2019

UNION AGENER
ANIMAL HEALTH

BENEFITS GUIDE

This booklet is intended to describe the essential features of the enclosed benefits in general terms. It is not intended to be a full description of coverage or benefits. All efforts have been made to ensure accuracy, but if an error has been made in this description or if there is any disagreement or discrepancy, the official Plan Documents or certificate of coverage issued by Union Agener or the relevant insurance provider will control.

BENEFIT ELIGIBILITY

All permanent, full-time employees who work a minimum of 40 hours or more per week are eligible for benefits on the first day of employment. Dependents eligible for coverage include your spouse, domestic partner and your children to age 26. You can enroll in benefits during your waiting period, or at our annual open enrollment period, and within 30 days of a qualifying event.

CHANGING YOUR COVERAGE DUE TO A QUALIFYING EVENT

When you enroll in the employee benefits program, you will have an option to make certain premium payments with pre-tax dollars through the Section 125 Plan. Please note that unless you opt out of the Section 125, you and/or your dependents cannot be termed from the benefits plan for any reason other than a qualifying event or until the beginning of the next plan year.

If you have a qualifying event, you must notify Human Resources within 30 days of the event in order to make the necessary plan changes. In most cases, only changes consistent with the qualifying event can be made. For example, if you have a baby, you can add the baby to your health coverage, but you cannot enroll yourself in dental because that decision is not related to the qualifying event. The following is a list of qualifying events:

- Marriage, divorce or death of yourself or a dependent
- Birth or adoption of a dependent child
- Employee's receipt of a qualified medical child support order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) medical coverage for a child
- Changes made by a spouse or dependent child during his/her annual enrollment period with another employer
- The employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid
- Significant employer or carrier initiated changes in or cancellation of the employee, spouse or dependent child's coverage

MEDICAL BENEFITS

Union Agener offers an excellent health insurance program that consists of two comprehensive medical and prescription drug plans through Blue Cross Blue Shield.

The employee bi-weekly cost per pay period is as follows. Employee premiums are deducted on a pre-tax basis.

	HSA	HRA
Employee Only	$39.23	$48.69
Employee + Spouse	$78.46	$97.38
Employee + Child(ren)	$117.69	$146.08
Employee + Family	$156.92	$194.77

BLUE CROSS BLUE SHIELD MEDICAL BENEFITS

	HSA OAP8 2.7K/20		HRA POS OAP5 1.5K/10	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible	*Embedded	*Embedded	*Embedded	*Embedded
Individual	$2,700	$8,100	$1,500	$4,500
Family	$5,400	$16,200	$4,500	$13,500

*Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member's deductible amount also goes toward the Family deductible and out-of- pocket maximum. Not everyone has to meet his or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses. The medical deductible and coinsurance on this plan will apply toward the out-of-pocket maximums. The following do not apply to out-of-pocket maximums: non-covered items, plan premiums, or any balance billing due to Out-of-Network services.

Coinsurance	80% after Ded	50% after Ded	90% after Ded	50% after Ded
Out of Pocket Max	Includes deductible, coinsurance, medical and RX copays			
Individual	$5,000	$15,000	$4,500	$13,500
Family	$10,000	$30,000	$9,000	$27,000
Physician Services				
Primary Care Physician	20% after Ded	50% after Ded	$25 copay	50% after Ded
Specialists	20% after Ded	50% after Ded	$50 copay	50% after Ded
Emergency Room	20% after Ded		$150 copay then 10%	
Inpatient Hospital	20% after Ded	50% after Ded	10% after Ded	50% after Ded
Outpatient Hospital	20% after Ded	50% after Ded	10% after Ded	50% after Ded
Prescription Drugs			Retail (60 days)	MOD (90 days)
Tier 1	20% after Ded		$15 Copay	$15 Copay
Tier 2	20% after Ded		$35 Copay	$70 Copay
Tier 3	20% after Ded		$60 Copay	$180 Copay
Tier 4 Mail Order (90 days)	20% after Ded		20% up to $300 max per prescription	20% up to $300 max per prescription
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

The above information is provided only as a guideline for services. Each state mandates actual benefits and copays. Please refer to your state specific Certificate of Coverage for plan details and complete benefits.

Union Agener contributes to your HRA or HSA to help you meet your deductible. Please refer to page 6 of this booklet for reimbursement levels.

BLUE VIEW - VISION BENEFITS (Plan A.10.10.130.130)

A voluntary vision insurance plan is available through BlueCross Blue Shield. The plan offers a $10 copay for an eye exam every 12 months as well as benefits for frames and lenses or contacts every 12 months. There is a $10 materials co-pay for standard eyeglass lenses and $130 frame allowance. For elective contact lenses, there is a $130 allowance. Benefit covers either one pair of eyeglasses every 12 months or contact lenses.

Bi-weekly Rates

Employee Only: $3.82 | **Employee + Spouse:** $7.64 | **Employee + Child(ren):** $7.83 | **Employee + Family:** $11.65

To locate providers, go to https://benefits.eyewearspecialoffers.com

DENTAL BENEFITS

A voluntary dental insurance plan is offered through BCBS. The dental plan offers an excellent network of dentists which allow you to save money at the time of service. A dentist participating in the network has agreed upon fees for all services and cannot balance bill you the difference in their normal charges and the allowed amount. To find an in-network provider, log onto www.bcbsga.com, then select "Dental Complete".

REMEMBER: You can save money by using in-network providers!

Predetermination of Benefits: If estimated charges are for more than $300, it is recommended that you have your dentist obtain a predetermination of benefits from the dental insurance company to see how your services will be covered.

BLUE CROSS BLUE SHIELD OF GEORGIA ESSENTIAL CHOICE DENTAL BENEFITS

Deductible	$50 individual / $150 family per calendar year for Basic and Major Services. The deductible does not apply to Preventive Services or orthodontia.
Coinsurance	After the deductible has been satisfied (when applicable), benefits for covered services will be paid as follows:
Dental Services	**Preventive - 100%** Exams, cleanings, x-rays, fluoride treatment, and sealants. **Basic - 80%** Fillings, simple extractions, emergency pain treatment, endodontics, periodontics. **Major - 50%** Oral surgery, crowns, inlays, onlays, bridges and dentures.
Annual Maximum	$5,000 per individual in a calendar year for all Preventive, Basic and Major Services combined.
Orthodontics	Plan pays 50% up to $2,000 lifetime maximum for children through age 18.
Out-of-Network Provider Claims	Claims will be paid at 90% usual and customary.

The employee bi-weekly cost per pay period is as follows. Employee dental premiums are deducted on a pre-tax basis.

Employee Only	$3.69
Employee + Spouse	$7.38
Employee + Child(ren)	$11.08
Employee + Family	$14.77

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) REIMBURSEMENT LEVELS

Deductible	Insurance Deductible	HRA Contribution	Your Deductible After HRA Contribution
Employee Only	$1,500	$950	$550
Employee + Spouse	$4,500	$3,675	$825
Employee + Child(ren)	$4,500	$3,400	$1,100
Employee + Family	$4,500	$3,400	$1,100

HEALTH SAVINGS ACCOUNT (HSA) REIMBURSEMENT LEVELS

Deductible	Insurance Deductible	HSA Contribution	Your Deductible After HSA Contribution
Employee Only	$2,700	$2,150	$550
Employee + Family	$5,400	$4,300	$1,100

In addition to the contributions Union Agener makes, you can contribute to the accounts listed below with pre-tax money in order to help you pay for your out-of-pocket medical and dependent care expenses.

MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA) – For employees not participating in the HSA

You can contribute up to $2,700 per plan year on a pre-tax basis to pay for deductibles, copays, prescriptions and other eligible medical expenses not covered under your health, dental or vision insurance plans. You cannot participate in this plan if you are enrolled in the Health Savings Account. However, you can participate in a Limited Purpose FSA.

LIMITED PURPOSE FSA – FOR EMPLOYEES PARTICIPATING IN THE HSA

The Limited Purpose FSA is limited to reimbursing vision and dental expenses only. The advantage of participating in the Limited Purpose FSA is that you are able to retain more funds in your Health Savings Account by paying for your dental and vision expenses through this type of FSA. The maximum amount you can contribute to this account is $2,700.

DEPENDENT CARE (DCFSA)

Dependent Care Flexible Spending Account (DCFSA) is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. The 2019 contribution limit for an individual who is married but filing jointly is $2,500. For married couples filing jointly or single parents filing as head of household, the limit is $5,000.

HEALTH SAVINGS ACCOUNT (HSA)

The maximum amount you can contribute to the HSA is $3,500 for an individual and $7,000 for a family. This includes the amount that Union Agener contributes. You can use the funds in this account to pay for the same expenses that you can be reimbursed for under the Medical FSA.

401(K) SAVINGS PLAN

You can contribute up to 50% of your W-2 compensation to the plan up to the annual maximum set by the IRS. This can be done on a pre-tax, or after-tax basis through the Roth 401(k) option. You can decide to increase, decrease or stop your contributions at any time. Additionally, Union Agener will make a matching contribution of 100% of the first 6% you contribute to the plan. You are fully vested in the plan after 2 years of employment (including time with Elanco).

If you do not make an affirmative election, you will be automatically enrolled in the plan at an initial savings rate of 6% of your base compensation. Additionally, if you are contributing less than 15%, your contributions will automatically increase 1% each year until you do contribute 15%. You can, however, elect out of the automatic increase.

PROFIT SHARING CONTRIBUTION

Beginning with the 2019 401(k) plan year, Union Agener may also make a profit-sharing contribution to your 401(k) account. This contribution, which will be 3% of your W-2 compensation for the 2019 plan year, will be made regardless of how much you contribute to the plan. Vesting for the profit-sharing contribution will be 20% per year of service after the first year, and will credit past Elanco service.

BASIC LIFE AND AD&D

Union Agener provides a company paid basic life and accidental death and dismemberment (AD&D) policy of 2x base annual salary to $350,000 Reliance Standard. AD&D provides benefits in the event of an accidental injury that results in the death or dismemberment of a covered person and is payable in addition to any life insurance.

VOLUNTARY LIFE INSURANCE

Each employee's life insurance needs are different. For this reason, we have a program through Reliance Standard allowing employees to elect additional life insurance for themselves, spouse and children. During your initial eligibility period, you will have the opportunity to elect insurance coverage without any medical questions. This amount is considered the Guarantee Issue. Employees who waive coverage during their initial eligibility period, or those who wish to increase their benefit amounts in the future, may do so, but will be subject to completing a medical questionnaire and/or health testing.

Employee to age 70:	The guarantee issue amount is $100,000. Benefits are available in $10,000 increments to $500,000.
Spouse to age 60:	The guarantee issue amount is $10,000. Benefits are available in increments of $10,000 to $500,000.
Children:	The guarantee issue amount is all of the elected amount. Benefit for children Birth to 6 months is $1,000. Benefit for children age 6 months to 20 years old (26 if Full-Time Student) is $10,000.

SHORT-TERM DISABILITY (STD) INSURANCE

Short-term disability is an employer paid benefit offered through Reliance Standard. The STD benefits help protect your income during short-term illness or disability. Since the employer pays the monthly premiums, benefits paid out are taxable. See Human Resources for more details.

The short-term disability plan pays 70% of earnings up to a maximum of $2,000 per week. Benefits are payable on the 8th day of disability due to an accident, sickness or pregnancy. Benefits can be paid up to a maximum of 39 weeks. Note that on the job injuries are not covered under this policy.

LONG-TERM DISABILITY (LTD) INSURANCE

Long-term disability insurance is income protection for employees out with a long-term disability. Union Agener provides a base LTD policy and an additional buy up option you can purchase for added income protection. Rates are based on your age.

After a 273 day waiting period, you are eligible to receive up to 60% of pre-disability earnings up to a $10,000 monthly maximum. The plan allows a benefit for the first two years if you are unable to perform the function of your own occupation, then any reasonable occupation up to age 65. Employees can purchase additional LTD at a buy-up rate of $0.13 per $100 of coverage.

For more information on the group life and disability plans, refer to the Reliance Standard *Certificate Booklets.*
The below benefits (Group Accident, Group Critical Illness and Cancer Plan) are all 100% employee paid benefits.

GROUP ACCIDENT

Accident Benefits Plan – Plan pays for immediate cash needs in the event of an accidental injury
Emergency Room - $200
Hospital Admission - $1,000 then $250 per day
See Certificate for other summaries

GROUP CRITICAL ILLNESS

Critical Illness plan pays for immediate lump sum cash needs for any critical illness related to cancer, heart attack, stroke, and many others (see contract for all benefits)
Critical Illness Benefit - $20,000 per event.

ALLSTATE CANCER PLAN

Allstate Benefits offers a Group Voluntary Cancer plan. Union Agener pays for employee coverage under this plan. If you want to cover dependents you would pay the full cost of covering your eligible dependents. The plan covers a wide range of benefits ranging from $100 Wellness Benefit to a one time benefit of $10,000 for initial diagnosis of Cancer. Other benefits included are $100 daily benefits for Hospital including confinement, Private Duty Nursing, At Home Nursing and Hospice. There is also a Radiation/Chemotherapy benefit limited to every 12 months up to $20,000. The plan includes many other benefits which are listed on the Allstate Group Voluntary Cancer Benefit Summary.

BENEFITSDIRECT BENEFIT CARE CARD

Offers discounts on everyday items such as:

- Telemedicine
- Pharmacy
- Vision
- Pet Care
- Diabetic Supplies
- Hearing Aids
- Lab Testing/MRI and CT Scans
- Vitamins
- Worklife Services

EMPLOYEE ASSISTANCE PLAN (EAP)

Because Union Agener values the health and well being of all employees and their dependents, an Employee Assistance Program (EAP) is provided by ACI Specialty Benefits through Reliance Standard. The EAP is a program designed to help assist at times when life's problems are too much to cope with on your own. Trained counselors are available at any time to assist with a full range of personal problems as well as a variety of work/life issues.

The EAP can help with:

- United Telephonic Clinical Assessment and Referral
- Up to 3 Sessions of Professional Assessment for Employees and Family Members
- Unlimited Child Care and Elder Care Referrals
- Legal Consultation for Unlimited Number of issues per Year
- Unlimited Pet Care Consultation
- Unlimited Education Referrals and Resources
- Unlimited Referrals and Resources for any Personal Service
- Unlimited Community-based Resource Referrals
- Online Legal Resource Center
- *Affinity* Online Work-Life Website
- myACI App for Mobile Access
- Multicultural and Multilingual Providers Available Nationwide

For information contact Reliance Standard at 855.775.4357. Assistance is available 24 hours a day, seven days a week at no cost to you. All calls are confidential.

CARRIER CONTACT LIST

Plan	Carrier	Website	Phone
Medical	BCBS	www.bcbsga.com	855.397.9267
Vision	BCBS	www.bcbsga.com	855.397.9267
Dental	BCBS	www.bcbsga.com	855.397.9267
Life, Disability, Group Critical Illness/Accident	Reliance Standard	www.reliancestandard.com	800.351.7500
EAP, Group Accident, Group Critical Illness	Reliance Standard	www.reliancestandard.com	855.775.4357
FSA, HRA and 401(k)	Swerdlin	www.swerdlin.net	866.687.4015
HSA	BenefitWallet	www.MyBenefitWallet.com	866.686.4798
Group Cancer Policy	Allstate Benefits	www.allstatebenefits.com	800.521.3535

Our insurance brokers at McGriff, Seibels & Williams at 404.847.1670 and 404.847.1664 are available for additional help.

VACATION AND HOLIDAYS

The amount of vacation you receive is based on your length of service. You will receive additional vacation time during every fifth anniversary year.

We also take time off between the days designated for the observance of Christmas Day and New Year's Day.

Additionally, you have ten holidays—three are floating to celebrate other holidays, events or special occasions that are important in your life. Or you can just take a day to celebrate you! Some years, the company will designate one floating holiday to occur on a specific date.

You earn vacation based on years of service.

Up to 1 year	10 hours per month
1 - 4 years	120 hours
5 years	120 hours + 40 hours of recognition vacation
6 - 9 years	120 hours
10 years	144 hours + 40 hours of recognition vacation
11 - 14 years	144 hours
15 years	168 hours + 40 hours of recognition vacation
16 - 19 years	168 hours
20 years	192 hours + 40 hours of recognition vacation
21 - 24 years	192 hours
25 years	216 hours + 40 hours of recognition vacation
26+ years	216 hours + 40 hours of recognition vacation at 30, 35, 40 years, etc.

A few things to know about your vacation:

- In general, during Annual Enrollment, you can purchase up to 40 vacation hours in 4-hour increments. You cannot change your decision after the Annual Enrollment period.

- You can use your vacation anytime during the year even before you earn it—just don't exceed your annual benefit. If you terminate employment with a negative vacation balance (if you 'borrowed' more than you earned), the value of that excess 'borrowed' time will be taken out of your last paycheck.

- Carefully plan your vacation time well in advance; otherwise you will forfeit any vacation time not used by the end of the year.

2019 Holiday Schedule

Day	Month	Date	Holiday Observed
Tuesday	January	1	New Year's Day
Monday	May	27	Memorial Day
Thursday	July	4	Independence Day
Monday	September	2	Labor Day
Thursday	November	28	Thanksgiving Day
Friday	November	29	Day After Thanksgiving
Tuesday	December	24	Company-Designated Floating Holiday
Wednesday	December	25	Christmas Day
	December	26-31	Company-Scheduled Year-End Vacation

DISCLOSURE NOTICES

This booklet is intended to describe the essential features of the enclosed benefits in general terms. It is not intended to be a full description of coverage or benefits. All efforts have been made to ensure accuracy, but if an error has been made in this description or if there is any disagreement or discrepancy, the official Plan Documents or certificate of coverage issued by Union Agener or the relevant insurance provider will control.

DISCLOSURE NOTICES

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid

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

ALASKA – Medicaid

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

ARKANSAS – Medicaid

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid

Website: http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

DISCLOSURE NOTICES

PAPERWORK REDUCTION ACT STATEMENT
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS
If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. However, you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

WOMEN'S HEALTH AND CANCER RIGHTS ACT
On October 21, 1998 Congress passed the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include: Reconstruction of the breast upon which the mastectomy has been performed, Surgery/reconstruction of the other breast to produce a symmetrical appearance, Prostheses, and Physical complications during all stages of mastectomy, including lymphedemas. In addition, the plan may not: interfere with a woman's rights under the plan to avoid these requirements, or offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA PRIVACY NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information in your company plan (herein referred to as the "Plan") creates or receives about you.

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013.

As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

HOW THE PLAN WILL USE OR DISCLOSE YOUR PHI
Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use,

disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to HHS;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with legal regulations; and
- Uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan:
For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.

- The PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- The PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For School Records. The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

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For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Right to Request Restrictions on PHI Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend. You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, effective January 1, 2013, you can request an accounting of all disclosures by the Plan of your electronic PHI during the three years prior to the date of your request.

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Right to Receive Confidential Communications. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.
- The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of you unsecured PHI.

Your Right to File a Complaint. You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information. If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan.

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

MEDICARE PART D CREDITABLE COVERAGE DISCLOSURE NOTICE
IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Employer has determined that the prescription drug coverage offered by Your Employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Employer coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Your Employer coverage, be aware that you and your dependents will be able to get this coverage back.

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When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About Your Options Under Medicare Prescription Drug Coverage. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

MEDICARE PART D NON-CREDITABLE COVERAGE DISCLOSURE NOTICE
IMPORTANT NOTICE FROM YOUR EMPLOYER ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Employer has determined that the prescription drug coverage offered by the Your Employer is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Your Employer. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you become eligible.
3. You can keep your current coverage from Your Employer. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you become eligible for Medicare and each year from October 15 to December 7. However, if you decide to drop your current coverage with Your Employer, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Your Employer.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? Since the coverage under Your Employer, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base benefit premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base benefit premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Employer coverage will not be affected. [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/ options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] If you do decide to join a Medicare drug plan and drop your current Your Employer coverage, be aware that you and your dependents will be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage. Contact the Your Employer Benefit Department. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Your Employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from

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Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUATION COVERAGE RIGHTS UNDER COBRA)
INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefit (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefit (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefit (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes. To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information. Please contact your Human Resources Department.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE
PART A: GENERAL INFORMATION | FORM APPROVED OMB NO. 1210-0149 (EXPIRES 5-31-2020)
When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment- based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer- offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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