is automatically included in your election. AD&D doubles your benefit amount in the event of accidental death or loss of limb.

Spouse: Coverage is guaranteed less than age 65. It is available in increments of $ 5,000 up to $ 30,000. To enroll Spouse with Supplemental Life insurance, the employee must first elect Supplemental Life Insurance and Coverage cannot exceed 50% of the employee's basic life. Spousal coverage terminates at age 70.

Dependent Child(ren): Coverage is guaranteed at $10,000. Coverage continues to the end of the month in which they turn age 20. If the child is unmarried, dependent on you and is a full-time student, coverage continues to end of the month in which they turn age 26.

Supp Life Rates and Cost Calculation Worksheet

To calculate the amount per pay period associated with Supplemental Life Insurance and AD&D, use the worksheet below:

SUPPLEMENTAL LIFE RATES

AGE	MONTHLY EMPLOYEE RATE (PER $1,000 OF COVERAGE)	MONTHLY SPOUSAL RATE (PER $1,000 OF COVERAGE)
<30	$0.075	$0.04
30-34	$0.085	$0.05
35-39	$0.115	$0.08
40-44	$0.175	$0.14
45-49	$0.245	$0.21
50-54	$0.425	$0.39
55-59	$0.645	$0.61
60-64	$0.665	$0.63
65-69	$1.205	$1.17
70+	$2.535	$2.50

AD&D:

You are automatically enrolled with your election of Supplemental Life. AD&D is available only to employees.

Child(ren):

$1.67 per month for $ 10,000 – covers any and all dependent children

Example:

Employee age 35 purchases $30,000 of supplemental coverage:
30 units x $0.115 = $3.45 dollars per pay period.

Employee: Supplemental Life insurance coverage is available in increments of $10,000 up to $150,000.

Spouse: Guaranteed Issue Life insurance is available for your spouse in increments of $5,000 up to $30,000, not to exceed 50% of employee's amount. Age is based off yours. Policy terminates at age 70.

Dependent Child(ren): Life Insurance coverage is available at $10,000 for dependent child(ren) 14 days to the end of the month in which they turn age 20; (or in which they turn age 26 if full time student, unmarried, and dependent).

To calculate your payment amount:

_____	Insert the $ amount of Supplemental Coverage.
÷ 1,000	Divide by 1,000.
=	Equals the number of "units" of coverage.
x	Multiply the rate associated with **your** age.
=	Equals your total monthly rate for Supplemental Life Insurance.
X 12	Multiply by the number of months in a year.
÷ 52	Divide by the number of pay weeks in a year.
=	Weekly deduction amount.

SHORT TERM DISABILITY – NO COST

Eligibility

Providence Community Health Centers offers all **Full Time (as defined by 35 weekly standard hours)** eligible employees ***at no cost***, Short-Term Disability (STD) insurance Coverage is effective on the 1st of the month following 30 days of employment.

Plan Overview

Coverage is effective on the 1st of the month following 30 days of employment. This benefit will begin the 15th day of an accident / sickness as indicated below for Union and Non-Union employees; all payments made under this Short Term Disability Benefit are reduced by any amounts received from TDI.

Eligible Non-Union Employees: Benefit will pay 70% weekly, to maximum of $750 weekly for a total of 13 weeks; reduced by any amounts received from TDI.

Eligible Union Employees: Benefit will pay for a total of 13 weeks, as follows, whichever is less:

a. 60% of your weekly earnings
b. $750 weekly payment
c. 70% of your weekly earnings; reduced by amounts received from TDI

LONG TERM DISABILITY – NO COST

GUARDIAN®

Eligibility

Providence Community Health Centers offers all **Full Time (as defined by 35 weekly standard hours)** eligible employees ***at no cost***, Long-Term Disability (LTD) insurance Coverage effective the 1st of the month following 30 days of employment.

Plan Overview

LTD replaces a portion of your salary if you become disabled beyond 3 months up to 65 years of age.

At 3 months of continuous disability, this benefit pays for Non-Union employees 60% of their salary not to exceed $12,000/month. For Union employees, this benefit pays 60% not to exceed $5,000/month.

Retirement

INTRODUCTION

The Providence Community Health Centers, Inc Retirement Plan has been adopted to provide you with the opportunity to save to retirement on a tax-advantaged basis and to provide additional income for retirement. This plan is a type of retirement plan commonly referred to as a 403(b) plan or Tax Sheltered Annuity (TSA).

ELIGIBILITY

With respect to making salary reduction contributions, you are eligible to participate in the plan on your date of hire; however Employer match contribution, up to 5% will be made following six (6) months of service.

PLAN MANAGEMENT

Our plan is managed by New England Pension Plan Systems, LLC. You may contact the plan consultant to schedule a meeting to ensure your portfolio is allocated to best suit your financial future. Please note, you must contact Human Resources in order to increase, decrease, or eliminate your contributions.

New England Pension Plan Systems, LLC
Sergio A DeCurtis; MBA; ARPS; AIF
790 North Main Street
Providence, RI 02904
401.274.5000 (o)
401.274.1635 (c)

ENROLLMENT

All eligible employees will be automatically enrolled in the plan beginning with your first paycheck at 1% of your eligible pay on a pre-tax basis. Upon 6 months continued service your automatic contribution will be matched dollar for dollar. In order to override the auto-enrollment, including contributing more, less, or even nothing you must you must complete and enrollment form instructing us to alter your contributions as directed.

CONTRIBUTIONS

You may change your deferral amount at the beginning of each quarter. Conversely, you may stop your contributions at any point in the year. Through your payroll deduction, you can choose a flat dollar amount or a percentage of earnings for each pay period. The IRS sets the maximum amount of contributions per tax year. Currently, in 2016 the annual amount allowable by the IRS is $18,000. Participants over the age of 50 can make catch up contributions at an additional $6,000.

MATCHING

Providence Community Health Centers, at 6 months of continuous service will contribute an amount equal to a percentage of your elective deferrals based on your years of service as set forth in the table below. Years of service are defined as your years of service for vesting.

YEARS OF SERVICE	MATCHING RATE
Less than 25 years	100% up to 5%
More than 25 years	100% up to 6%
More than 30 years	100% up to 7%
More than 35 years	100% up to 8%

LOANS

Our plan allows loans at a minimum of $1,000 against the value of your account. Loans are repaid with interest back to you account through payroll deductions and you will be responsible for any loan fees that may be charged. You may contact NEPPS, LLC to request a loan.

ONLINE SERVICES

NEPPS, LLC offers a multitude of online account management and research tools. This provides simple, convenient accessibility 24 hours a day; 7 days a week and gives you complete control over your financial future. Some examples of NEPPS' online services include:

- Check Account Balances
- View Account Activity
- Calculate Retirement Goals
- View Personal Rates of Return
- View Summary Plan Description
- Asset Allocation
- Stress Test
- View Fund Performance
- Mutual Fund Research
- View Transaction History

To log on:

1. Go to www.newenglandpension.com
2. On the left, under "secure Login" enter your UserID and Password
    a. User ID is set to your Social Security Number
    b. Password is set to the last FOUR digits of your SSN
3. Ensure the "Participant" circle is selected
4. Click the "Submit" button
5. Once you are logged on, be sure to visit the "Personal Information" tab to update any of your information and to set up an alternate questions in case you forget your password.

Voluntary Benefits and Discounts

OVERVIEW

Providence Community Health Centers also offer an array of voluntary benefits to try and meet the many needs of our employees. The purpose of our voluntary benefits is to offer group rates for coverages with the convenience of payroll deductions. This means typically a lower rate than obtaining the product directly and the ease of automatic payments.

We make you monthly payments on your behalf, deducted automatically from your weekly earnings on a post-tax basis.

These policies belong to the specific Vendor and any claims, questions or cancellations should go directly through them.

ELIGIBILITY

Some of the voluntary benefits are available to you immediately upon eligibility (regular, active employees with at least 20 standard hours per week).

PLANS AND PROVIDERS AT A GLANCE

VOLUNTARY INSURANCE PRODUCTS

Benefit	Carrier	Enrollment	Phone
Universal Life	TransAmerica	Coming soon	Coming Soon
Critical Illness w/ Cancer Rider	TransAmerica	Coming soon	Coming soon
Accident Insurance	TransAmerica	Coming soon	Coming soon
Auto and Home Insurance	Liberty Mutual	Coming soon	Coming soon
Pet Insurance	Nationwide	Coming soon	Coming soon

DISCOUNTS PROGRAMS

Product	Lead	Phone	Email
Verizon	Ken Petrie	401.256.6801	Ken.Petrie@verizonwireless.com
AAA	Kari Miller	401.272.7100	kmiller@aaanortheast.com
BJ's Wholesale	Debbie Lisonbee	508.399.7202	dlisonbee@bjs.com

Contact Information

MEDICAL, FSA, & HRA	DENTAL	VISION
Blue Cross and Blue Shield of RI	**Delta Dental of RI**	**VSP - Vision Care for Life**
Customer Service Department	Customer Service Department	Customer Service Department
500 Exchange Street	PO Box 1517	One Gatehall Drive
Providence, RI 02903-2699	Providence, RI 02901-1517	Parsipanny, NJ 07054
401.459.5000	401.751.6100	973.270.1220
800.639.2227	800.843.3582	800.524.0910 - Option 2
www.BCBSRI.com	www.deltadentalri.com	www.vsp.com

LIFE AND LTD	SHORT TERM DISABILITY	RETIREMENT
Guardian	**London Health Administrators**	**New England Pensions Systems**
1601 Chestnut Street		Sergio A DeCurtis; MBA;ARPS;AIF
Philadelphia, PA 19192	40 Commercial Way	790 North Main Street
Group Service Center	East Providence, RI 02914	Providence, RI 02904
800.331.9548	401.435.4700	401.274.5000
		401.274.1653
www.guardian.com	www.londonhealthusa.com	www.newenglandpension.com

EAP
Coastline EAP
300 Centerville Road, Suite 301S
Warwick, RI 02886-0219
800.445.1195
401.732.9444
www.coastlineeap.com

MELANIE GOMES
BENEFITS COORDINATOR

401.780.2567
MGOMES@PROVIDENCECHC.ORG

PCHC
PROVIDENCE COMMUNITY HEALTH CENTERS

APPENDIX – REQUIRED FORMS

Providence Community Health Centers

2016 Benefits Enrollment Form

Non-Union Staff

Welcome to your Benefit Elections. By submitting a completed, signed form to Human Recourses, you are instructing Providence Community Health Centers (PCHC) to enroll or change your benefit elections for either yourself, and/or your dependents. Please ensure each section carefully is filled out completely to avoid delays in processing.

Please note that all insurance plans are a la carte, in other words: for a family of 3 you may select 1 person medical, 2 person Dental, and 3 person Vision; however you must always be named as the primary subscriber, (for example you cannot enroll only your dependents into medical). IN order to ensure the correct enrollment of your dependents, please be sure to check ENROLLMENT box for each dependent in Section 3 of this form.

SECTION 1: EMPLOYEE DEMOGRAPHICS								
SELECT:	☐ NEW HIRE Hire Date:		☐ QUALIFYING EVENT (*marriage, birth, death, newly eligible*) Date of Event:				☐ OPEN ENROLLMENT Effective: 1/1/2017	
Name:						SSN:		
Status:	☐Single	☐Married	☐Divorced	☐Widowed	☐Common Law Spouse	☐Domestic Partner	Gender: ☐Male ☐Female	
eMail:							DOB:	
Address:								
City			State			Zip		

SECTION 2: SECTION 2: HEALTH & WELFARE ELECTIONS			
Plan	Individual	2-Person	Family
Medical – BCBS Vantage Blue	☐ $ 11.00 weekly	☐ $ 22.00 weekly	☐ $ 33.00 weekly
Medical – WAIVE MEDICAL PLAN	☐ Please complete the PCHC Insurance Waiver Form		
Dental – Delta Dental High Option	☐ $ 9.42 weekly	☐ $ 18.84 weekly	☐ $ 31.31 weekly
Dental – Delta Dental Low Option	☐ $ 7.31 weekly	☐ $ 14.62 weekly	☐ $ 26.54 weekly
Dental – WAIVE DENTAL	☐ No additional information necessary		
Vision - VSP	☐ $ 1.85 weekly	☐ $ 2.69 weekly	☐ $ 4.82 weekly
Vision – WAIVE VISION	☐ No additional information necessary		

Providence Community Health Centers

2016 Benefits Enrollment Form

Non-Union Staff

SECTION 3: ELIGIBLE DEPENDENTS

Name	Birthday	SSN	Relationship: (spouse, domestic partner, common law, child)	Sex	Enroll In:
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis

SECTION 4: YOUR AUTHORIZATION

Providence Community Health Centers has implemented a pre-tax premium payment program under IRC section 125. Pursuant to the plan document and summary plan description, all eligible employees will be automatically enrolled in the pre-tax premium payment program unless said employee declines enrollment by written notice to their center's human resources manager. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of obtaining a benefit that the employee/retiree, spouse and/or dependent would not otherwise be entitled. In signing this form you confirm that the information contained herein (including dependent information) is accurate to the best of your knowledge. Further you acknowledge that it is your responsibility to notify the Plan of any changes to dependent (spouse and/or children) eligibility.

Employee Signature _____ Date Signed _____

2016 Health Insurance Waiver Form

Employee Name (please print): _____

I elect to waive: (please select one)

____ **Individual** health insurance benefits provided to me by The Providence Community Health Centers, Inc. (PCHC). I understand that I will receive $25.00 per week, provided I meet the eligibility requirements.

____ **Individual Plus 1** health insurance benefits provided to me by The Providence Community Health Centers, Inc. (PCHC). I understand that I will receive $50.00per week, provided I meet the eligibility requirements .

____ **Family** health insurance benefits provided to me by The Providence Community Health Centers, Inc. (PCHC). I understand that I will receive $75.00per week, provided I meet the eligibility requirements.

This amount will be added to my gross salary and paid out to me in my weekly paycheck during my qualified employment at PCHC. In order to qualify and receive this waiver, **I attest to the following:**

- I am presently covered by the following health insurance plan:

  Health Insurance Plan Name: _____

  Group Number: _____ Policy Number: _____

  Policyholder Name: _____

  Policyholder's Relationship to Employee: _____

- I am not under any legal obligation by way of any court order/divorce decree, etc. to provide health insurance coverage for any other individuals.

- I understand that I must provide acceptable documentation of other health insurance coverage to PCHC's Human Resources Department (letter from insured's employer or proof of coverage from other health insurance plan i.e., copy of health insurance card).

- I understand that this decision is binding for the benefit year beginning **January 1, 2016** and ending **December 31, 2016**.

In case of a qualifying event*, health insurance may be elected by providing documentation verifying the qualifying event to Melanie Gomes, Benefits Coordinator in Human Resources, within 31 days of loss of other coverage.

_____ _____ _____

Employee Signature Date

If you decline medical coverage offered by Providence Community Health Centers that is considered to be affordable and of minimum value essential under the Patient Protection and Affordable Care Act (ACA), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace. Also, if you sign a waiver, you cannot enroll in the Employer's health plan until next open enrollment unless you incur a qualifying event. However if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. There is a time limit for enrolling after the coverage is lost. You must request to enroll in the plan within 30 days of losing coverage.

Providence Community Health Centers

2016 Benefits Enrollment Form

Union Staff

Welcome to your Benefit Elections. By submitting a completed, signed form to Human Recourses, you are instructing Providence Community Health Centers (PCHC) to enroll or change your benefit elections for either yourself, and/or your dependents. Please ensure each section carefully is filled out completely to avoid delays in processing.

Please note that all insurance plans are a la carte, in other words: for a family of 3 you may select 1 person medical, 2 person Dental, and 3 person Vision; however you must always be named as the primary subscriber, (for example you cannot enroll only your dependents into medical). IN order to ensure the correct enrollment of your dependents, please be sure to check ENROLLMENT box for each dependent in Section 3 of this form.

SECTION 1: EMPLOYEE DEMOGRAPHICS			
SELECT:	☐ NEW HIRE Hire Date:	☐ QUALIFYING EVENT (*marriage, birth, death, newly eligible*) Date of Event:	☐ OPEN ENROLLMENT Effective: 1/1/2017
Name:			SSN:
Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Common Law Spouse ☐Domestic Partner eMail:			Gender: ☐Male ☐Female DOB:
Address:			
City	State		Zip

SECTION 2: HEALTH & WELFARE ELECTIONS			
Plan	Individual		Family
Medical – BCBS Vantage Blue	☐ $ 15.00 weekly		☐ $ 25.00 weekly
Medical – BCBS Vantage Blue +50,000 ANNUAL SALLARY	☐ $ 20.00 weekly		☐ $ 30.00 weekly
Medical – WAIVE MEDICAL PLAN	☐ Please complete the PCHC Insurance Waiver Form		
	Individual	2 Person	Family
Dental – Delta Dental High Option	☐ $ 9.42 weekly	☐ $ 18.84 weekly	☐ $ 31.31 weekly
Dental – Delta Dental Low Option	☐ $ 7.31 weekly	☐ $ 14.62 weekly	☐ $ 26.54 weekly
Dental – WAIVE DENTAL PLAN	☐ I do not wish to enroll in Dental Insurance		
	Individual	2 Person	Family
Vision - VSP	☐ $ 1.85 weekly	☐ $ 2.69 weekly	☐ $ 4.82 weekly
Vision – WAIVE VISION PLAN	☐ I do not wish to enroll in Vision Insurance		

Providence Community Health Centers

2016 Benefits Enrollment Form

Union Staff

SECTION 3: ELIGIBLE DEPENDENTS

Name	Birthday	SSN	Relationship: (spouse, domestic partner, common law, child)	Sex	Enroll In:
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis
				☐ M ☐ F	☐ Med ☐ Den ☐ Vis

SECTION 4: YOUR AUTHORIZATION

Providence Community Health Centers has implemented a pre-tax premium payment program under IRC section 125. Pursuant to the plan document and summary plan description, all eligible employees will be automatically enrolled in the pre-tax premium payment program unless said employee declines enrollment by written notice to their center's human resources manager. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of obtaining a benefit that the employee/retiree, spouse and/or dependent would not otherwise be entitled. In signing this form you confirm that the information contained herein (including dependent information) is accurate to the best of your knowledge. Further you acknowledge that it is your responsibility to notify the Plan of any changes to dependent (spouse and/or children) eligibility.

Employee Signature _____ Date Signed _____

PCHC
PROVIDENCE COMMUNITY
HEALTH CENTERS

Union Health Insurance Waiver Form

Employee Name (please print): _____

I elect to waive: (please select one)

____ The **individual** health insurance benefits provided to me by The Providence Community Health Centers, Inc. (PCHC). I understand that I will receive $24.04 per week, provided I meet the eligibility requirements of part-time/full-time regular employment with **21+** standard weekly hours.

____ The **family** health insurance benefits provided to me by The Providence Community Health Centers, Inc. (PCHC). I understand that I will receive $48.08 per week, provided I meet the eligibility requirements of part-time/full-time regular employment with **28+** standard weekly hours.

This amount will be added to my gross salary and paid out to me in my weekly paycheck during my qualified employment at PCHC. In order to qualify and receive this waiver, **I attest to the following:**

- I am presently covered by the following health insurance plan:

  Health Insurance Plan Name: _____

  Group Number: _____ Policy Number: _____

  Policyholder Name: _____

  Policyholder's Relationship to Employee: _____

- I <u>am not</u> under any legal obligation by way of any court order/divorce decree, etc. to provide health insurance coverage for any other individuals.

- I understand that I must provide acceptable documentation of other health insurance coverage to PCHC's Human Resources Department (letter from insured's employer, proof of coverage from other health insurance plan, copy of both sides of health insurance card).

- I understand that this decision is binding for the benefit year beginning **January 1, 2016** and ending **December 31, 2016**.

In case of a qualifying event*, health insurance may be elected by providing documentation verifying the qualifying event to Melanie Gomes, Benefits Coordinator, in Human Resources, within 31 days of loss of other coverage.

_____	_____	_____
Employee Signature	Date	Standard Weekly Hours

*These are changes in legal marital status, increase or decrease in the number of eligible dependents, the employment status of the employee, spouse, or dependents satisfying or ceasing to satisfy eligibility requirements.

Providence Community Health Centers, Inc

403B Participant Enrollment Form

PARTICIPANT PROFILE INFORMATION

NAME: _____ **SOCIAL SECURITY NUMBER**: _____

ADDRESS: _____ **BIRTH DATE**: _____

_____ **PHONE NUMBER**: _____

EMAIL: _____ **DATE OF HIRE**: _____

BENEFICIARY INFORMATION

PRIMARY BENEFICIARY: _____ RELATIONSHIP: _____ % _____

CONTINGENT BENEFICIARY: _____ RELATIONSHIP: _____ % _____

* If you are married and designate someone else as your primary beneficiary, your spouse must sign a spousal consent form and have it notarized.

* If additional beneficiaries, please attach separate list and sign.

STATEMENT PREFERENCE: ☐ PAPER ☐ ELECTRONIC

PAYROLL DEDUCTION: ☐ I WISH TO PARTICIPATE AT THIS TIME. THE TOTAL AMOUNT DEDUCTED FROM MY PAY WILL BE: $ _____ OR % _____

☐ I DO NOT WISH TO PARTICIPATE AT THE TIME.

INVESTMENT SELECTION: CHOOSE A MIX OF FUNDS TOTALING 100% OR AN INVESTMENT PORTFOLIO.

FIXED
METLIFE Stable Value Fund _____ %

US GOV'T _____ %
Vanguard GNMA Adm _____ %
Vanguard Infl Protected Sec _____ %
Vanguard Inter Term Tres

BOND _____ %
Loomis Sayles Strategic Income _____ %
Income Fund of America _____ %
Harbor Bond Institutional

HIGH YIELD BOND _____ %
High Income Trust
LARGE VALUE _____%
Washington Mutual _____ %
Fairholme _____ %
Capital World Growth & Income

Value
Yacktman Services _____ %
Dodge & Cox Stock _____ %

Growth
Vanguard S&P 500 _____ %
Vanguard Prime Cap _____ %
Mairs & Power Growth _____ %

MID-CAP
Blackrock Flexible Equity _____ %

International
Europacific Growth _____ %

SMALL CAP
Royce Opportunity Inst _____ %
Fidelity Low-Priced Stock _____ %

OR

ACTIVE MODELS
_____ **%** Income Portfolio
_____ **%** Income & Growth Portfolio
_____ **%** Growth & Income Portfolio
_____ **%** Capital Growth Portfolio

PASSIVE MODELS
_____ **%** Institutional Index 20/80
_____**%** Institutional Index 40/60
_____ **%** Institutional Index 60/40
_____**%** Institutional Index 80/20

By signing this enrollment form, you:

1) Authorize your employer to deduct from your compensation the amount state above.
2) Authorize your Trustee/Plan Administrator to invest your Investment Allocations as directed above.
3) Acknowledge receipt of the current prospectus of the mutual fund(s) selected above.

Signature_____ Date_____

GUARDIAN®

P.O. Box 14334
Lexington, KY 40512

Basic and Supplemental Life Insurance: Beneficiary Designation/ Change Form

PLEASE TYPE or PRINT CLEARLY. *(The entire form, properly completed, signed and dated by the Insured, must be submitted or the changes cannot be processed.)*

EMPLOYER/PLANHOLDER NAME:	GROUP NUMBER
Providence Community Health Centers	522533
EMPLOYEE NAME (LAST, FIRST, M.)	SOCIAL SECURITY #
EMPLOYEE HOME ADDRESS (STREET, CITY, STATE, ZIP)	

I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan.
(PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.)

BENEFICIARY INFORMATION: *(Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter.*

Primary: 1) Name	Relationship	%	Social Security #	Date of Birth
Address	Phone#	Email		
2) Name	Relationship	%	Social Security #	Date of Birth
Address	Phone#	Email		
Contingent: 1) Name	Relationship	%	Social Security #	Date of Birth
Address	Phone#	Email		
2) Name	Relationship	%	Social Security #	Date of Birth
Address	Phone#	Email		

If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan.

SIGNATURE OF INSURED	SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY)	DATE

Community Property State Consent for Residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married and live in a community property state your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the insured Employee's spouse, I am aware that my spouse, the Employee named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such life insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse _____

ALL SIGNATURES MUST BE IN INK

CHANGE IN BENEFICIARY'S NAME *(Complete only if the name has been legally changed.)*

FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE

CHANGE IN INSURED'S NAME *(Complete only if the name has been legally changed.)*

FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE
SIGNATURE OF INSURED			DATE

ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM

THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY.

This is to certify that the following changes have been recorded in connection with the insurance for the above named insured.

☐ The BENEFICIARY has been changed ☐ The NAME of the BENEFICIARY has been changed ☐ New Employee

Recorded by _____ Date _____

FORWARD FORM TO PCHC Human Resources for RECORDING

Providence Community Health Centers

375 Allens Ave Providence, RI

Group LTD Election Form for Taxation of Benefits 2016

I certify that I have been given the option to irrevocably elect that my Disability premiums paid by my employer, ***PCHC*** should be added to my W-2 income for the upcoming tax year. This election is being made in reliance of Revenue Ruling 2004-55 which I received with this mailing.

I further certify that I understand the implications of this irrevocable election as it pertains to the taxation of my benefits should I become disabled. Specifically, if the premiums paid by my employer are added to my W-2 income I will be taxed on the premium paid for the year and furthermore, should I become disabled during the upcoming year the benefits I receive will be "tax free". If I do not make this election then the premiums paid by ***PCHC*** will not be taxed to me as income and should I become disabled during the upcoming year, the benefits received will be "taxable" as earned income.

I understand that this form does not constitute tax advice from my employer ***PCHC***, their insurance broker, ***bWell***, or the specific insurance carrier providing coverage.

I understand that the group disability coverage premiums may change from time to time and that any change in premiums will not invalidate or change this election during the upcoming year and that I will not be given an opportunity to change my election until December of 2016 for the following year.

Lastly, I understand that my election may affect other employment related taxes and/or retirement benefits that are based on taxable wages and income.

_____ I irrevocably elect and instruct ***PCHC*** to pay my disability premiums with post-tax dollars. (Non-Taxable Benefit)

_____ I irrevocably elect and instruct ***PCHC*** to pay my disability premiums with pre-tax dollars. (Taxable Benefit)

X_____ _____

Signature Print Name

_____ _____

Date Social Security Number

Blue Cross Blue Shield of Rhode Island

DECLARATION OF DOMESTIC PARTNERSHIP

Employee Name _____ Domestic Partner Name _____

Providence Community Health Centers
Group Name ("GROUP")(if applicable)

1. **Eligibility Certification.** By signing below, we hereby certify that we meet the following eligibility criteria:
   a. We are at least eighteen (18) years of age and are mentally competent to contract.
   b. Neither of us is married to anyone else.
   c. We are not related by blood to a degree which would prohibit marriage in our state of legal residence.
   d. We reside together and have resided together for at least one (1) year.
   e. We are financially interdependent and can demonstrate such interdependence by submitting the Required Documentation listed in paragraph 2 of this Declaration.

2. **Required Documentation.** We have included documentation to substantiate two (2) of the following items (check applicable items):
   - ❑ Notarized domestic partnership agreement or relationship contract.
   - ❑ Joint mortgage or joint ownership of primary residence.
   - ❑ Joint ownership of automobile. (Joint title or joint bill of sale accepted.)
   - ❑ Joint lease. Must be dated one (1) year prior to the request for coverage.
   - ❑ Joint checking, savings, or credit account. Must be dated one (1) year prior to the request for coverage.
   - ❑ The domestic partner has been designated as a beneficiary for the employee's will, retirement contract, or life insurance. Must be dated one (1) year prior to the request for coverage.

3. **Notice of Changes.** We agree to notify the GROUP if the status of this relationship changes, including termination of the relationship or our failure to meet the criteria outlined in paragraph 1 of this Declaration, no later than 30 days from the date of such change.

4. **Penalties for Misrepresentation.** We affirm the statements attested to in this Declaration are true and correct to the best of our knowledge. We understand that we are responsible for reimbursing the GROUP and/or BCBSRI for any expenses incurred as a result of any false or misleading statement contained in this Declaration, including but not limited to reimbursement for premiums and amounts paid in claims.

Under penalties of perjury, we certify that the foregoing representations are true, correct, and complete.

_____ _____
Employee Signature Domestic Partner Signature

_____ _____
Employee Name (Print) Domestic Partner Name (Print)

Blue Cross Blue Shield of Rhode Island

AFFIDAVIT OF COMMON LAW MARRIAGE

Employee Name _____ Common Law Spouse Name _____

Providence Community Health Centers
Group Name ("GROUP")(if applicable)

Date of Declaration of Common-Law Marrige _____

1. **Eligibility Certification.** By signing below, we hereby certify that we meet the following eligibility criteria:

   a. We are at least eighteen (18) years of age and are mentally competent to contract.
   b. Neither of us is married to anyone else.
   c. We are not related by blood to a degree which would prohibit marriage in our state of legal residence.
   d. We reside together.
   e. We are financially interdependent and can demonstrate such interdependence by submitting the Required Documentation listed in paragraph 2 of this Affidavit.

2. **Required Documentation.** We have included documentation to substantiate two (2) of the following items (check applicable items):

   ☐ Most recent signed Federal Tax Form indicating we are married. (Black out financial information and do not and do not include any schedules.)
   ☐ Notarized Common Law Marriage Agreement or Relationship Contract.[1]
   ☐ Joint mortgage or joint ownership of primary residence.
   ☐ Joint ownership of automobile. (Joint title or joint bill of sale accepted.)
   ☐ Joint lease.
   ☐ Joint checking, savings, credit account, or utility billing statement. Must be dated one (1) year prior to the request for coverage.
   ☐ The spouse has been designated as a beneficiary for the employee's will, retirement contract, or life insurance.

3. **Notice of Changes.** We agree to notify the GROUP if the status of this relationship changes, including termination of the relationship or our failure to meet any of the criteria outlined in paragraph 1 of this Affidavit, no later than 30 days from the date of such change.

4. **Penalties for Misrepresentation.** We affirm the statements attested to in thisAffidavit are true and correct to the best of our knowledge. We understand that we are responsible for reimbursing the GROUP and/or BCBSRI for any expenses incurred as a result of any false or misleading statement contained in this Affidavit, including but not limited to reimbursement for premiums and amounts paid in claims.

Under penalties of perjury, we certify that the foregoing representations are true, correct, and complete. We understand that by signing, we are attesting that we are married under Rhode Island law and have all the obligations and responsibilities of a marital relationship, and that only a divorce proceeding in Rhode Island state court can terminate the marital relationship and its obligations.

Employee Signature _____ Common Law Spouse Signature _____

Employee Name (Print) _____ Common Law Spouse Name (Print) _____

[1] Common Law Marriage Agreement or Relationship Contract means a written agreement which has been executed by the parties, and which at a minimum provides that each party is obligated to provide support for the other party, AND provides, in the event of the termination of the marital relationship, for equal division of any property acquired during the relationship.