Feel Good

About the options you choose

Your Benefits Enrollment Guide

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice.

Table of Contents

Benefits Overview

ABC Healthcare is proud to offer a comprehensive benefits package. The complete benefits package is briefly summarized in this booklet. You may request plan booklets for specific carriers, which give you more detailed information about each of these programs.

You share the costs of some benefits and ABC Healthcare provides other benefits at no cost to you. In addition, there are voluntary benefits with reasonable group rates that you can purchase through ABC Healthcare payroll deductions.

Benefit Plans Offered

» Medical
» Health Savings Account (HSA)
» Flexible Spending Account (FSA)
» Dependent Care Flexible Account (FSA)
» Accident, Critical Illness, and Hospital Indemnity
» Dental
» Vision
» Life, Accidental Death & Dismemberment (AD&D) Insurance
» Disability Insurance
» Legal Benefits
» Identity Theft Protection
» Pet Insurance
» Auto and Home Insurance

Eligibility

You and your dependents are eligible for ABC Healthcare, benefits on the first of the month following 30 days of employment.

Individuals considered dependents are your spouse, children under age 26, and/or disabled dependents of any age. Elections made now will remain in place until the next open enrollment unless you or your family members experience a Qualifying Life Event (QLE). If you experience a QLE, you must contact HR and take action within 30 days of the QLE date.

Qualifying Events

» Loss of Dependent Coverage (including spousal coverage through employer)
» Marriage
» Divorce
» Legal Separation
» Birth of a Child
» Adoption or Change in Custody
» Death

Highlights

More details about the plans can be found in this Benefits Guide.

» ABC Healthcare will increase the employer HSA funding on the $3,000 plan to $500 for individual and $1,000 for family.
» Urgent Care coinsurance will decrease to 10% on the High Deductible Health Plans.
» MetLife is the new Voluntary Accident, Critical Illness, and Hospital Indemnity provider. Look for details on pages 15-16.
» Chubb is the new provider for Permanent Life Insurance.
» LegalShield is the new provider for Legal Services.
» It is **mandatory** that all benefit eligible employees access **Ultipro** to either **enroll or decline** the years benefits.
» Please have the Social Security Number, Date of Birth and address for all people enrolling in benefits.
» First Stop Health - talk to a doctor within minutes! All you have to do is call, log in at fsh.com or download the First Stop Health mobile app to request your doctor visit. You're all set to get started - no registration required!

NEED ASSISTANCE?

If you have questions or need assistance enrolling in your benefits, call 888-728-2566, option #1, then option #1 again. The ABC Healthcare's Benefits Team is available Monday through Friday, 8:00 am - 5:00 pm (PST).

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or the ABC Healthcare Benefits Team.

Benefit	Administrator	Phone	Website
ABC Healthcare's Benefits Team		888.728.2566, option #1, then option #1 again	Email: benefits@abchealthcare.com
Enrollment Assistance	Worksite Communication	866.998.2915	
Medical	Ameriben Kaiser—CA	866.504.6811 800.464.4000	www.ameriben.com www.kaiserpermanente.org
Telemedicine	First Stop Health	888.691.7867	www.fshealth.com
Health Savings Account (HSA)	Discovery Benefits	866.451.3399	www.discoverybenefits.com
Flexible Spending Account (FSA)	Discovery Benefits	866.451.3399	www.discoverybenefits.com
Pharmacy	Elixir Rx Solutions	866.909.5170	www.elixirsolutions.com
Accident, Critical Illness, and Hospital Indemnity	MetLife	800.GET.MET8 800.438.6388	www.metlife.com
Dental	Delta Dental of Georgia	800.521.2651	www.deltadental.com
Vision	VSP	800.877.7195	www.vsp.com
Life and AD&D	CIGNA	800.362.4462	www.mycigna.com
Permanent Life	Chubb	855.241.9891	www.chubb.com
Disability Insurance	CIGNA	800.362.4462	www.mycigna.com
Legal Benefits	LegalShield	800.654.7757	http://benefits.legalshield.com/xxx
Identity Theft Protection	Allstate Identity Protection (formerly InfoArmor)	800.789.2720	www.infoarmor.com
Pet Insurance	VPI	877.738.7874	www.petinsurance.com/xxxx
Auto and Home Insurance	MetLife Auto & Home®	800.GET.MET8 800.438.6388	www.metlife.com/mybenefits

Assistance finding quality, cost-effective options for MRIs, CT scans, and total knee and hip replacements.

AmeriBen Concierge Consumer Support

Find a Quality, Cost-Effective Option

Common procedures such as MRIs, CT scans, total knee replacements, and total hip replacements can vary widely in cost with little to no difference in results. If your physician has recommended one of these four procedures for you, call the Concierge Consumer Support Coordinator at 1-866-955-1489 to receive your complimentary cost and quality comparison.

Already Have Your Procedure Scheduled?

Sometimes by electing to have a procedure performed at a different location you can significantly lower the overall cost without compromising quality. Be sure to talk with your physician as many physicians are able to perform procedures at multiple locations (e.g., hospitals, surgery centers, and outpatient facilities). If you have already scheduled a procedure or have a preferred facility, we will make sure they are included in the comparison.

Receive Cash Incentives

After receiving your cost and quality comparison, if you choose to elect and utilize a more cost-effective, quality facility, you are eligible to receive a gift card incentive of up to $500*.

*based on a percentage of savings

AmeriBen

Call: 1-866-955-1489 or Visit: www.myameriben.com
E-mail: medicalmanagement@ameriben.com

first step health®

Care you will love. | (888) 691-7867 | fshealth.com

Care You Will Love—Anytime, Anywhere

Telemedicine from Avalon Health Care Management, Inc.

Getting the care you need shouldn't be a pain. With First Stop Health from Avalon Health Care Management, Inc., you can talk to a doctor via phone or video for treatment in MINUTES.

Talk to a doctor 24/7

Talk to a doctor in minutes for a wide variety of health concerns.

- Sore Throat
- Cough
- Sinus Infection
- Skin Rash
- Eye Infection
- Earache
- Urinary Tract Infection
- Aches and Pains
- Medical Question
- Medication Refill*

*Doctors can write prescriptions when needed. Prescription costs are applicable to your medical plan.

Affordable

There are no fees or copays! If you are enrolled in a HDHP, a $25 consult fee will apply if a prescription is written.

Care for your family

Provided to AmeriBen medical-enrolled employees and their immediate family members.

"This is my first time using a service like this and I could not be any more grateful. The doctor was able to diagnose my daughter over the phone at 10 p.m. and sent in medication immediately."

– Client from Texas

Get the app

Download on the App Store | GET IT ON Google Play

Medical Benefits

Administered by:
Ameriben | www.ameriben.com | 866.504.6811
Find if your doctor is in network at www.bcbs.com
TIV = Intermountain Healthcare Network
QIV = Value Care Network

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. Early detection of health problems can often be treated at little cost. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through ABC Healthcare. Medical plans are available for all eligible, full time, employees who work 30 hours or more per week.

ABC Healthcare offers you the choice between the following medical plans.

Ameriben Plan - ValueCare (All employees) & Participating (Utah Employees Only)

	$1,750 Deductible		$2,000 Deductible (with HSA)		$3,000 Deductible (with HSA)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Maximum Benefit	Unlimited		Unlimited		Unlimited	
HSA Eligible	No		Yes		Yes	
HSA Funding by Employer	No		$200 For individuals $400 For Family		$500 For Individuals $1,000 For Family	
Deductible (Included in Out-of-pocket Maximum)	$1,750 Ind / $3,500 Family	$3,500 Ind / $7,000 Family	$2,000 Ind / $4,000 Family	$4,000 Ind / $8,000 Family	$3,000 Ind / $6,000 Family	$6,000 Ind / $12,000 Family
Deductible Embedded*	Yes		No		Yes	
Out-of-pocket Maximum (embedded)	$4,500 Ind / $9,000 Family	$12,000 Ind / $24,000 Family	$5,000 Ind / $10,000 Family	$15,000 Ind / $30,000 Family	$5,500 Single / $11,000 Family	$18,000 Single / $36,000 Family
Office Visits	$30 PCP / $60 Specialist	40% AD	20% AD	40% AD	20% AD	40% AD
Coinsurance	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Telemedicine	$0	N/A	$25 consult fee***	N/A	$25 consult fee***	N/A
Ambulance Services	20% AD	20% AD	20% AD	20% AD	20% AD	20% AD
Durable Medical Equipment**	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Emergency Room	20% AD	20% AD	20% AD	20% AD	20% AD	20% AD
Urgent Care	$60	40% AD	10% AD	40% AD	10% AD	40% AD
Home Health (120 Visits)	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Hospice Care	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Hospital Services**	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Maternity**	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Mental Health / Chemical Dependency-Inpatient**	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Mental Health / Chemical Dependency-Outpatient**	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD

*Embedded = Once one member in the family meets the Individual Deductible or Out-of-pocket Maximums, benefits begin to pay for the individual. Non Embedded= If enrolling with two or more people on the plan, the Family Deductible must be satisfied before the benefits are payable.

** Services may require a pre-authorization. Please contact Ameriben for information.

*** If prescription is required

Ameriben Plan - ValueCare (All employees) & Participating (Utah Only)

	$1,750 Deductible		$2,000 Deductible (with HSA)		$3,000 Deductible (with HSA)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Neurodevelopmental Therapy	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Nutritional Counseling (3 visits)	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Orthotics/Prosthesis**	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Preventive Services/ Immunizations	0% (deductible waived)	40% AD	0% (deductible waived)	40% AD	0% (deductible waived)	40% AD
Outpatient Radiology & Laboratory**	0% (deductible waived)	40% AD	20% AD	40% AD	20% AD	40% AD
Rehabilitation- Inpatient (15 days)	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Imaging (CT/PET scans, MRIs)**	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Rehabilitation- Outpatient (40 visits)	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Skilled Nursing Facility (120 days)	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Spinal Manipulations (limit of 30)	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
TMJ	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Transplants**	20% AD	40% AD	20% AD	40% AD	20% AD	40% AD
Vision Exam	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

** Services may require a pre-authorization. Please contact Ameriben for information

Elixir RX Pharmacy Plans

Prescription	$1,750 Deductible Retail	$1,750 Deductible Mail Order	$2,000 Deductible Retail	$2,000 Deductible Mail Order	$3,000 Deductible Retail	$3,000 Deductible Mail Order
Deductible	$0		Shared with Medical		Shared with Medical	
Out-of-Pocket Maximum	Shared with Medical		Shared with Medical		Shared with Medical	
Generic	$10	$25	20% AD	20% AD	20% AD	20% AD
Brand Name - Formulary	30% max $50	30% max $125	20% AD	20% AD	20% AD	20% AD
Brand Name - Non-Formulary	45% max $80	45% max $200	20% AD	20% AD	20% AD	20% AD
Specialty Medications - Generic	50% max $300		20% AD	20% AD	20% AD	20% AD
Specialty Medications - Brand Preferred	50% max $300		20% AD	20% AD	20% AD	20% AD
Specialty Medications - Brand Non-Preferred	50% max $300		20% AD	20% AD	20% AD	20% AD

Prescriptions by mail - it's just what the doctor ordered! Get the medications you need delivered on time, safely and confidentially directly to your home. Visit www.elixirsolutions.com or call 866.909.5170 to get started.

PLEASE NOTE: To remain compliant with State and Federal regulations including the Affordable Care Act, these benefits are subject to change. Any errors are unintentional and non-binding. For final benefits, please refer to the group's Benefit Booklet.

Out-of-network payments are based upon eligible charges, and are subject to balance billing.

Medical Benefits

Administered by:
Kaiser | www.kaiserpermanente.org | 800.464.4000 (CA)

ABC Healthcare also offers California employees a choice of the following Kaiser medical plans.

Kaiser HMO Plan

	$1,500 Deductible In-Network	$2,000 Deductible In-Network (with HSA)	$2,800 Deductible In-Network (with HSA)
HSA Eligible	No	Yes	Yes
HSA Funding by Employer	No	$200 Individuals / $400 Family	$400 Individuals / $800 Family
Annual Deductible (individual/each family member/ Entire family over two members)	$1,500/$1,500/$3,000	$2,000/$2,800/$4,000	$2,800/$2,800/$5,650
Annual Out-of-Pocket Maximum (individual/family)	$4,000/$4,000/$8,000	$3,500/$3,500/$7,000	$5,250/$5,250/$10,500
Drug Deductible	$0	Same as Medical	Same as Medical
Coinsurance	20%	20%	30%
Doctor's Office			
Office Visits (PCP/SCP)	$20 per visit	$30 per visit after Plan Deductible	$30 per visit after Plan Deductible
Preventive Care	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)	No charge (Plan Deductible doesn't apply)
Prescription Drugs			
Retail—30 day supply			
Generic Drug	$10	$10 AD	$15 AD
Preferred Brand Drug	$30	$30 AD	$30 AD
Specialty Items	20% coinsurance up to a maximum of $200 per prescription, per fill.	20% coinsurance up to a maximum of $200 per prescription, per fill AD.	20% coinsurance up to a maximum of $200 per prescription, per fill AD.
Mail Order—up to 100 day supply			
Generic Drug	$20	$20 AD	$30 AD
Preferred Brand Drug	$60	$60 AD	$60 AD
Hospital Services			
Emergency Room	20% Coinsurance after Plan Deductible	$100 per visit after Plan Deductible	30% Coinsurance after Plan Deductible
Urgent Care	$20 per visit	$30 per visit after Plan Deductible	$30 per visit after Plan Deductible
Inpatient	20% Coinsurance after Plan Deductible	$250 per admission after Plan Deductible	30% Coinsurance after Plan Deductible
Outpatient Surgery	20% Coinsurance after Plan Deductible	$150 per procedure after Plan Deductible	30% Coinsurance after Plan Deductible
Ambulance Service	$150 per trip after Plan Deductible	$100 per trip after Plan Deductible	$100 per trip after Plan Deductible
Mental Health Services			
Inpatient Services	20% Coinsurance after Plan Deductible	$250 per admission after Plan Deductible	30% Coinsurance after Plan Deductible
Individual Outpatient Services	$20 per visit	$30 per visit after Plan Deductible	$30 per visit after Plan Deductible
Group Outpatient Services	$10 per visit after	$15 per visit after Plan Deductible	$15 per visit after Plan Deductible

Kaiser HMO Plan

	$1,500 Deductible In-Network	$2,000 Deductible In-Network (with HSA)	$2,800 Deductible In-Network (with HSA)
Substance Abuse Services			
Inpatient Services	20% Coinsurance after Plan Deductible	$250 per admission after Plan Deductible	30% Coinsurance after Plan Deductible
Outpatient Services	$20 per visit	$30 per visit after Plan Deductible	$30 per visit after Plan Deductible
Group Outpatient Services	$5 per visit after	$5 per visit after Plan Deductible	$5 per visit after Plan Deductible
Other Services			
Hospice	No charge after Plan Deductible	No charge after Plan Deductible	No charge after Plan Deductible
Home health care (up to 100 visits per Accumulation Period)	No charge after Plan Deductible	No charge after Plan Deductible	No charge after Plan Deductible
Skilled Nursing Facility (up to 100 days per Accumulation Period)	20% Coinsurance after Plan Deductible	$250 per admission after Plan Deductible	30% Coinsurance after Plan Deductible

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

Kaiser Pharmacy Plans

Tier	You Pay	WHAT'S COVERED
1	Lowest Cost Share	**Most Generic Prescription Drugs** Generic prescription drugs use the same active ingredients as brand-name prescription drugs and work the same way. Generic drugs are equivalent to a brand product in dosage form, strength, quality, and intended use.
2	Second Lowest Cost Share	**Preferred Brand Name Drugs** Drugs sold under a specific trade name that are favorably priced by the pharmacy plan.
3	Highest Cost Share	**Non-Preferred Brand Name Drugs** Drugs sold under a specific trade name that have a reasonable, more cost effective alternative on Tier 1 or Tier 2.

For more detailed information regarding your plan please refer to your SPD or Certificates of Coverage. These are printable in the document section in UltiPro or contact the ABC Healthcare Benefits Team to request a copy.

Medical insurance usage:

» Do you expect your usage to be moderate to low (only wellness visits and occasional illness)? If so, consider plans with higher deductibles. You could save money by paying less from your paycheck for your coverage. If you are concerned about the risk of unexpected expenses, consider purchasing one or more supplemental medical plans for added protection (see next section).

» Do you expect your usage to be high (you or a dependent has a serious medical condition or you expect a hospitalization)? If so, you may want to choose a plan with a lower deductible to reduce your costs when you need care.

» Payment preference:
Would you rather pay less from your paycheck and more if you need care? If so, select a plan with a higher deductible and lower plan cost.

» Would you rather pay more from your paycheck and less if you need care? If so, select a plan with a lower deductible and higher plan cost.

» Unexpected Expenses:
If an expensive illness or injury occurred in your family, how confident are you that you could afford the costs your plan does not cover?

If you're very confident, you may want to choose a plan that costs less to buy, but has a higher deductible.

If you're not confident, you may want to choose a plan that costs more to buy, but has a lower deductible. Or, you may want to consider purchasing one or more supplemental medical plans for added protection (see next section).

» Consider combining medical insurance with supplemental medical insurance, like hospital indemnity, accident, and critical illness insurance. These options, are intended to supplement your medical plan's coverage. In fact, based on your situation, you may be able to save money by purchasing a lower cost medical plan and adding one or more supplemental plans. The combined coverage could offer effective protection against out-of-pocket expenses at a lower plan cost.

» In-Network vs. Out-of-Network:
Most plans allow you to see any provider of your choice. However, you will typically pay less for in-network care. Visit your insurance company's website using the links on page 5 of this booklet to search for in-network providers. Using an in-network provider will ensure you receive the preferred cost-sharing on services.

Health Savings Account (HSA)

Administered by:
Discovery Benefits | www.discoverybenefits.com | 866.451.3399

When you enroll in a High Deductible Health Plan, you are allowed to open a Health Savings Account (HSA). This allows you to put money away, tax free, through payroll deductions, accrue interest, tax free, and then use it for qualified medical, dental and vision expenses, tax free.

What is an HSA?

With an HSA you own the account and it is fully portable. Balances roll over year after year, growing tax free. You never lose your contributions to your HSA, unlike other health accounts, such as a flexible spending account (FSA). Even if you change jobs, health plans, or retire, you keep your HSA.

HSA's can be used to pay for eligible medical, dental and vision expenses for you, your spouse, and any family member who qualifies as a tax dependent. (See IRS Publications 969 for a list of eligible expenses). This includes things like pre-deductible medical expenses and prescription costs.

Yearly HSA Contribution Limit

Individual HSA: $3,600* for current YEAR
Family HSA: $7,200* for current YEAR

*A $1,000 additional catch up contribution is allowed for account holder's age 55+.

Benefits of an HSA

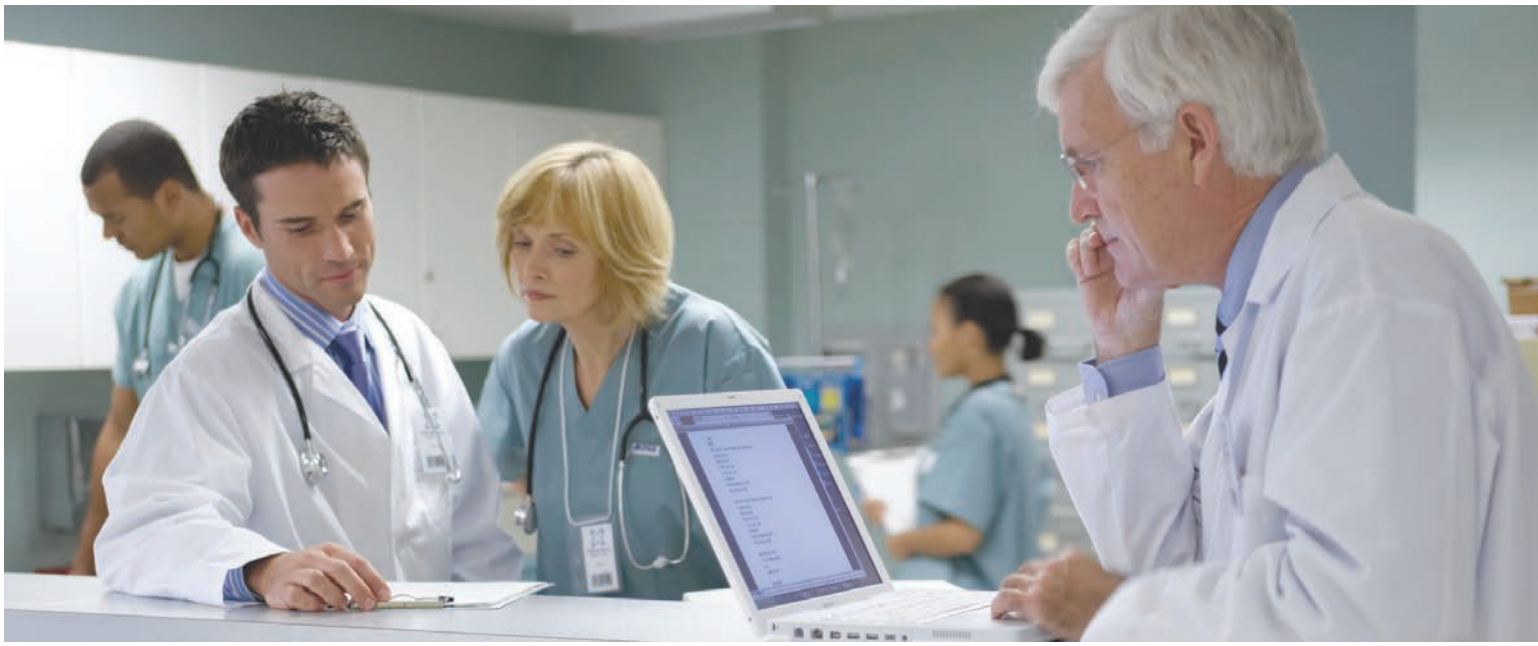
» Pay for qualified medical, dental and vision expenses with tax free dollars.
» Lower health insurance premiums with an HSA qualified health plan.
» Keep your contributions year after year and watch your balance grow. There is no "use it or lose it." It's yours.
» Invest your balance over the threshold amount to grow your HSA further.

Here's How an HSA works

1. You decide the annual amount you want to contribute to your HSA; not to exceed the yearly IRS limits. You may change your election at any time during the year.
2. Your contributions are deducted from each paycheck pretax, and deposited into your HSA.
3. You can pay for eligible medical, dental and vision expenses with your HSA debit card. You may also pay the provider directly through your Discovery Benefits online account, or you can request a reimbursement if you paid out-of-pocket and did not use your HSA debit card.

Tax Advantage accounts require enrollment each year.

Take the guesswork out of HSA contributions and make calculated decisions with the Discovery Benefits HSA Calculator. **Check it out here: www.DiscoveryBenefits.com/hsacalculator.**



Flexible Spending Account (FSA)

Administered by:
Discovery Benefits | www.discoverybenefits.com | 866.451.3399

ABC Healthcare offers a Section 125 Cafeteria Plan. This plan will allow you to withhold funds pretax from your pay check to pay for out-of-pocket healthcare and dependent day care expenses.

Due to new legislation passed through the Coronavirus Aid, Relief, & Economic Security Act (CARES) Act, reimbursement for over-the-counter (OTC) products is available without a prescription. This can include pain relief medications, cold and flu products, and menstrual products to name a few.

Employees will be allowed to carry over up to $550 of unused FSA amounts for qualified medical expenses incurred during the following year. As a result, the 2 1/2 month grace period provision allowing employees to incur and spend all remaining FSA amounts into the new year does not apply to the ABC Healthcare plan.

The carryover amount becomes available to an FSA participant at the end of the run-out period (the last date participants can submit documentation or file a claim) from the previous plan year, which is March 31. Any remaining balance that remains in a Medical FSA after the carryover has been made will be forfeited.

Healthcare

You may authorize ABC Healthcare to withhold money each pay period (26 pay periods per year) to help pay your medical, dental and vision expenses that are not covered by insurance.

In order for qualified expenses to be reimbursed, each member must be enrolled in ABC Healthcare's PPO Medical Plan or another employer sponsored plan.

Maximum Annual Healthcare Election Amount: **$2,750**.

Please visit the link below to view some of the eligible expenses and plan information.

www.discoverybenefits.com

Day Care

If you are required to pay babysitting or day care expenses so that you can work, these expenses may be paid with pretax dollars.

Maximum Annual Day Care Election Amount: **$5,000** (married filing jointly, or for a single parent) or **$2,500** (married filing separately.)

You will need to make an election for the amount you would like withheld for the plan year for both healthcare and day care. Day Care reimbursements can only be made once the Administrator is in receipt of your funds from payroll. Keep in mind that this is a use it or lose it plan. No portion of your election will roll into the following year.

Enrollment and claim forms can be found at: **www.discoverybenefits.com** or call the ABC Healthcare's Benefits Team.

Supplemental Medical Insurance

Administered by:
MetLife | www.metlife.com | 800.GET.MET8

Supplemental medical insurance can help protect you from significant or unexpected out-of-pocket expenses. Keep in mind these plans are intended to supplement a medical plan, and they do not, on their own, provide the minimum level of medical coverage needed to meet the Affordable Care Act requirement for medical insurance. Supplemental Medical Insurance is available for all Full-time and Part-time employees working 20 or more hours a week.

Consider your anticipated medical needs, along with the cost of the insurance plans available to you. Adding a supplemental plan to a lower cost medical plan may help you save money while providing important coverage.

The following three supplemental medical plans are available to you:

Voluntary Hospital Indemnity Insurance

When hospitalized, you may not realize that most primary health insurance plans do not cover all hospital costs. Hospital Indemnity Insurance can complement your medical coverage by helping to ease the financial impact of a hospitalization due to accident, illness or pregnancy. Coverage is available for employees, spouses, and families. Benefits are paid directly to employees unless otherwise specified and regardless of any other insurance. Eligible employees and dependents will be able to elect coverage during Open Enrollment regardless of prior health history. You must be insured under the policy for 30 days before benefits are payable.

MetLife pays predetermined cash directly to you for covered hospital, outpatient, nursing, transportation, or physician services.

Benefit Amounts	Low Plan	High Plan
First Day Hospital Confinement Benefit	$1,000	$2,000
Daily Hospital Confinement Benefit	$100	$200
Hospital Intensive Care Benefit	$100	$200
Rehabilitation Facility Benefit - Up to 31 days per confinement	$50	$100

Voluntary Critical Illness

No one knows what lies ahead on the road through life. Will you have to undergo a major organ transplant or a coronary artery bypass procedure? Will you suffer a stroke or a heart attack? The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed. Critical illness coverage can help offer peace of mind when a critical illness diagnosis occurs. Coverage is available for you, your spouse and dependent children at $15,000 and $30,000 coverage levels.

The plan has limitations and exclusions that may affect benefits payable. Following is for illustrative purposes only and is not a complete list of benefits payable. Refer to your certificate for complete details, definitions, limitations, and exclusions.

Initial Critical Illness Benefits	Low Plan	High Plan
Heart Attack	$15,000	$30,000
Stroke	$15,000	$30,000
Coronary Artery Bypass Surgery - 25% of base amount	$3,750	$7,500
Major Organ Transplant	$15,000	$30,000
End Stage Renal Failure	$15,000	$30,000
Cancer Critical Illness Benefits		
Invasive Cancer	$15,000	$30,000
Non-Invasive Cancer- 25% of base amount	$3,750	$7,500
Critical Illness Additional Benefit		
Recurrence Benefit - Second Event Initial Critical Illness Benefit	Yes	Yes
Additional Benefit		
Health Screening Benefit (per year*)	$75	$100

* The Health Screening benefit is included with your Critical Illness and Accident Insurance coverage. It provides an annual benefit payment if you complete a health screening test, whether or not there is any out-of-pocket cost to you.

Voluntary Accident Insurance

Administered by:
MetLife | www.metlife.com | 800.GET.MET8

An accidental injury can be costly, especially if you are financially unprepared. Your current medical coverage will help pay for expenses associated with an injury, but won't cover all of the out-of-pocket expenses you may face. Don't wait until you are rushed to the emergency room to realize you need more protection. With accident insurance, you will receive additional coverage your medical insurance may not cover.

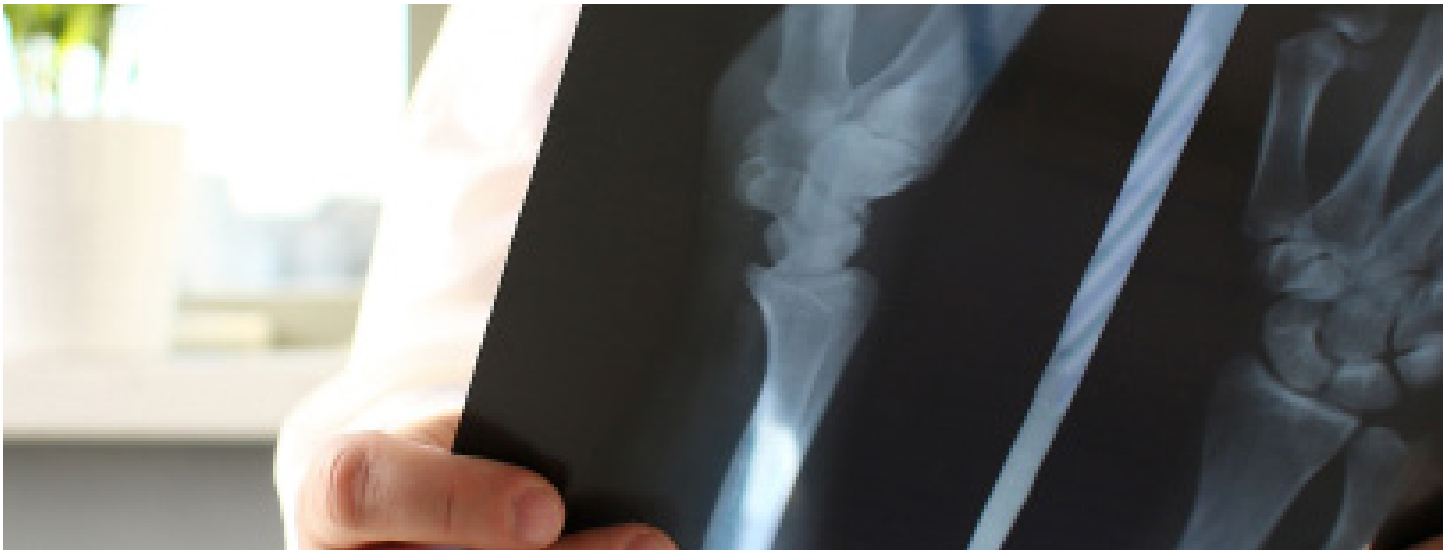
This plan provides a lump-sum payment for over 150 different covered events, such as:

Accident Event	Benefit
Fractures	$200 - $10,000
Dislocations	$150 - $5,000
Second and third degree burns	$100 - $18,000
Concussions (1 time per calendar year)	$250
Coma (1 time per accident unlimited time(s) per calendar year)	$7,000
Cuts or lacerations	$60 - $960
Broken teeth benefit	$50 - $375
Eye Injuries (1 time per accident; unlimited times per calendar year)	$375

You'll receive a lump-sum payment when you have these covered medical services or treatments:

Accident Event	Benefit
Ambulance	$250 - $1,000
Emergency Room	$300
Physician Office	$125
Urgent Care	$150
Medical Testing (x-rays, MRI, CT scans, EEG)	$125 (2 times per accident; 6 times per calendar year)
Physician Follow-up visits	$125
Transportation (3 times per accident; 3 times per calendar year)	$400
Therapy services (including physical and occupational therapy, speech therapy)	$100 (6 times per accident; unlimited times per calendar year
Health Screening Benefit (1 time per calendar year per insured)	$150

See your Certificate of Coverage for full details on your coverage.



Dental Insurance

Administered by:
Delta Dental of Georgia | www.deltadental.com | 800.521.2651

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the ABC Healthcare dental benefit plan.

Delta Dental does not provide ID cards. Employees and Dependents are billed to Delta Dental of Georgia under Group #19838 using the employees social security number.

IN-NETWORK DENTAL PLAN SUMMARY

	STANDARD DENTAL PLAN		ENHANCED DENTAL PLAN WITH ORTHODONTIA*	
	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Annual Maximum Benefit	$1,500	$1,500	$2,000	$2,000
Individual/Family Deductible (waived for preventive services)	$50/$150	$50/$150	$50/$150	$50/$150
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Major Services	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Orthodontia Services	Not covered	Not covered	Plan pays 50%	Plan pays 50%
Orthodontia Maximum Lifetime (in-network and out-of-network)	Not covered	Not covered	$1,500*	$1,500*

*Orthodontia coverage available for eligible children up to age 19.
**Out-of-network payments are based upon 80th percentile of Reasonable & Customary charges, and are subject to balance billing.

Key Words to Know:

Deductible: The amount you pay before the plan begins to pay.

Preventive Services: Services designed to prevent or diagnose dental conditions; including oral evaluations, routine cleanings, X-rays, fluoride treatments, and sealants.

Basic Services: Services such as basic restorations, some oral surgery, endodontics, and periodontics.

Major Services: Services such as crowns, dentures, implants, and some oral surgery.

Orthodontia: Services such as straightening or moving misaligned teeth and/or jaws with braces and/or surgery.

The easiest way to maintain a healthy smile is through preventive care.

Here are tips on keeping your teeth healthy:

- Brush twice a day with a fluoride toothpaste.
- Clean between your teeth daily with floss.
- Eat nutritious meals and limit snacking.
- Visit your dentist regularly for cleanings and oral exams.

Vision Insurance

Administered by:

VSP | www.vsp.com | 800.877.7195

You can enroll in one of the following vision plans to help you save money on eligible vision care expenses, such as eye exams, glasses, and contact lenses.

	STANDARD VISION PLAN	ENHANCED VISION PLAN
Benefit Frequency		
Exam Every:	12 months	12 months
Lenses Every:	12 months	12 months
Frame Every:	24 months	12 months
Covered Services	**Copay**	**Copay**
Exam	$10	$10
Materials	$25	$10
Contact Lens Exam	$60	$60
Diabetic Eyecare Plus Plan	$20	$20
Covered Services	**In-Network**	**In-Network**
Examination	Covered in full	Covered in full
Single Vision Lenses	Covered in full	Covered in full
Lined Bifocals	Covered in full	Covered in full
Lined Trifocals	Covered in full	Covered in full
Lenticular Lenses	Covered in full	Covered in full
Retail Frame Value	$130	$175
Elective Contact Lenses	$130	$175
Necessary Contact Lenses	Covered in full	Covered in full
Diabetic Eyecare Plus Plan	As needed	As needed
Covered Services	**Out-of-Network**	**Out-of-Network**
Examination, up to	$45	$45
Single Vision Lenses, up to	$30	$30
Lined Bifocals, up to	$50	$50
Lined Trifocals, up to	$65	$65
Lenticular Lenses, up to	$100	$100
Frame, up to	$70	$70
Elective Contact lenses, up to	$105	$105
Necessary Contact Lenses, up to	$210	$210

VSP does not provide ID cards. Employees and Dependents are billed to VSP under Group #687260 using the employees social security number.

Key Words to Know:

Copay: An amount you pay for a covered service each time you use that service.

Retail Allowance: Maximum allowance paid toward the cost of vision materials. Amounts in excess of the retail allowance are the financial responsibility of the participant.

Life and Accidental Death & Dismemberment Insurance

Insured by:
CIGNA | www.mycigna.com | 800.362.4462

Life insurance provides important financial protection for you and your family.

Employer-Paid Life and Accidental Death and Dismemberment (AD&D)
Eligible Full-time employees working 30 or more hours a week will receive $15,000 of employee term life and accidental death and dismemberment (AD&D) insurance at no cost to you.

Employee-Paid Term Life

Eligible Full-time or Part-time employees working 20 or more hours a week can supplement coverage by purchasing additional term life insurance for yourself in increments of $10,000 up to the lesser of 5x your salary or $500,000. This coverage is tied to your employment and typically ends if you leave your employer. In most cases, you may be able to retain this coverage with the same insurance carrier if you leave your employer.

Spouse Term Life

You can purchase term life insurance for your spouse in increments of $5,000 up to $500,000 not to exceed 100% of Employee Term Life coverage amount. This coverage is tied to your employment and typically ends if you leave your employer. In most cases, you may be able to retain this coverage for your spouse with the same insurance carrier if you leave your employer.

Child Term Life

You can purchase term life insurance for your dependent children in increments of $2,000 up to $10,000. This coverage is tied to your employment and typically ends if you leave your employer. In most cases, you may be able to retain this coverage for your children with the same insurance carrier if you leave your employer.

Portability of inforce coverage is available for employees and covered dependents when coverage ends at age 70 or when employment ends. Inforce amounts do not require medical underwriting.

Evidence of Insurability

If you did not elect this benefit when first eligible, your coverage will require medical underwriting and may not be guaranteed.

For more detailed information regarding your plan please refer to your SPD or Certificates of Coverage. These are printable in the document section in UltiPro or contact the ABC Healthcare Benefits Team to request a copy.

Additional benefits offered by CIGNA

Health Advocate – Concierge service to help employees and their family members with:

- Medical, Dental, or Vision coverage (i.e. find a doctor, schedule an appointment, estimate procedure cost, locate home care/special needs/senior care)
- Help negotiate medical or dental bills over $400 that are not covered by insurance – save out of pocket cost, expedite payment to healthcare, or secure larger discount

Healthy Rewards – Discounts on a variety of health and wellness products and services such as:

- Gym Memberships
- Acupuncture and Massage Therapy
- Lasik Eye Surgery
- Smoking Cessation

Permanent Life

Insured by:
Chubb | www.chubb.com | 855.241.9891

You also have the option to purchase permanent life insurance. With a permanent life insurance policy, you could be the policy owner and can maintain the coverage, whether or not you leave your employer, for as long as you choose to continue to pay the premium. This option offers you the ability to provide lasting protection for your family. With the purchase of an employee permanent life policy, you may also purchase additional life insurance for your eligible dependents.

Short-Term Disability Insurance (STD)

Administered by:
CIGNA | www.mycigna.com | 800.362.4462

Short-Term Disability (STD) insurance provides income if you become disabled due to an injury or illness. Benefits begin on the 14th day of any injury, hospitalization or illness and can continue for up to 24 weeks.

Benefit Amounts— from $25 up to 60% of your before-tax weekly earnings

Benefit Maximum— $1,000 per week

Preexisting — any injury or illness that occurred during the first 12 months of coverage due to a preexisting condition during the 3 months prior to coverage are excluded.

TAKE NOTE:
If you did not elect this benefit when first eligible, your coverage will require medical underwriting and may not be guaranteed.

For more detailed information regarding your plan please refer to your SPD or Certificates of Coverage. These are printable in the document section in UltiPro or contact the ABC Healthcare Benefits Team to request a copy.

Long-Term Disability Insurance (LTD)

Administered by:
CIGNA | www.mycigna.com | 800.362.4462

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income, and possibly Social Security. Disability insurance provides protection for your most valuable asset—your ability to earn an income. LTD coverage provides income when you have been disabled for 180 days or more.

Benefit Amounts— from $100/10% up to 50% of your before-tax monthly earnings

Benefit Maximum— $2,500 per month

Preexisting—Disabilities that occur during the first 12 months of coverage due to preexisting condition during the 6 months prior to coverage are excluded.

TAKE NOTE:
If you did not elect this benefit when first eligible, your coverage will require medical underwriting and may not be guaranteed.

For more detailed information regarding your plan please refer to your SPD or Certificates of Coverage. These are printable in the document section in UltiPro or contact the ABC Healthcare Benefits Team to request a copy.

Legal Benefits

Administered by:
LegalShield | http://benefits.legalshield.com/ABC | 800.654.7757

At ABC Healthcare, we pride ourselves on putting the health and security of our employees first, and that is why this year we are offering LegalShield, a legal protection plan. With LegalShield you will have direct access to a dedicated law firm who can review and prepare legal documents, assist with personal legal matters such as speeding tickets, neighbor disputes and family related matters such as adoption.

For **$18.00** a month, LegalShield puts a law firm in the palm of your hand.

LegalShield Plan Benefits:

- Dedicated law firm
- Legal consultation and advice
- Court representation
- Legal document preparation and review
- Letters and phone calls on your behalf
- 24/7 emergency legal access

WHATEVER LIFE THROWS AT YOU - THROW IT OUR WAY.

Life Assistance Program℠

Life. Just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, your Life Assistance & Work/Life Support Program is there for you. It can help you and your family find solutions and restore your peace of mind.

Call us anytime, any day.

We're just a phone call away whenever you need us. At no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

Visit a specialist.

You have face-to-face sessions with a behavioral counselor available to you - and your household members. Call us to request a referral.

Monthly Webinars

Educational seminars on a variety of relevant topics such as managing your life, work, money and health, are available in a quarterly calendar of monthly webcasts distributed to your employer.

Achieve work/life balance.

For help handling life's challenges go on line for articles and resources including on family, care giving, pet care, aging, grief, balancing, working smarter, and more.

Legal consultation and referrals*
Receive a free 30-minute consultation with a network attorney. And up to a 25% discount on select fees.

Financial consultations.
Receive a free 30-minute consultation and 25% discount on tax planning and preparation.

Life Assistance Program – 24/7 support

Phone: **800.538.3543**
website: **www.cignalap.com**

Together, all the way.®

Cigna®

Offered by: Life Insurance Company of North America or Connecticut General Life Insurance Company.

*Legal consultations and discounts are excluded for employment-related issues.

These programs are NOT insurance and do not provide reimbursement for financial losses. Some restrictions may apply. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Programs are provided through third party vendors who are solely responsible for their products and services. Full terms, conditions and exclusions are contained in the applicable client program description, and are subject to change. Program availability may vary by plan type and location, and are not available where prohibited by law. These programs are not available under policies insured by Cigna Life Insurance Company of New York (New York, NY).

WILL PREPARATION

Plan for your family's future and financial well-being.

Sixty-four percent of Americans do not have a will.* That means that they have little or no control over decisions after they die. It also leaves a burden on family members. They must make hard choices at an emotional time. Advance planning helps to make the process easier. And Cigna's Will Center can help you with the planning process.

Getting started is easy

Go to **CignaWillCenter.com**. It's easy to use and available to you and your spouse anytime day or night. Once you're registered on the site, you can:

- **Get resources and tools to help you plan** and learn more about:
  - Will preparation
  - Estate planning
  - Funeral planning
- Create a central location to store important information for easy access
- **Create state-specific, legal documents online**, including:
  - Last will and testament
  - Living will
  - Financial power of attorney
  - Power of attorney for health care
  - Medical treatment authorization for minors
- **Manage your legal documents**. You can:
  - Preview
  - Edit
  - Download
  - Print

Service representatives are available to help you at **1.800.901.7534****

Visit CignaWillCenter.com today.

For help, call **800.901.7534**.**

Representatives are available between 7:00 AM and 7:00 PM (CST). Or you can email a help request to **Service@ARAGdirect.com**.

*"Perspectives on Wills," conducted by ARAG, April 2013
** No legal advice is provided

Together, all the way.℠

Cigna®

Registrations and customized documents are maintained for two years, which allows individuals to easily make revisions to their legal documents as their personal situation changes.

Will preparation services are independently administered by ARAG®. Cigna does not provide legal services and makes no representations or warranties as to the quality of the information on the ARAG website or the services of ARAG.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Life Insurance Company of North America, Cigna Life Insurance Company of New York, and Connecticut General Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

SOLUTIONS FOR ALL TYPES OF PERSONAL FINANCIAL CHALLENGES

My Secure Advantage

Cigna knows that financial issues are one of the leading causes of stress in America.* That's why we offer a full-service financial wellness program. My Secure Advantage™ can help support the financial health of your household, at no additional cost to you.

MY SECURE ADVANTAGE PROGRAM INCLUDES:

My Secure Advantage (MSA) Money Coaching

- You can take advantage of a free 30-minute consultation with a certified financial expert before you decide to participate in Money Coaching.
- Individuals and couples can work with a designated Money Coach for 30 days, paid for by Cigna.
- Your Money Coach can help you handle a wide range of financial challenge, including but not limited to: Basic money management, getting out of debt, saving for college or retirement, purchasing a home, marriage or divorce, loss of income, death in the family, and more.
- Through an easy-to-use online portal, you can communicate with your Coach, view educational webinars and access a library of financial tools, forms and tips.
- After the first 30-day coaching period, you may continue working with your Money Coach for $39.95 per month.
- Even if you don't participate in Money Coaching you can get a 25% discount on tax planning and preparation.

Identity theft protection and will preparation services include:

- Education on how to avoid identity theft, consultation with a Fraud Resolution Specialist, and a fraud resolution kit that provides the right documents to use and steps to follow
- Online resources to create and execute state-specific wills, powers of attorney and a variety of other important legal documents
- Free 30-minute legal consultation with a licensed practicing attorney to obtain advice or review legal documents, and a 25% discount off standard fixed or hourly attorney's fees

Call 888.724.2262, Monday - Friday from 9:00 am to 11:00 pm EST (6:00 am to 8:00 pm PST) to speak with an MSA representative.

All you'll need to give is your name, city, state, zip code and the name of your employer or plan sponsor. You can also visit cigna.mysecureadvantage.com for more information, or to register and access online tools and educational resources and create legal documents.

Together, all the way.®

Cigna®

Offered by: Life Insurance Company of North America or Connecticut General Life Insurance Company.

* Stress in America™: Coping with Change American Psychological Association, January, 2017.

My Secure Advantage is a trademark of CLC Incorporated (CLC). The My Secure Advantage Financial Wellness Program is independently administered by CLC. Cigna does not provide financial services and makes no representations or warranties as to the quality of the information on the CLC website or the services of CLC.

These programs are NOT insurance and do not provide reimbursement for financial losses. Presented here are only the highlights of these programs. Full terms, conditions and exclusions are contained in the applicable offering descriptions. Program availability may vary by plan type and location and is subject to change. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Programs are provided through third party vendors who are solely responsible for their products and services. These programs are not available under policies insured by Cigna Life Insurance Company of New York.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Life Insurance Company of North America and Connecticut General Life Insurance Company.The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Identity Theft Protection

Administered by:
Allstate | www.infoarmor.com | 800.789.2720

Allstate's Identity Protection is a monitoring solution that protects you from the hassles of identity theft. By proactively seeking out fraud at the source (when thieves first use personal information) we are able to detect fraud sooner to reduce damages.

We start by employing patented technology used by top financial institutions and banks to monitor applications for misuse of participant's information. Our solution includes monitoring for compromised credentials, application submissions, and High Risk Transactions (such as unauthorized account access, fund transfers and password resets) to detect more fraud, sooner.

If we detect fraud or unusual activity indicative of fraud, you will be the first to know.

Rest assured, when there is a situation that needs attention, a Privacy Advocate will help do the work to resolve it, start to finish, all on your behalf.

You have the option of two levels of coverage. Identity Protection Pro, and Identity Protection Pro Plus. Both options provide superior protection, but the Identity Protection Pro Plus offers Tri-Bureau credit monitoring.

Pet Insurance

Administered by:
Veterinary Pet Insurance/Nationwide
www.petinsurance.com/ABC | 877.738.7874

For pet owners, the cost of providing unexpected veterinary care if medical issues arise could add up to hundreds or even thousands of dollars. Veterinary Pet Insurance (VPI) is a cost effective way to protect you from the risk of these expenses and provide medical care for your pet with peace of mind.

Automotive Rebate Program

Administered by:
Bonus Drive
www.bonusdrive.com | 888.982.6687

We are happy to bring a special offer from BonusDrive to our valued employees. When you purchase or lease a qualifying new vehicle, you can now get cash ($250) back from BonusDrive on top of applicable discounts and incentives you get at the dealership.

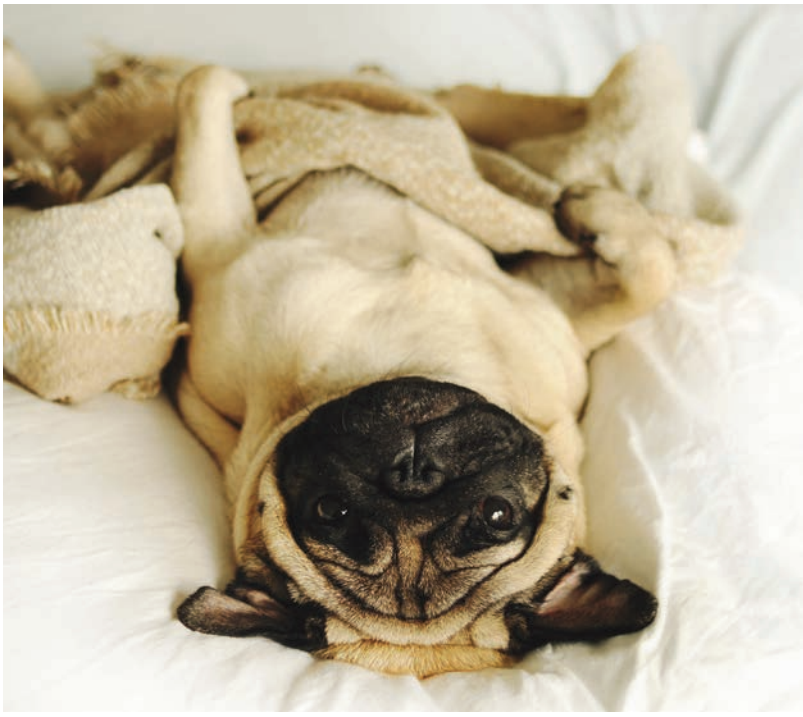
Auto and Home Insurance

Administered by:
METLIFE | www.metlife.com/mybenefits | 800.438.6388

MetLife Auto & Home is a voluntary group auto and home benefit program that provides you with access to insurance coverage for your personal insurance needs. Policies available include: auto, home, landlord's rental dwelling, condo, mobile home, renters, recreational vehicle, boat, and personal excess liability policies.

The program gives you access to special group discounts. You could also benefit from these program features:

- One easy-to-remember, toll-free number, 1 800 GET-MET 8, for all your insurance needs, such as receiving free insurance quotes, making changes to your policy, or just asking questions
- 24-hour claim reporting
- Extended customer service hours, including weekday evenings and Saturdays
- Coverage you can take with you, should you retire or leave the company for another reason
- Enhanced product coverages that are built into every auto policy



Benefit Advocate

Administered by:
ABC Healthcare's Benefits Team

Understanding and managing your healthcare benefits can be a challenge. If you do not receive satisfactory service from your insurance carriers, we are here to help.

Call us for confidential, personal, and friendly help with your insurance needs.
Monday - Friday
8:00 am - 5:00 PM PT

We can assist you in the following:

- Finding qualified doctors, hospitals, dentists, and other providers nationwide
- Answering benefit related questions and helping you get accurate information
- Requesting new ID cards
- Guidance through the claims appeal process
- Determining what is covered and what is your responsibility
- Estimating and understanding healthcare costs to help you make informed decisions
- Resolving insurance claims and uncovering billing errors

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

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
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	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
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	

To see if any other states have added a premium assistance program since August 10, 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

OMB Control Number (This year's 1210-0137 expires on 12/31/XXXX)

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.

Important Notices and Disclosures

ABC Healthcare reserves the right to change, amend or terminate any benefits plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefits does not constitute eligibility.

The Benefits Enrollment Guide, combined with these legal notices, provides an overview of the benefits available to eligible employees and their families. This guide is meant to supplement certain information in the Summary Plan Document (SPD), so retain it for future reference along with your SPD. In the event of a discrepancy between the information presented in the Benefits Enrollment Guide and official plan documents, the official plan documents will govern.

Women's Health and Cancer Rights Act (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please contact your plan administrator.

Newborns' and Mothers' Protection Act (NMHPA) Notice

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Michelle's Law

Michelle's Law allows for extended dependent medical coverage during student medical leaves. The ABC Healthcare plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school or change in school enrollment status (for example, switching from full-time to part-time status) starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact Human Resources at 801-656-2776 as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward 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 your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

Qualified Medical Child Support Orders (QMCSO)

Coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient treated as covered under the Plan and are subject to the limitations, restrictions, provisions, and procedures as all other plan participants.

Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage (COBRA)

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully.

Important Notices and Disclosures

The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with health care benefits. This notice describes the plans' health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information' (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information about You

The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures descried in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the plans by third-party administrators known as "business associates." For example, the plans may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims. or the identity, description, or location of the person who committed the crime.

Worker's Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker's compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U. S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and coy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives

You may exercise your rights through a personal authorized 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 plans retain 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.

Change to this Notice

The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI

You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U. S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and nay of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at the Employer, Attention: Privacy Officer.

Updated and effective March 26, 2013

Prescription Drug Coverage and Medicare

Date of this Notice: October XXXX

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ABC Healthcare 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. ABC HEALTHCARE has determined that the prescription drug coverage offered by ABC Healthcare 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 (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 through 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-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 ABC Healthcare coverage will be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your ABC Healthcare prescription drug coverage, be aware that you may not be able to get this coverage back.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In addition, your current coverage pays other health expenses in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

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 ABC Healthcare and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage, please contact Human Resources.

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 and You handbook. You will receive 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 inside back cover of your copy of the Medicare and 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.

Important Notices and Disclosures

Remember to 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).

Mental Health Parity Notice

The Mental Health Parity Act (MHPA) provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. In general, group health plans offering mental health benefits cannot set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits.

A plan that does not impose an annual or lifetime dollar limit on medical/surgical benefits may not impose such a dollar limit on mental health benefits under the plan. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

For more information about mental health coverage under your plan, please refer to the plan's Summary Plan Description (SPD). You may obtain a copy of the SPD by contacting Human Resources.

Family & Medical Leave Act (FMLA)

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees.

There may be times when you need an extended leave of absence. The ABC Healthcare has a Family and Medical Leave Policy that is in compliance with The Family and Medical Leave Act of 1993 (FMLA), as amended. FMLA provides an entitlement of up to 12 weeks, which protects employees' jobs and benefits in the event of a medical or family circumstance, which requires the employee to take time off from work without pay. In general, the employee must have worked for at least 12 months and at least, 1,250 hours within the last 12 months immediately prior to the first day of leave.

Circumstances Permitting Family and Medical Leave

- Birth of an employee's child (within 12 months after birth)
- Adoption of a child by an employee (within 12 months after placement)
- Placement of a child with the employee for foster care (within 12 months after placement)
- Care of a child, spouse or parent having a serious health condition
- Incapacity of the employee due to a serious health condition.
- Military Leave

Additional leave laws may apply to you depending upon your specific state and if you or a dependent or a military member. Whenever possible leave must be requested in advance. If you have questions about FMLA or any leave requests, please contact Human Resources.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.