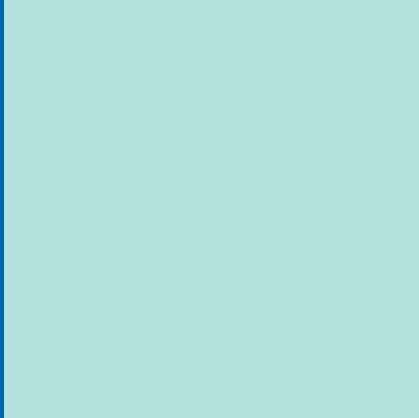


2009



Benefits Guidebook



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ABOUT THIS BENEFITS GUIDEBOOK

This Benefits Guidebook describes the highlights of the Trinitas Regional Medical Center Employee Benefits Plan in non-technical language. Your specific rights to benefits under this plan are governed solely, and in every respect, by the official documents and not the information contained within this Benefits Guidebook.

If there is any discrepancy between the descriptions of the plan elements in this Benefits Guidebook or other benefits enrollment materials you receive and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. Eligibility for any benefit plan is determined by applicable plan documents and policies. You should be aware that any and all elements of the Trinitas Regional Medical Center Employee Benefits Plan may be modified in the future to meet Internal Revenue Service rules or otherwise as determined by Trinitas Regional Medical Center.

This Benefits Guidebook may not be reproduced or redistributed in any form or by any means without express, prior permission, in writing from Trinitas Regional Medical Center.

W Welcome



We appreciate your commitment – to the people and communities we serve, as well as the overall success of Trinitas Regional Medical Center. We are proud to offer you and your family an Employee Benefits Plan that's valuable, flexible and competitive.

- ☑ It's **valuable** because it helps protect you and your family from financial hardship.
- ☑ It's **flexible** because it offers you a number of benefit choices, so you may select plan options based on your personal situation.
- ☑ It's **competitive** because it offers employees a wide range of benefits while keeping cost in mind.

Now it's time for you to learn about the Trinitas Regional Medical Center Employee Benefits Plan and enroll in the benefits that best meet your needs.

HOW TO PROCEED

This Benefits Guidebook will help familiarize you with the Trinitas Regional Medical Center Employee Benefits Plan. Carefully consider each benefit option, its cost and value to you and whether it meets your particular needs. At the back of this Benefits Guidebook is a step-by-step Decision Guide that outlines each step in the enrollment process. Please make sure that you submit your benefit elections on or before the enrollment deadline (call the Employee Benefits Service Center at 1-800-307-0230 if you have any questions about this deadline).

If you need any help along the way, please take advantage of the resources identified on the Contact Information page as they provide the best avenues for making informed benefit decisions.



Plan Notes

Plan Year

The Trinitas Regional Medical Center benefits plan year begins on January 1st and ends the following December 31st. This Benefits Guidebook outlines the benefits that apply to this plan year. **Please Note:** *The Flexible Spending Account benefit period runs from January 1st through March 15th of the following year.*

Eligibility

Generally, if you are a regular, full-time or part-time employee (see chart below), you are eligible to participate in the Trinitas Regional Medical Center Employee Benefits Plan on the first of the month following three continuous months of employment.

Benefits-Eligible Employees	
Employee Type	Description
Regular Full-Time Employee*	An employee who is budgeted to work at least 37.5 hours per week.
Regular Part-Time Employee	An employee who is budgeted to work at least 30 hours per week, but less than 37.5 hours.

***Please Note:** *Baylor nurses are considered regular full-time employees for benefit eligibility purposes.*

If you do not enroll in benefits within 31 calendar days of when you are initially eligible (as indicated above), you will not be able to enroll in benefits until the next annual open enrollment period unless you experience a Qualifying Life Event as outlined on page 3.

Dependent Coverage

In addition to electing coverage for yourself, you can elect to cover your eligible dependents. Your covered dependents include:

- Your legal spouse;
- Your same sex domestic partner (see below for specifics);
- Your unmarried dependent children who are 19 years of age or younger and;
- Your unmarried dependent children through the end of the calendar year in which they reach age 19 (or through the end of the month in which they marry);
- Your unmarried dependent children through the end of the calendar year in which they reach age 23 who are registered full-time students at an accredited learning institution (or through the end of the month in which they cease to be full-time students); and/or
- Your dependent children of any age who are mentally or physically disabled and dependent upon you for support.

Same sex domestic partners are eligible for Dental coverage through the Trinitas Regional Medical Center Employee Benefits Plan per New Jersey law. For more information regarding same sex domestic partner coverage, please contact the Human Resources Department. All other eligible dependents may be covered under the following benefits: Medical/Prescription, Dental and Flexible Spending Accounts.

Certifying Your Dependents

When covering a new dependent under the Trinitas Regional Medical Center Employee Benefits Plan, you must provide documentation that certifies the individual is your dependent and is eligible for coverage under the plan. To certify your **spouse**, please provide a copy of a *marriage license*. To certify **all other dependents**, please provide a copy of either a *birth certificate*, *adoption agreement* or *court order*.

If certification is not received within 30 days of your eligibility date, the dependent will then be removed from your coverage and any applicable payroll contributions will be returned to you.



Plan Notes

Employee Benefits Plan Details

The benefits provided through the Trinitas Regional Medical Center Employee Benefits Plan are divided into two categories: **1)** those in which you are automatically enrolled and **2)** those in which you have the option of enrolling.

If you meet the eligibility requirements, you will automatically be enrolled in the following benefits:

- Basic Life Insurance
- Basic Accidental Death & Dismemberment (AD&D) Insurance

These benefits are offered at no cost to you.

You are also given the option of enrolling in the following benefits:

- Medical/Prescription
- Flexible Spending Accounts
- Voluntary Long-Term Disability
- Dental (full-time employees only)
- Supplemental Life Insurance

When you enroll in these optional benefits, you either share a portion of the cost with Trinitas Regional Medical Center (Medical and Dental) or pay 100% of the benefit cost (Flexible Spending Accounts and Supplemental Life Insurance).

Changing Your Benefits (Qualifying Life Events)

The Internal Revenue Service (IRS) states that employees enrolled in pre-tax benefit plans may only make elections to these plans once a year. As such, your benefit choices for Medical/Prescription, Dental and Flexible Spending Accounts are binding through December 31st. The following special circumstances are the **ONLY** reasons you may change your benefits during the year:

- Marriage
- Birth, adoption or placement for adoption of an eligible child
- Divorce, legal separation or annulment
- Loss of spouse's job or change in work status where coverage is maintained through the spouse's plan
- A significant change in your health coverage or your spouse's health coverage attributable to your spouse's employment
- Death of spouse or dependent
- Loss of dependent status
- Employer-directed transfers to facilities where network benefits are not available
- Becoming eligible for Medicare or Medicaid during the year
- Receiving a Qualified Medical Child Support Order (QMCSO)

These special circumstances, often referred to as "Qualifying Life Events" or life event changes, will allow you to make plan changes any time during the year in which they occur. For any allowable changes, you must inform the Human Resources Department within 31 calendar days of the event. Changes that are requested due to a "change of mind" cannot be allowed until the next annual open enrollment period. For additional information concerning plan changes, please contact the Human Resources Department at 908-994-5741.

No Cost Benefits:

Basic Life Insurance
Basic AD&D Insurance

Pre-Tax Benefits:

Medical/Prescription
Dental
Flexible Spending
Accounts

Post-Tax Benefit:

Supplemental Life
Insurance
Voluntary Long-Term
Disability

The 31-calendar day deadline is a critical factor toward successfully completing a life event change. If you do not notify the Human Resources Department of the event and provide the requested documentation within 31 calendar days of the event, you will not be eligible to make changes until the next annual open enrollment period.



Medical Benefits

Medical insurance represents one of the largest components of the Trinitas Regional Medical Center Employee Benefits Plan. It is for this reason that we offer eligible employees a comprehensive Preferred Provider Organization (PPO) Plan through QualCare, which is designed to provide you and your family with access to quality, affordable health care. The QualCare PPO Plan is summarized below and on the pages that follow.

Plan Overview and Description

QualCare PPO Plan

The QualCare PPO Plan covers a wide variety of health care services and supplies from office visits to hospitalization and durable medical equipment. Each time you seek health care services, you are given the flexibility to choose from three levels of network access: Inner Circle, In-Network and Out-of-Network. In addition, you are not required to designate a Primary Care Physician (PCP) to coordinate your care. As a result, you may visit health care providers, including specialists, without obtaining a referral and coordinate your care based on your individual needs.

Please Note: *You will receive the highest benefit levels when you receive care through the Trinitas Regional Medical Center Inner Circle. If you choose to receive care from an in-network or out-of-network provider, your out-of-pocket costs will be higher.*

Network Access

The Inner Circle

The Trinitas Regional Medical Center Inner Circle allows you to receive care through the Medical Center's network of providers and health care facilities. You will get the most from your medical benefits by visiting Trinitas Regional Medical Center Inner Circle providers since you are not required to meet a deductible and most services are covered at 100% or require a minimal copay. In the event that a service is not available within the Trinitas Inner Circle, you will be reimbursed for that service at the in-network level, unless you obtain services on an out-of-network basis.

In-Network Services

The in-network component allows you to receive care from providers, hospitals and other health care facilities that are part of the QualCare network. When you visit a QualCare network physician, there will be a \$25 copay for each visit. The Plan pays 90% of the cost for most other health care services after you meet your deductible. Once your covered charges reach \$10,000 (in- and out-of-network combined), the Plan will pay 100% of the cost for the care you receive for the remainder of the plan year.

Out-of-Network Services

The out-of-network component provides medical plan participants with the freedom to receive care from any physician, hospital or health care facility of their choosing. However, when you receive care outside of the network, you are required to pay more out-of-pocket as the Plan pays 70% of the of the Plan's allowable charges once the annual deductible has been satisfied. Because out-of-network providers normally balance bill you for the difference between their charges and that which is paid for under your insurance plan(s), you are strongly encouraged to identify your out-of-pocket costs before utilizing an out-of-network provider when possible, to protect yourself from receiving a larger than expected bill.

Provider Network Access: Out-of-State Residents

Under the QualCare PPO Plan, Pennsylvania residents are given access to the Berkshire Health Partners network of providers payable at the in-network level of benefits. In addition, New York residents may receive benefits at the in-network level by visiting health care providers that are part of the New York Multiplan network.

Network:

An insurance company's group or list of approved or contracted providers from which you can obtain service at a higher benefit level than other non-participating providers.

Copay:

A per occurrence payment that is due at the time of service. An example would be an office visit copay when visiting a doctor's office.

Deductible:

The amount you pay toward medical expenses each year before the plan begins sharing costs with you for certain services. Not all services are subject to a deductible.



Medical Plan Summary

This chart summarizes the benefits provided under the QualCare PPO Plan. For more information, please refer to your Summary Plan Description.

Benefit Description	QualCare PPO Plan		
	Inner Circle Benefits	In-Network Benefits	Out-of-Network Benefits ¹
Deductible			
Individual	None	\$250	\$500
Family	None	\$500	\$1,000
Coinsurance (Plan Pays)	100%	90% after deductible	70% after deductible
Maximum Out-of-Pocket* <i>(Does not include deductibles, non-covered amounts, copays and pre-certification penalties)</i>		<i>Plan pays 100% once deductible is met and covered charges reach \$10,000.</i>	<i>Plan pays 100% once deductible is met and covered charges reach \$10,000.</i>
Individual	None	\$1,000	\$3,000
Family	None	\$2,000	\$6,000
Lifetime Maximum	\$2,000,000 – Inner Circle, In-Network and Out-of-Network combined		
PHYSICIAN SERVICES			
PCP or Specialist Office Visits	\$15 copay	\$25 copay	70% after deductible
Adult Wellness Exams	\$15 copay	\$25 copay	Not Covered
Well-Baby Care	\$15 copay	\$25 copay	Not Covered
Allergy Injections	\$15 copay	\$25 copay	70% after deductible
Maternity Care	\$15 copay for initial visit, then 100% coverage	\$25 copay for initial visit, then 100% coverage	70% of fee schedule after deductible
DIAGNOSTIC SERVICES			
Laboratory Procedures			
Wellness	Covered 100%	90%, deductible waived	Not Covered
Sick	Covered 100%	90% after deductible	70% after deductible
X-Ray Procedures			
Wellness	Covered 100%	90%, deductible waived	Not Covered
Sick	Covered 100%	90% after deductible	70% after deductible
EMERGENCY SERVICES			
Emergency Room***			
Facility Charges <i>(copay waived if admitted)</i>	\$35 copay	\$35 copay	\$35 copay
Physician Charges	Covered 100%	90% after deductible	70% after deductible
Ambulance	Covered 100%	90% after deductible	70% after deductible
HOSPITAL SERVICES			
Semi-Private Hospitalizations**	Covered 100%	\$300 per admission, then 90% coverage after deductible***	\$600 per admission, then 70% coverage after deductible ⁺
Inpatient Doctor Visits	Covered 100%	90% after deductible	70% after deductible
Outpatient/Same Day Surgery**	Covered 100%	90% after deductible	70% after deductible

¹Reimbursements to out-of-network providers are based upon the Plan Allowable Charges. Any out-of-network excess charges can be billed to the patient and will increase your out-of-pocket expenses.

*Maximum Out-of-Pocket for in-network and out-of-network providers is combined.

**Failure to pre-certify these services will result in a penalty of \$400 per occurrence.

***Per admission charge is waived if admitted for a true emergency or if service is not available at Trinitas Regional Medical Center.

⁺Per admission charge is waived if admitted for a true emergency or if service is not available at Trinitas Regional Medical Center or within the QualCare network.



Medical Plan Summary

This chart summarizes the benefits provided under the QualCare PPO Plan. For more information, please refer to your Summary Plan Description.

Benefit Description	QualCare PPO Plan		
	Inner Circle Benefits	In-Network Benefits	Out-of-Network Benefits ¹
Anesthesiologist Fees	Covered 100%	90% after deductible	70% after deductible
Surgeon Fees	Covered 100%	90% after deductible	70% after deductible
THERAPY SERVICES			
Speech Therapy**			
Hospital Based	Covered 100%	90% after deductible	70% after deductible
Office Based	\$15 copay	90% after deductible	70% after deductible
<i>\$1,000 maximum per calendar year combined</i>			
Physical Therapy**			
Hospital Based	Covered 100%	90% after deductible	70% after deductible
Office Based	\$15 copay	90% after deductible	70% after deductible
<i>50 visit maximum per calendar year combined</i>			
Occupational Therapy**			
Hospital Based	Covered 100%	90% after deductible	70% after deductible
Office Based	\$15 copay	90% after deductible	70% after deductible
<i>50 visit maximum per calendar year combined</i>			
Chiropractic Services	No Inner Circle Benefit	90% after deductible	70% after deductible
<i>\$1,000 maximum per calendar year combined</i>			
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES			
Inpatient Treatment/Partial Hospitalizations <i>(2 partial days = 1 inpatient day)</i>	Covered 100%	90% after deductible	70% after deductible
<i>30 day maximum per calendar year combined</i>			
Outpatient Services	\$25 copay, then 100% coverage	\$25 copay, then 100% coverage	70% after deductible
<i>60 day maximum per calendar year combined</i>			
OTHER SERVICES			
Vision Exam <i>(1 exam per calendar year)</i>	\$15 copay	\$25 copay	Not Covered
Optical Benefit	\$100 allowance every 24 months		
Extended Care/Skilled Nursing**	See Network Benefits	90% after deductible	70% after deductible
<i>60 day maximum per calendar year combined</i>			
Private Duty Nursing**	See Network Benefits	90% after deductible	70% after deductible
<i>\$25,000 maximum per calendar year combined</i>			
Home Health Care**	See Network Benefits	90% after deductible	70% after deductible
<i>60 visit maximum per calendar year</i>			
Hospice Care**	See Network Benefits	90% after deductible	70% after deductible
Durable Medical Equipment**	See Network Benefits	90% after deductible	70% after deductible
Prosthetics/Orthotics	Covered 100%	90% after deductible	70% after deductible

¹Reimbursements to out-of-network providers are based upon the Plan Allowable Charges. Any out-of-network excess charges can be billed to the patient and will increase your out-of-pocket expenses.

**Failure to pre-certify these services will result in a penalty of \$400 per occurrence.



Prescription Benefits

If you enroll in the QualCare PPO Plan, you will automatically be provided with prescription benefits. These prescription benefits are provided through Medco. Medco offers a network of more than 55,000 participating pharmacies throughout the United States, as well as convenient home delivery for up to 90-day supplies of medications.

The prescription benefits available to you are built around different pricing structures or “tiers” that enable you to control cost based on the types of medications you select (see “Generic vs. Preferred Brand vs. Non-Preferred Brand Medications” section). The copay amounts that you will be responsible for paying are indicated in the table below.

For more information on your prescription benefits, please visit the Medco website at www.medco.com. The website can help you manage your personal prescription drug program by providing you with access to tools that enable you to locate a pharmacy, order and track refills through Medco By Mail and much more.

Your Prescription Benefits – Provided through Medco		
Medication Type*	Retail Pharmacy (up to a 30-day supply)	Medco By Mail (up to a 90-day supply)
Generic	\$5 copay	\$10 copay
Preferred Brand	\$25 copay	\$50 copay
Non-Preferred Brand	\$40 copay	\$80 copay

*Coverage is not provided for contraceptives.

Medco By Mail (Home Delivery Service)

Medco By Mail offers participants an easy, convenient way to get prescription medications that are taken on an ongoing basis. This program offers valuable savings when ordering up to 90-day supplies of medications and eliminates trips to the pharmacy by delivering prescriptions right to your door.

If you would like more information on how to take advantage of the Medco By Mail program, please visit www.medco.com or call 1-800-633-2662.

Generic vs. Preferred Brand vs. Non-Preferred Brand Medications

Whether you obtain your prescriptions at a retail pharmacy or through Medco By Mail, you will be responsible for satisfying a copay that is based upon the medication type you select. **In all instances, your copay is the lowest when you select the generic version of a prescription medication.**

Preferred brand medications identified on the Medco formulary can be obtained at the next highest copay amount. The copays for preferred brand medications are lower than non-preferred brand medications because preferred brand medications have been selected by Medco for their clinical value and cost-effectiveness.

Choosing brand name medications that are not listed on the Medco formulary (i.e. non-preferred medications) result in the highest copay amount. Many of these drugs are covered under your prescription benefits, but will generally cost you the most.

To get the most from your prescription benefits, ask your doctor to prescribe generic medications whenever possible and use the Medco By Mail program to obtain up to a 90-day supply of medications that you take on an ongoing basis at the cost of only two copays.

Formulary:

A formulary is an insurance company’s list of approved prescription drugs. These are typically drugs that have been found to effectively treat most medical conditions at a reasonable cost. To obtain a currently formulary listing, please visit www.medco.com.



Dental Benefits

Good dental health is important to your overall well-being. At the same time, we all need different levels of dental treatment. Trinitas Regional Medical Center offers full-time employees and their eligible dependents two dental plan options.

Both dental plan options available to you cover four main types of dental expenses:

1. Preventive and Diagnostic Care
2. Basic Care
3. Major Care
4. Orthodontia

The plans differ in how they provide access to care and how they share costs with you. The descriptions below and the Dental Plan Summary on the following page provide further explanations of how each plan works and pays benefits.

Option 1 – Aetna DMO Plan

The Aetna DMO Plan provides benefits when a participating dentist performs covered dental services. If you enroll in this plan you will be required to select a Primary Care Dentist (PCD) that will be responsible for coordinating all of your dental care. This plan does not include coverage for care and services obtained outside of the Aetna network.

Option 2 – Delta Dental PPO Plan

The Delta Dental PPO Plus Premier Plan features a participating provider component and a non-participating provider component. The participating provider component lets participants receive care from dentists who participate in the Delta Dental PPO network. In addition, when eligible patients are treated by a Delta Dental Premier dentist who does not participate in the Delta Dental PPO program or by a participating specialist, the provider has agreed not to charge eligible patients more than their filed fee or Delta Dental's established UCR for the procedure. You will get the most from your dental benefits and incur the least out-of-pocket expenses by selecting a participating provider from the Delta Dental networks.

Which Dental Plan is Right for You?

Before you decide, consider the following:

- ☑ **Your commitment to preventive dental care** – Both the Aetna DMO Plan and the Delta Dental PPO Plan pay the full cost of routine care.
- ☑ **Your dental care needs** – How often do you and members of your family visit the dentist? What type of dental services do you typically require? While both dental plans provide coverage for the same types of procedures the amount each plan pays for services differs.
- ☑ **Your desire to visit the dentist of your choice** – With the Aetna DMO Plan, you must visit a participating dentist and be accepted on their panel (some dentists do not accept new patients) to receive benefits. With the Delta Dental PPO Plan benefits are available regardless of whether or not you visit a participating provider.

Compare the costs and coverage provided under each plan, check out the provider networks and then decide what makes sense for your situation.



Dental Plan Summary

This chart summarizes the benefits provided under each dental plan option. For more information, please refer to your Summary Plan Description.

General Questions	Aetna DMO Plan	Delta Dental PPO Plan	
	Participating Providers ONLY	Participating Providers (PPO/Premier)	Non-Participating Providers
Where can I go to receive benefits?	An Aetna DMO network dentist	A Delta Dental PPO or Premier network dentist	Any Licensed Dentist
Do I have to choose a Primary Care Dentist (PCD)?	YES	NO	NO

If you enroll in the Aetna DMO Plan, you and each covered family member must select a PCD. **This choice must be made at the time of enrollment.** If you wish to change your PCD in the future, you may call Aetna Member Services (see "Contact Information" page).

Benefit Description	Aetna DMO Plan	Delta Dental PPO Plan		
	Participating Providers ONLY	Participating Providers		Non-Participating Providers ³
		PPO Network ¹	Premier Network ²	
Calendar Year Deductible				
Individual	None	\$50	\$50	\$50
Family	None	\$150	\$150	\$150
Calendar Year Maximum (per person)	None	\$1,500	\$1,500	\$1,500
Calendar Year Maximum Carryover	Not Applicable	25% of unused maximum up to \$500	25% of unused maximum up to \$500	25% of unused maximum up to \$500
Preventive & Diagnostic Care – Includes exams, cleanings, x-rays, fluoride treatments and space maintainers	Covered 100%	Covered 100%, deductible waived	Covered 100%, deductible waived	Covered 100%, deductible waived
Basic Care – Includes fillings, extractions, oral surgery, endodontics, periodontics and sealants	Covered 100%	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Major Care – Includes crowns, crown-related procedures, bridgework, full and partial dentures, repair of dentures and inlays/onlays	Covered 50%	Covered 50% after deductible	Covered 50% after deductible	Covered 50% after deductible
Orthodontia* Dependent children under age 20	Covered 50%, no deductible	Covered 50%, no deductible	Covered 50%, no deductible	Covered 50%, no deductible
Orthodontia Lifetime Maximum Dependent children under age 20	None	\$1,500	\$1,500	\$1,500

¹Delta Dental PPO dentists are paid up to the Delta Dental PPO Maximum Plan Allowance.

²Delta Dental Premier dentists are paid up to the Delta Dental PPO Maximum Plan Allowance. The dentist can bill you the difference between the Delta Dental PPO Maximum Plan Allowance and the Delta Dental Premier Maximum Plan Allowance.

³For eligible services provided by a non-participating dentist, Delta reimburses the dentist up to the Delta Dental PPO Maximum Plan Allowance. The non-participating provider can then bill you the difference between Delta's reimbursement and his/her actual charge.

*Orthodontia treatment is a benefit limited to once a lifetime under the Delta Dental PPO Plan.



Flexible Spending Accounts

Why Use a Flexible Spending Account?

Trinitas Regional Medical Center lets you redirect a portion of your pay, through payroll deduction, into Flexible Spending Accounts (FSAs) administered by CONEXIS. The money that goes into your FSA is deducted from your pay on a pre-tax basis (before Federal and Social Security taxes are calculated). Because you do not pay these taxes on money that goes into your FSA, you decrease your taxable income and potentially increase your spendable income.

Each pay period money accumulates in your FSA. With a Health Care FSA, you can be reimbursed up to the total annual contribution amount you have elected regardless of your account balance. You can begin to use all or some of the total amount you elected as soon as the plan year begins. With a Dependent Care FSA, your expenses are reimbursed based on the availability of funds in your account.

How much money should you put into an FSA each pay period? That depends on your expenses. The best way to estimate your expenses for the year is by looking over the eligible expenses you incurred over the past few years. Divide the total predictable expenses by the number of pay periods in the year. The resulting number represents the amount you should consider contributing each pay period to an FSA. For additional assistance determining your FSA contribution amount, please visit www.conexis.org and use the Online Savings Calculator. It is important to estimate carefully. **If there is any money remaining in your FSA after March 31st, federal law requires you to forfeit the balance.**

FSA Year-End Grace Period

As an FSA participant, the window of time during which you can incur qualified expenses that can be reimbursed through an FSA extends from January 1st through the following March 15th (14 months and 15 days). You have until March 31st to submit claims for eligible expenses incurred on or before March 15th of the current benefit period.

Savings Example*

By anticipating your family's health care and dependent care costs for the year, you can actually lower your taxable income and potentially increase your spendable income. Here's an example:

	FSA	No FSA
Annual Taxable Income	\$35,000	\$35,000
Out-of-Pocket Expenses:		
<i>Health Care</i>	\$1,000	\$0
<i>Dependent Care</i>	\$2,500	\$0
Total Pre-Tax FSA Contribution	(\$3,500)	\$0
Taxable Income After FSA Contribution	\$31,500	\$35,000
Federal & State Income & Social Security Taxes (40%)	(\$12,600)	(\$14,000)
After-tax Income	\$18,900	\$21,000
After-tax Dollars Spent on Health & Dependent Care Expenses	\$0	\$3,500
Take-home Pay	\$18,900	\$17,500
Increased Take-home Pay	\$1,400	\$0

*This example is intended to demonstrate typical tax savings based on a total income tax rate of 40%. Actual savings is based on individual tax situations.

FSA Fact

You **cannot** change the amount you contribute to an FSA in the middle of a plan year unless you experience a Qualifying Life Event. If there is any money remaining in your FSA at the end of the plan year, federal law requires you to forfeit the balance.

Calculate Your Savings

To calculate your specific annual savings by participating in an FSA, log on to the CONEXIS website at www.conexis.org and use the **Online Savings Calculator**.



Flexible Spending Accounts

Health Care FSA

A Health Care FSA provides you with the ability to save money on a pre-tax basis for any IRS-allowed health expenses not covered by your health care coverage. These expenses include, but are not limited to, deductibles, copayments, coinsurance payments, routine physicals, uninsured dental expenses, qualified over-the-counter drug costs, vision care expenses (e.g. eyeglasses or contact lenses), hearing care expenses (e.g. a hearing exam or a hearing aid) and orthodontia expenses.

The maximum annual amount you can deposit into a Health Care FSA is \$3,000; the minimum annual contribution is \$300.

EXPENSE WORKSHEET

Use the space provided at right to estimate your annual expenses that qualify for reimbursement through a Health Care FSA.

Deductibles and/or copayments	\$ _____
Over-the-counter drugs (antacids, allergy, pain, cold medications)	\$ _____
Non-reimbursed physician, dental, prescription services	\$ _____
Vision services and eyewear	\$ _____
Prescription copayments	\$ _____
Total Estimated Health Care Expenses	\$ _____

Dependent Care FSA

A Dependent Care FSA provides you with the ability to set aside money on a pre-tax basis for day care expenses for your child, disabled parent or spouse. Generally, expenses will qualify for reimbursement if they are the result of care for:

- your children, under the age of 13, for whom you are entitled to a personal exemption on your Federal income tax return; and
- your spouse or other dependents, including parents, who are physically or mentally incapable of self-care.

The maximum annual amount you can deposit into a Dependent Care FSA is \$5,000; the minimum annual contribution is \$500.

EXPENSE WORKSHEET

Use the space provided at right to estimate your annual expenses that qualify for reimbursement through a Dependent Care FSA.

Dependent care provider inside and outside the home	\$ _____
Elder care center	\$ _____
Nursery school or day care center	\$ _____
Total Estimated Dependent Care Expenses	\$ _____

Please Note: Any amount deducted in excess of the IRS maximum of \$5,000 (single or married and filing jointly) or \$2,500 (married and filing individually) will be considered taxable income.

Please keep in mind that you may be able to take a federal tax credit for eligible dependent care expenses up to \$3,000 (for one dependent) or \$6,000 (for more than one dependent). The credit can equal 35% of the expenses, reduced by one percentage point (but not below 20%) for each \$2,000 (or fraction) by which your adjusted gross income exceeds \$15,000. Any amounts deferred to a Dependent Care FSA will reduce, dollar-for-dollar, the maximum allowable expense under the tax credit. You should consult your personal tax advisor if you think you may be eligible for this tax credit.



Flexible Spending Accounts

Choose the Smart Way to Pay!

The Flex Convenience Debit Card provides participants with the following benefits:

- ☑ Instant access to FSA funds (no need to use dollars out of your own pocket)
- ☑ Virtually eliminates claim forms
- ☑ No more paying up front and waiting for reimbursement checks
- ☑ Health Care and Dependent Care funds can be accessed through a single card
- ☑ Account balances may be viewed 24 hours a day online at www.conexis.org.

Flex Convenience Debit Card

The Flex Convenience Debit Card makes using your flex dollars even easier. However, the Flex Convenience Debit Card may only be used at health care providers who have a health care-related merchant category code (such as physicians, dentists, vision care offices, hospital, pharmacies and other medical care providers) or at grocery stores and discount stores who utilize an Inventory Information Approval System (IIAS). Using your Flex Convenience Debit Card eliminates the need to pay cash up front and then wait for reimbursement.

How It Works

When you enroll in an FSA, your pre-tax funds are loaded into your account. With a Health Care FSA, you may access your total annual contribution amount. However, with a Dependent Care FSA, you are only given access to your current account balance. Your Flex Convenience Debit Card can be used immediately to pay for qualifying expenses. Funds are deducted directly from your account. Purchases that exceed the available funds in your account will be denied. In these instances you will have to use another form of payment for the product or service and then submit a claim form to receive reimbursement for the expense.

The Flex Convenience Debit Card is similar to a credit card in that you always select “Credit” and sign for purchases. Your card does not require a PIN and you cannot withdraw cash. If the merchant or service provider does not utilize an Inventory Information Approval System (IIAS), you will need to use another form of payment and submit a claim for reimbursement.

IMPORTANT: ALWAYS SAVE YOUR RECEIPTS

Whenever you incur an eligible health care or dependent care expense, you should always save your receipt and keep it in a safe place, even when you use your Flex Convenience Debit Card. If the debit card purchase cannot be automatically identified at the point-of-sale, you will receive a letter requesting the receipt. For merchants that have implemented an Inventory Information Approval System (IIAS), all eligible health care items can be automatically identified at the point-of-sale. This means that you will have to submit fewer receipts for pharmacy and over-the-counter purchases made from these merchants or service providers.

Submitting Paper Claims

When not using the Flex Convenience Debit Card, you must submit a claim in order to be reimbursed for the qualifying expenses incurred. To submit a claim, complete a claim form and submit it along with proof-of-expense documentation to CONEXIS.

Claim documents can be submitted using one of these convenient methods:

- ☑ **ONLINE** – Submit your claims for reimbursement online at www.conexis.org.
- ☑ **FAX** – Submit your claims to CONEXIS at 1-888-866-3312.
- ☑ **MAIL** – Mail your claims to CONEXIS Cafeteria Plan Services • P.O. Box 227197 • Dallas, TX 75222.

Upon receipt, CONEXIS will review your reimbursement claim form and quickly process it for payment. Claims are paid out on a daily basis. Reimbursements will be made directly to you.



Flexible Spending Accounts

Online Account Access

Through the CONEXIS website, you will have instant access to real-time account information 24 hours a day, 365 days a year. By registering online at www.conexis.org, you will be able to:

- Check the status of a claim;
- View your account history;
- Ask questions online via email;
- and much more!

What Expenses Qualify Under A Health Care FSA?

Health care expenses covered by your FSA include:

- Ambulance hire
- Artificial limbs and teeth
- Automobile modification (hand controls, special equipment, mechanical lifts)
- Braille books & magazines
- Contact lenses & solutions
- Crutches/slings
- Doctor copays
- Eyeglasses
- Halfway house residency
- Hearing devices
- Hospital bills
- Iron lungs, operating cost
- Laetrile, when prescribed by doctor
- Laser eye surgery
- Lifetime care at medical facility
- Over-the-counter medications (only IRS-eligible items)
- Nursing care
- Obstetrical expenses
- Oxygen equipment
- Prescription Drugs
- Rental of medical or healing equipment (requires doctor's note)
- Special education
- Special television that provides hearing impaired individuals with display of audio portion of television programs
- Telephones for the hearing impaired
- Transportation expense relative to illness (including doctor's visit)
- X-rays

Fees paid to the following providers, when accompanied by an authorized referral as treatment for a specific disease:

- | | | |
|--|--|---|
| - Acupuncture | - Gynecologist | - Osteopath |
| - Chiroprapist (expense) | - Hospital | - Pediatrician |
| - Chiropractor | - Laboratory | - Physician |
| - Christian Science practitioner office visits | - Lip reading lessons for the hearing impaired | - Physiotherapist |
| - Clinic | - Midwife | - Podiatrist |
| - Dentist | - Nurse | - Practical Nurse |
| - Diagnosis | - Obstetrician | - Psychiatrist |
| - Diathermy | - Oculist | - Psychoanalyst |
| - Doctor | - Operation | - Psychologist |
| - Examination, physical | - Ophthalmologist | - Psychopathologist |
| - Eye examination | - Optician | - Sanitarium |
| - Family counseling | - Optometrist | - Specialist |
| - (no marriage counseling) | - Oral | - Surgeon (when prescribed as treatment for a specific disease) |

What Expenses Qualify Under A Dependent Care FSA?

To qualify as an expense under a Dependent Care FSA, the expense must be related to dependent care that enables an individual or married couple to remain gainfully employed or look for work. If married, your spouse must work or be a full-time student. Some examples of qualified expenses are:

- **Care of a dependent child** under the age of 13 by babysitters, nursery schools, pre-school or day care centers.
- **Care for any member of your household who is physically or mentally incapable of caring for him/herself** and for whom you can claim an exemption.
- **Care for an elderly dependent family member** who lives with you and qualifies as a tax dependent.



Life/AD&D & Disability Benefits

Life/Accidental Death and Dismemberment (AD&D) and Disability benefits are important parts of your financial security, especially if others depend on you for support. That's why Trinitas Regional Medical Center provides you with Basic Life/AD&D Insurance at no cost. You are also given the option of enrolling in Supplemental Life Insurance and Voluntary Long-Term Disability benefits if additional coverage is needed to meet your personal financial and security needs.

AD&D Insurance

This insurance is similar to regular life insurance. If you die in an accident – for example a car accident – the amount of coverage you receive is paid to your beneficiary. However, AD&D Insurance also pays a benefit if you are seriously injured in an accident. Part of your benefit may be paid to you if you lose a limb, or the ability to see, hear or talk. **For more information, please refer to the Aetna Certificate of Coverage.**

Definition of Disability

You are considered to be disabled if because of a covered injury or illness you are unable to perform all of the material duties of your regular occupation or a qualified alternative. After 24 months you are considered disabled if you are unable to perform the material duties of any occupation for which you are or may suitably become qualified for.

Basic Life/AD&D Insurance

Eligible full-time and part-time employees are provided with Basic Life/AD&D Insurance in an amount that is based upon job classification. For specific details regarding your Basic Life/AD&D coverage amount, please contact the Human Resources Department at 908-994-5325. **This coverage is provided at no cost to you by Trinitas Regional Medical Center and is insured by Aetna.**

Supplemental Life Insurance

If you need additional protection beyond the Basic Life/AD&D Insurance provided to you at no cost, you may purchase Supplemental Life Insurance for yourself through Aetna. Coverage can be elected in increments of salary (1x - 5x) to a maximum of \$1 million (Basic and Supplemental coverage combined). If you elect Supplemental Life Insurance, you are responsible for paying 100% of the benefit cost and deductions will be taken from your paycheck in after-tax dollars.

Evidence of Insurability

Evidence of Insurability (EOI) is an insurance company requirement that is satisfied by completing a form supplied by Aetna and answering any questions that may be presented to you. EOI applies in the following situations:

1. If you request more than the Guaranteed Issue amount, which is the lesser of one times (1x) your base annual salary or \$200,000, when initially eligible (within 31 days of initial eligibility date);
2. On all Supplemental Life Insurance purchases, regardless of amount, when requested outside of the initial eligibility period (late entrants); and
3. On all incremental increases to Supplemental Life Insurance coverage during future open enrollments that are greater than one multiple of base annual salary or \$200,000 (e.g. 1x salary to 3x salary).

Supplemental Life Insurance purchase amounts requiring EOI do not become effective, and therefore are not deducted from your paycheck, until approval is obtained from Aetna.

Voluntary Long-Term Disability

Eligible full-time and part-time employees may enroll in Voluntary Long-Term Disability coverage. If you remain disabled for 180 consecutive calendar days due to any one disabling accident or illness, you will be eligible to apply for Long-Term Disability benefits. This coverage provides income replacement that normally equals 60% of your monthly covered earnings up to a maximum of \$10,000 per month. Once you qualify for benefits under this plan, you will continue to receive coverage until the end of the benefit period or until you no longer qualify for benefits, whichever comes first.

If you elect Voluntary Long-Term Disability coverage, you will be responsible for paying 100% of the benefit cost. Any benefits you receive from this plan would be exempt from taxes (i.e. tax-free) since you pay for this coverage using after-tax dollars. If you are a Leadership Council member, your salary will be grossed up to provide for a tax-free benefit. Your Voluntary Long-Term Disability coverage is insured by CIGNA.

Please Note: Your Voluntary Long-Term Disability coverage also works with other sources of coverage to replace a certain percentage of your earnings. As a result, the disability benefits you receive from this plan will be reduced by any benefits you are eligible to receive from Social Security, Workers' Compensation, Retirement Benefits or any other disability coverage to which you are entitled.



Paid Time Off/Tuition Benefits

Paid Time Off

At Trinitas Regional Medical Center we recognize the importance of helping you balance your professional life with your personal responsibilities. To that end, our Paid Time Off (PTO) Program provides a flexible system designed to support your individual needs and effectively manage your time away from work by combining personal, sick and vacation days into one total time off pool.

All regular full-time and part-time benefits-eligible employees, with budgeted scheduled hours of 30 or more per week, are eligible to receive PTO. The amount of PTO you are eligible to receive is determined by your job classification (i.e. PTO Group), date of hire and scheduled budgeted hours per week.

Current employees will be advanced their annual allowance of PTO hours with their first paycheck of the payroll year. Newly hired employees will receive a prorated PTO allowance for use during the current payroll year after they have completed three months of continuous employment with Trinitas Regional Medical Center. Your available PTO hours are reflected on your bi-weekly payroll stub.

All employees must use their PTO by the end of the last pay period of the payroll year. There is no PTO carryover from one payroll year to the next payroll year. If you are a full-time employee only, any remaining PTO as of the last day of the last pay period of the year will be transferred to your IPP bank for the forthcoming payroll year only. Part-time employees will forfeit any time not taken.

Income Protection Plan (IPP)

The Income Protection Plan (IPP) provides a specific amount of income replacement for full-time employees. When you suffer an illness or injury that keeps you from performing your regular job duties for more than five (5) consecutive work days, you will be eligible to continue your salary through the IPP. At the start of each year, you will be eligible for a specific amount of income replacement based on your job title and your years of service at Trinitas Regional Medical Center.

Holidays

Full-time and part-time employees, with budgeted scheduled hours of 30 or more per week, are paid for the following holidays: New Years Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas.

Tuition Reimbursement

Regular full-time employees who have worked a minimum of three months before the course(s) commence will be reimbursed 100% of tuition (excluding registration and laboratory fees, books and incidental expenses) to a maximum of \$2,500 per calendar year (January 1- December 31).

Course of study must be job-related or in the health care field. A completed tuition reimbursement application form must be submitted to the Human Resources Department with required signatures before the beginning of the courses. After completion of the course(s), passing grades and an itemized receipt must be submitted to the Human Resources Department for reimbursement.

Full-time employees and students graduating from Sisters of Charity nursing schools who matriculate in the College of St. Elizabeth undergraduate degree programs receive a 50% tuition reduction. The College of St. Elizabeth also extends a special 50% tuition reduction to full-time employees of Sisters of Charity of St. Elizabeth health care institutions, who are enrolled at the College of St. Elizabeth taking Graduate courses leading to a Master of Science in Health Care Management degree or an Executive Certificate in Health Care Management.

529 College Savings Plan

A 529 Savings Plan is an education savings plan that helps families set aside funds for future college costs. For more information on saving for your child's college education contact the following:

Fidelity Investments:

1-800-605-9984

Vanguard:

1-866-734-4530

NJ Best 529 College Savings Plan:

1-877-465-2378



Retirement Benefits/Employee Contributions

Trinitas Regional Medical Center Savings and Retirement Plan

Trinitas Regional Medical Center realizes the importance of saving towards retirement and has established a Savings and Retirement Plan to assist you. This plan allows you to use tax-deferred money to save for your retirement while earning interest and receiving free money through the employer match.

Catch-Up Contribution

If you are age 50 or over and have reached the annual IRS benefit maximum contribution limit for the year, you may make an additional deferral contribution to the plan up to the IRS Catch-Up Provision Limit.

All employees who are 21 years of age who have completed one year of service and worked a minimum of 1,000 hours during that year are eligible to participate in the Trinitas Regional Medical Center Savings and Retirement Plan. Through automatic payroll deduction, you may contribute a percentage of your salary (up to 50%) to the Trinitas Regional Medical Center Savings and Retirement Plan up to the annual IRS benefit maximum. Highly compensated employees will be limited in their contributions in accordance with IRS regulations. Trinitas Regional Medical Center will match 50% of your contributions up to 6% of your annual salary.

Both employee and employer contributions are immediately 100% vested if you were hired prior to April 1, 2003. If you were hire after April 1, 2003 employer matching contributions will be 100% vested upon the completion of six years of employment.

There are a variety of investment options available through the Trinitas Regional Medical Center Savings and Retirement Plan. For a complete listing of investment options, fund performance and prospectus information, please visit Fidelity NetBenefits® at www.fidelity.com/atwork or call a Fidelity Retirement Specialist at 1-800-343-0860.

403(b) Tax Sheltered Annuity

This voluntary program allows employees to save for retirement with pre-tax income through a convenient payroll deduction. Employees may contribute up to the lesser of 20% of their salary or the IRS maximum. This benefit is available after three (3) months of employment.

2009 Bi-Weekly Employee Contributions

Your medical and dental plan options, coverage levels and corresponding bi-weekly employee contributions are listed below.

2009 Medical Contributions – QualCare PPO Plan

Full-Time Employees			Part-Time Employees		
Coverage Level	Annual Salary Less Than \$50,000	Annual Salary \$50,000 or Greater	Coverage Level	Annual Salary Less Than \$50,000	Annual Salary \$50,000 or Greater
Self	\$20.00	\$30.00	Self	\$40.00	\$50.00
Self + One	\$30.00	\$40.00	Self + One	\$65.00	\$75.00
Self + Two or More	\$40.00	\$50.00	Self + Two or More	\$90.00	\$100.00

2009 Dental Contributions

Full-Time Employees

Coverage Level	Delta Dental PPO Plus Premier Plan	Aetna DMO Plan
Self	\$5.00	\$2.50
Self + One	\$7.50	\$5.00
Self + Two or More	\$10.00	\$7.50



Other Benefits

Long-Term Care Insurance Eligibility

An eligible employee is defined as age 18-64, actively at work and scheduled to work at least 30 hours per week. To qualify for simplified underwriting, you must apply for coverage within 60 days of your eligibility date. Full underwriting applies to employees age 18-64 who do not apply for coverage within 60 days and all employees over age 64.

Group Legal Services Highlights

- ☑ Provides common legal services you require at an amount you can afford.
- ☑ Covers you and your family members.
- ☑ Ensures complete confidentiality between yourself and plan attorneys.

Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential, professional counseling and referral service available to employees and their families at no cost. The EAP provides up to three face-to-face visits with a counselor at no charge when you visit a Trinitas EAP provider. **Keep in mind that any help you receive through the EAP is strictly confidential.** For more information on the EAP, please call 908-994-7286 or 908-994-7092.

Long-Term Care Insurance

Long-Term Care Insurance is no longer a benefit exclusively for the elderly. You or a loved one could require long-term care in your home or elsewhere as a result of a disabling disease or serious accident or illness – situations that could happen at any age, regardless of your prior health. Long-Term Care Insurance is specifically designed to help protect you, your family, your assets and your lifestyle from the potential high costs associated with long-term care. If interested, please contact William S. Oakes at John Hancock at 973-716-7510.

Group Legal Services

All eligible employees have the option to enroll in the Pre-Paid Legal Services Plan with Identity Theft ShieldSM. This voluntary plan provides employees and their families with access to high-quality attorneys and legal services at discounted rates or no direct cost at all (other than your per pay contribution). Plan benefits emphasize preventive legal care to help keep minor legal problems from becoming serious or financially devastating.

In addition, with Identity Theft ShieldSM, experts will regularly monitor your credit report to prevent and detect identity theft issues. If identity theft is committed against you, Pre-Paid Legal Services will help restore your identity and protect it against future violation.

You must utilize the network of attorneys available under this plan in order to receive benefits. For those who enroll, a membership kit will be mailed to your home that contains information about how to access attorneys and the benefits available to you. For more information regarding the Pre-Paid Legal Services Plan with Identity Theft ShieldSM, please call 732-735-3961.

New Jersey Manufacturer's Insurance Company

A benefit of your employment at Trinitas Regional Medical Center is the ability to apply for auto, homeowners and renters insurance with New Jersey Manufacturer's Insurance Company. Through group purchasing, you will receive discounted premiums on these policies. For more information on this benefit, please call 1-800-232-6600.

Travelers Insurance Company

As an employee of Trinitas Regional Medical Center, you will receive discounted rates on auto and homeowners insurance policies through Travelers Insurance Company. You have the flexibility of paying for your premiums several different ways – through payroll deduction, electronic fund transfer, mortgage escrow or direct bill. This is a strictly voluntary program. To request a free, no obligations quote, please call 1-888-642-6650.

Atlantic Federal Credit Union

Upon hire, all employees are eligible to have voluntary payroll deductions deposited into a Checking Account, Savings Account, Christmas Club and/or Vacation Club. You can learn more about the Atlantic Federal Credit Union by calling 908-994-5900.

Wachovia At Work Program

This program allows members to receive preferred pricing on a range of banking and financial services, including but not limited to, free on-site ATM services, select checking accounts, brokerage services, loans, mortgages and financial planning. To learn more about this program call 1-888-353-7375.



Decision Guide

You've reviewed your benefit plan options and made your choices. Now take a moment to wrap up the enrollment process by completing the steps below.

Step 1 – Make Your Medical and Dental Benefit Elections

Before you do, have you considered what levels of coverage are best for you? Think about the expenses that you and your family had in the past year. Do you need the higher level of protection? Do your doctors participate in your plans of choice? Does your spouse have available coverage? You may be better off waiving one or more of these coverages and picking them up under your spouse's plan.

Step 2 – Make Your Flexible Spending Account (FSA) Elections

Consider the pre-tax benefits associated with using a Health Care and/or Dependent Care FSA to pay for your ongoing expenses that qualify for reimbursement. While using an FSA can be very beneficial, it does require careful advanced planning.

Step 3 – Make Your Life/AD&D Insurance and Disability Benefit Elections

After reviewing your options, stop and consider how much money your family would need to cover your financial obligations if something should happen to you. Think of things like rent or mortgage payments, college tuition and regular day-to-day living expenses. How much coverage do you have elsewhere? Remember to consider all sources of protection you have available.

Step 4 – Consider Your Additional Benefit Options

Think about the value of enrolling in the Trinitas Regional Medical Center Savings and Retirement Plan, 403(b) Tax Shelter Annuity, Group Legal Services, Long-Term Care Insurance and many of the other benefits offered by Trinitas Regional Medical Center.

Step 5 – Double-Check Your Elections

Double-check your benefit elections, making sure they accurately reflect the benefits you wish to maintain throughout the plan year.

Step 6 – Submit Your Benefit Elections

Once you have decided what benefit options best meets your needs, you may submit your benefit elections to the Employee Benefits Service Center:

- online at www.mytrinitasbenefits.org;
- via fax at 1-866-406-6946; or
- via mail using the postage-paid envelope provided.

If you submit an enrollment form, please sign and date your enrollment form make a copy of it for your records. **You must submit your benefit elections within the required timeframe (call 1-800-307-0230 if you are not sure when your elections are due).**

Step 7 – Confirm Your Benefit Elections

When enrolling online, a confirmation statement will automatically be generated when you submit your benefit elections. It is recommended that you print a copy of this statement and keep it for your records. In addition, all employees will receive a paper confirmation statement at their home address once the Employee Benefits Service Center processes all enrollments. Check your confirmation statement for accuracy, and follow the instructions included with the statement to report any necessary corrections.

Benefit Questions

If you have questions regarding your benefit options please contact the Human Resources Department at 908-994-5325.

Enrollment Questions

If need assistance completing your enrollment form or submitting your benefit elections online, please contact the Employee Benefits Service Center at 1-800-307-0230.



Your Plan Rights

Trinitas Regional Medical Center is required to provide you certain protections administered by the Internal Revenue Service and the United States Department of Labor. This Flexible Benefits Plan is classified by the Department of Labor as a “welfare plan” and by the IRS as a “specified fringe benefit plan” under IRC s.6039(D). This plan is also governed by Internal Revenue Code Section 125. Plan participants are entitled to certain protections and directions for recourse in the event of mistreatment by the Plan, its sponsor or administrator. Since these protections are essentially the same as federal law, this statement of rights is published here for your information.

The Employer Identification Number assigned to Trinitas Regional Medical Center is 22-3601678 The ERISA number for this group is 501. You should refer to these numbers in any correspondence about the Plan.

Statement of Plan Rights

Trinitas Regional Medical Center is designated as the Administrator in connection with claims processed under the Plan. Such claim matters may be served by directing the process to the Plan Administrator at Trinitas Regional Medical Center • 18 South Broad Street • Elizabeth, NJ 07207.

The Internal Revenue Code and specific Department of Labor Regulations were enacted to help assure that all employer-sponsored group benefit programs conform to standards set by Congress. An employee who is a participant in all benefit plans is entitled to certain rights and protections under federal law, which provides that all participants will be entitled to (1) examine, without charge, at the Benefits Office, all Plan documents and copies of all Plan documents and other Plan information upon written request to the Human Resources Department, subject to a reasonable charge for the copies; and (2) receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. Plan records are kept on a plan year basis.

In addition to creating rights for Plan participants, federal law imposes duties upon those responsible for the operation of a Plan who are called “fiduciaries” and who have a duty to operate the Plan prudently and in the interest of participants and beneficiaries. If a claim for a benefit under a Plan is denied in whole or in part, the claimant must receive a written explanation of a reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under federal law, there are steps an employee covered under a Plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if an employee covered under a Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the claimant is successful, the court may order the Employer to pay these costs and fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If an employee covered under a Plan has any questions about the Plan, the employee should contact the Benefits Department. If an employee has any questions about this statement of the employee’s rights under Federal law, the employee should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Please refer to your plan document for a full explanation of your plan rights.



Important Federal Laws

Mental Health Parity Act of 1996 (MHPA)

The MHPA requires Trinitas Regional Medical Center to satisfy new minimum standards regarding mental health benefits. The new standards require parity between mental health benefits and other health benefits with respect to lifetime and annual dollar limits. Thus, Trinitas Regional Medical Center medical plans offer coverage for both medical/surgical benefits and mental health benefits, but cannot impose different lifetime or annual dollar limits on the two classes of benefits the plan can reimburse.

Newborn & Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife or physician's assistant) after consultation with the mother, discharges the mother or newborn earlier. Plans and issuers may not select the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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

Women's Health & Cancer Rights Act

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

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

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

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

HIPAA requires that you be informed of your Special Enrollment rights when you and/or your eligible dependents decline health care coverage during the initial enrollment period.

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in a Trinitas Regional Medical Center medical plan provided that you request coverage within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or a court order, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption or the court order.

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

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



Common Questions

Who can I consider as my dependents?

Your dependents that are eligible for coverage under the Trinitas Regional Medical Center Employee Benefits Plan include:

- Your legal spouse;
- Your same sex domestic partner (**dental coverage only**);
- Your unmarried dependent children who are 19 years of age or younger and;
- Your unmarried dependent children through the end of the calendar year in which they reach age 19 (or through the end of the month in which they marry);
- Your unmarried dependent children through the end of the calendar year in which they reach age 23 who are registered full-time students at an accredited learning institution (or through the end of the month in which they cease to be full-time students); and/or
- Your dependent children of any age who are mentally or physically disabled and dependent upon you for support.

Why do I need to provide dependent certification?

Trinitas Regional Medical Center requires you to provide certification for each new dependent that is enrolled in the Employee Benefits Plan to ensure that a dependent is eligible for coverage. To certify your **spouse**, please provide a copy of a *marriage license*. To certify **all other dependents**, please provide a copy of either a *birth certificate, adoption agreement or court order*.

If certification is not received within 30 days of your eligibility date, the dependent will then be removed from your coverage and any applicable payroll contributions will be returned to you.

What happens if I do not choose any benefits?

Existing Employees – If you are an existing employee outside of your eligibility period and you do not enroll by the annual open enrollment period deadline, you will automatically be re-enrolled in the benefits you currently maintain. However, you will not automatically be re-enrolled in a Health Care and/or Dependent Care FSA. Your FSA benefits must be elected annually. If any of the benefits you maintain today are no longer offered, you may receive a “default” or replacement benefit to be communicated in advance by Trinitas Regional Medical Center.

New Benefit-Eligible Employees – When you become eligible to participate in the Trinitas Regional Medical Center Employee Benefits Plan (see “Eligibility” section on page 2 for eligibility timeframe), you must enroll within 31 days of your benefits effective date. If you do not enroll in benefits within this timeframe, you will only be assigned Basic Life/AD&D Insurance. You will not be enrolled in the following benefits: Medical/Prescription, Dental, Flexible Spending Accounts, Supplemental Life Insurance, Voluntary Long-Term Disability and any other additional voluntary benefits provided by Trinitas Regional Medical Center.

Why do I pay for benefits with pre-tax money?

There is a definite advantage of paying for some benefits with pre-tax contributions. Taking the money out before your taxes are calculated lowers the amount of your taxable income. Therefore, you pay less in taxes. However, this tax advantage is not available for all benefits in accordance with IRS rules. Your pre-tax benefits include: Medical/Prescription, Dental (excluding domestic partner coverage) and Flexible Spending Accounts.



Contact Information

The resources identified below are available to assist you if you have any questions about your benefits.

Questions Regarding	Call	Phone/Fax Number	Online/Address	Group/Policy #
General eligibility, plan options, payroll deductions, life event changes, etc.	The Human Resources Department	908-994-5325	bgates@trinitas.org	N/A
Benefits Enrollment	The Employe Benefits Service Center	1-800-307-0230 (p) 1-866-406-6946 (f)	www.mytrinitasbenefits.org	N/A
Medical Benefits	QualCare	1-800-992-6613	www.qualcareinc.com	117001
Prescription Benefits	Medco	1-800-633-2662	www.medco.com	QCAREX
Dental Benefits	Aetna Delta Dental	1-877-238-6200 1-800-452-9310	www.aetna.com www.deltadentalnj.com	812426 3206
Flexible Spending Accounts	CONEXIS	1-877-687-5465 (p) 1-888-866-3312 (f)	www.conexis.org Mail claims to: CONEXIS P.O. Box 227197 Dallas, TX 75222	11967
Basic Life/AD&D Insurance	Aetna	908-994-5741	www.aetna.com	812426-11
Supplemental Life Insurance	Aetna	908-994-5741	www.aetna.com	812426-12
Voluntary Long-Term Disability	CIGNA	908-994-5741	www.cigna.com	VDT-030042
Paid Time Off/IPP	The Human Resources Department	908-994-5325	Trinitas Intranet	Benefits – B12
529 College Savings Plan	Fidelity Investments	1-800-605-9984	www.fidelity.com/college	N/A
	Vanguard	1-866-734-4530	www.vanguard.com	N/A
	NJ Best 529 College Savings Plan	1-877-465-2378	www.njbest.com	N/A
Employee Assistance Program	EAP Department	908-994-7286 908-994-7092	Trinitas Intranet	N/A
Trinitas Regional Medical Center Savings & Retirement Plan – 401(k) Plan	Fidelity	1-800-343-0860	www.fidelity.com/atwork	57522
403(b) Tax Shelter Annuity	Fidelity	1-800-343-0860	www.fidelity.com/atwork	60432
Discounted Auto, Homeowners & Renters Insurance	New Jersey Manufacturer's Insurance Company	1-800-232-6600	www.njm.com	190728
	Traveler's Insurance Company	1-888-642-6650	www.niagroup.com	OMI440001
Group Legal Services	Pre-Paid Legal Services	732-735-3961	www.prepaidlegal.com/ hub/ruthpogany	0123503
Long-Term Care Insurance	William S. Oakes at John Hancock	973-716-7510	woakes@jhnetwork.com	N/A
Credit Union	Atlantic Federal Credit Union	908-994-5900	www.atlfedcu.com	N/A
Wachovia At Work	Wachovia	1-888-353-7375	www.wachovia.com/ wachoviaatwork	N/A