January 1, 2018 thru
December 31, 2018

CITY OF PALM COAST, FLORIDA
PALM COAST
INCORPORATED 1999

2018

Your Benefits Overview

GENERAL INFORMATION

What is a "Copayment"?

- A copayment is a pre-determined amount you must pay out-of-pocket when seeing a service provider. It is paid directly to the provider and is due at the time services are rendered.

What is a "Deductible"?

- A deductible is a pre-determined amount that is paid by you before the insurer begins to pay.

What is "Coinsurance"?

- Coinsurance is the percentage paid by the insurer and the per-centage paid by you after you have met the deductible.

What is "Precertification"?

- Certain services, such as hospitalization or outpatient surgery, may require prior authorization with your insurer to verify coverage for those services. When required, your participating physician must obtain a precertification for you prior to your treatment.

Where can I find an in-network provider?

- Directories of participating service providers may be found on your insurer's website. If you do not have internet access, you may call member services to find an in-network provider near you.

Should I use a Convenient Care Center, an Urgent Care Center, or the Emergency Room?

- Convenient Care Centers (found in many CVS and Walgreens stores) are a great way to address the common cough, cold, and sore throat. The cost is normally the same co-payment as seeing your doctor. Urgent Care Centers are another great alternative to the Emergency Room when your doctor's office is closed. The co-payments are normally a lot less that an Emergency Room visit.

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City of Palm Coast Employee Health Clinic

All full time employees whether on City's health insurance and dependents on the Medical Plan can obtain free routine medical care, at our Employee Health Clinic which is operated by MediQuick at the Pinnacles. MediQuick has set aside specific days and hours for the exclusive use of City employees. Services available "free of charge" include, annual physicals, acute medical care such as sore throat, sinus infections, etc. Additionally, lab testing (bloodwork), X-rays, EKG's, minor surgical procedures and treatment of chronic illnesses (i.e., asthma, diabetes, hypertension, etc.) are also covered at the Clinic.

CITY OF PALM COAST EMPLOYEES' HEALTH CLINIC

MediQuick at the Pinnacles
140 Pinnacles Drive (off Rte. 100)
Palm Coast, FL 32164 (386) 597-2829

	Effective 06/01/2017
MONDAYS	3 – 6 pm
WEDNESDAYS	8 – 10 am
FRIDAYS	1 – 4 pm

BY APPOINTMENT ONLY

Doctor "B"
Brian Bogdanowicz, *MD*

Annual physicals, treatment of chronic illnesses, acute conditions; minor surgical procedures, x-rays, EKGs, lab & misc. testing.

Eligible to use Clinic:

All full time employees whether on City health insurance or not
Family members enrolled in City's health insurance

Blue Options 03769

Blended Plan

Blue Cross Blue Shield of Florida

Name of Network: BlueOptions Healthcare Services	In-Network
Lifetime Maximum	No Maximum
Calendar/Plan Deductible Individual Family	 $500 $1000
Annual Out-of-Pocket Maximum (Includes deductible, copay, coinsurance, and Rx) Individual Family	 $2500 $5000
Co-Insurance	20%
Physician Services Office Visit Specialist Chiropractic Care	 $35 $50 $50
Adult and Child Wellness Exams	100% Covered
Hospital Services Inpatient Hospital Per Admission Emergency Room Urgent Care/Outpatient Surgical Facility	 DED + 20% $250 $75/DED + 20%
Diagnostic Services Independent Facility - Lab/X-ray Independent Facility - Advanced Imaging (CT, PET, MRI) 3D Mammograms Colonoscopy	 $0 (Lab)-Ded + Coins (Xrays) $200 No Cost to Employee No Cost to Employee
Prescription Drugs—*Retail (30/31 day supply):* Generic Preferred Brand Non-preferred Brand Specialty	 $20 $40 $70 10%
Non-Network	
Deductible –Individual/Family Coinsurance Maximum Out-of-Pocket	$2000/$4000 40% $5000/$10,000

MEDICAL PLAN RATES

Bi-Weekly

Who is covered	Medical Plan Cost
You Only	$35.31
You + Spouse	$96.99
You + Child(ren)	$78.21
You + Family	$263.54

Blue Options 03160/03161

HDHP with HSA

Blue Cross Blue Shield of Florida

Healthcare Services	In-Network
Lifetime Maximum	Unlimited
Calendar/Plan or Policy Deductible Individual Family	 $1500 $3000
Annual Out-of-Pocket Maximum (Includes deductible, copay, coinsurance, and Rx) Individual Family	 $2500 $5000
Co-Insurance	20%
Physician Services Office Visit Specialist Chiropractic Care	 DED + 20% DED + 20% DED + 20%
Adult and Child Wellness Exams	100% Covered
Hospital Services Inpatient Hospital Per Admission Emergency Room Urgent Care Outpatient Surgical Facility	 DED + 20% DED + 20% DED + 20% DED + 20%
Diagnostic Services Independent Facility - Lab/X-ray Independent Facility - Advanced Imaging (CT, PET, MRI) 3D Mammograms Colonoscopy	 DED (Lab) DED+ 20% (Xrays) DED + 20% No Cost to Employee No Cost to Employee
Prescription Drugs— *Retail (30/31 day supply):* Generic Preferred Brand Non-preferred Brand Specialty	 $20 $40 $70 10%
Non-Network	
Deductible Coinsurance Maximum Out-of-Pocket	$3000/$6000 40% $5000/$10,000

MEDICAL PLAN RATES

Bi-Weekly

Who is covered	Medical Plan Cost
You Only	$16.99
You + Spouse	$66.23
You + Child(ren)	$47.44
You + Family	$232.63

Health Savings Account

Qualifying High-Deductible Health Insurance Plan

Provides health care benefits after the deductible has been met.

Health Savings Account

A Health Savings Account (HSA) combines high deductible health insurance with a tax-favored savings account. Money in the savings account can help pay the costs of qualified medical expenses not covered by medical insurance for you and your dependents. Money left in the savings account earns interest and is yours to keep.

- EMPLOYEE OWNED ACCOUNT
- Pre-tax contributions
- ***City of Palm Coast*** will contribute ***$1500*** for the plan year (prorated if enrollment occurs after Open Enrollment) to an HSA account for each employee who enrolls in the High Deductible Health Plan. *Employees with dependents on their health insurance may receive an additional match up to a max of* ***$750*** *from the City.*
- Pay for any qualified medical expenses. (See IRS Publication 502 for a list of qualified medical expenses).
- Maximum annual contribution:
  - ⇒ Employee only coverage: $3,450
  - ⇒ Family coverage: $6,900
  - ⇒ Age 55 or older – additional election of $1,000

To be HSA-eligible for a month, an individual must:

- ♦ Be covered by an HDHP on the first day of the month;
- ♦ Not be covered by other health coverage that is not an HDHP (with certain exceptions);
- ♦ Not be enrolled in Medicare; and
- ♦ Not be eligible to be claimed as a dependent on another person's tax return.

Why might an HSA be the right choice for you?

- ♦ It is Tax Free and **saves you money**. For individuals with few regular health expenses, paying a traditional health plan premium can feel like throwing money out the window. HDHPs come with much lower premiums than traditional health plans, meaning less money is deducted from your paychecks. Plus, HSAs are basically "cash" accounts, so you may be able to negotiate pricing on many medical services.

DENTAL COVERAGE - PPO

Provided by SunLife

Below is your PPO dental plan which gives you freedom to use in-network or out-of-network dentists. Since network providers offer reduced contracted rates, you save money by using network providers for all your dental needs. All benefits received from out-of-network dentists are subject to "reasonable and customary" fees. Any amount that exceeds the dental carrier's "reasonable and customary" amounts is the patient's responsibility.

You can access the dental provider's network and find a dentist near you at www.assurantemployeebenefits.com

Dental Services	In-Network	Out-of-Network
Annual Maximum Benefit	$2000	
Calendar Year Deductible: Per Person	$50	$50
PREVENTATIVE PROCEDURES:	Deductible Waived	
Routine Exams - *1 per 6 months* Teeth Cleaning - *1 per 6 months* Bitewing X-rays - *1 per year* Full Mouth X-rays - *1 per 36 months* Fluoride Treatments (under 19) - *1 per calendar year* Sealants (under 19) permanent molar teeth	Plan pays 100%	Plan pays 100%* of allowed charges
BASIC PROCEDURES:	Deductible Applies	
Periodontal Scaling - *1/quadrant per 24 months* Root Canal Therapy - *1/tooth per lifetime* Fillings - 1/surface per 24 months	Plan pays 80%	Plan pays 80%* of allowed charges
MAJOR PROCEDURES:	Deductible Applies	
Crowns - *1 per 10 years* Fixed Bridges & Repairs - *1 in 10 years* Full & Partial Dentures & Repairs - *1 in 10 years* Oral & Periodontal Surgery Implants - *1 in 10 years*	Plan Pays 50%	Plan pays 50%* of allowed charges
Orthodontic Procedures:		
Lifetime maximum	$1000	

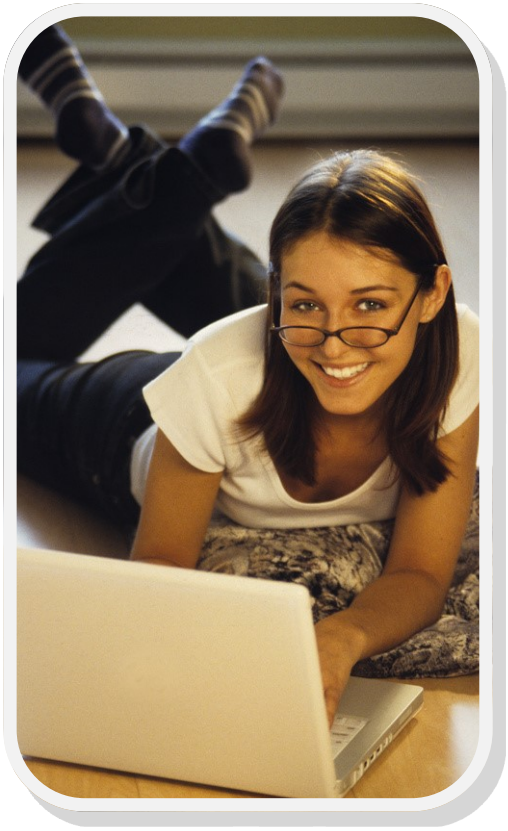
* Percent of allowed charges

DENTAL PLAN RATES

Bi-Weekly

Who is covered	Dental Plan Cost
You Only	$19.14
You + Spouse	$36.15
You + Child(ren)	$40.40
You + Family	$57.41

VISION COVERAGE



Provided by Humana Vision 130

This plan covers eye exams, prescription lenses and frames, or contact lenses for you and your dependents when you receive services from in-network or out-of-network providers. To find a participating provider log on to www.myhumana.vcp.com.

Vision Coverage Rates

Based on your Bi-Weekly deduction

Who is covered	Vision Plan
You Only	$2.57
You + Spouse	$5.14
You + Child(ren)	$4.88
You + Family	$7.67

Vision Services	In-Network	Out-of-Network
Eye Exams Frequency	$10 Once every 12 months	Up to $30 Once every 12 months
BASIC LENSES		
Frequency Single vision Bifocal vision Trifocal vision	Once every 12 months $15 $15 $15	Once every 12 months Up to $25 Up to $40 Up to $60
FRAMES		
Frequency* Benefit	Once every 24 months $130 allowance**	Once every 24 months $65 allowance
CONTACTS		
Frequency* Benefit	Once every 12 months Up to $55 –10% off retail (fitting) $130 allowance	Not Covered

*Contacts and Eyeglasses cannot be purchased in the same year

**20% off balance over $130

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available January 01, 2018– December 31, 2018. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

DISABILITY COVERAGE

Provided by SunLife Financial

You count on your income to provide the things you need today and to achieve the dreams you have for tomorrow. But, what would happen if you were suddenly unable to earn a living because of an unexpected accident or illness?

Short-Term Disability

If you become disabled because of a non-occupational illness or injury and cannot work, you can be covered by the short-term disability insurance policy. Benefits can begin on the ***8th day following an accident and the 8th day of a sickness.*** The short-term disability plan replaces up to ***60%*** of your basic weekly earnings, with a maximum weekly benefit of ***$1,000***. You can receive short-term disability benefits for up to ***12 weeks.***

The estimated rates are on the following page based on your monthly gross income. The final premium calculations will be done by SunLife.

Long-Term Disability

If you become unable to perform your regular job duties for an extended period of time due to sickness, or accidental injury, you can be covered by the long-term disability (LTD) policy.

Your income replacement benefit would equal ***60%*** of your basic monthly earnings. The maximum monthly benefit you can receive is ***$5,000***. Benefits begin after you have been unable to work for ***90 days*** due to a covered sickness or accident and will continue to be paid for up to ***normal social security age.***

Your LTD benefit will be reduced by any disability income you receive for other sources, such as Social Security, worker's compensation, and/or state disability plans, to provide you with a combined monthly benefit equal to 60% of your basic monthly earnings.

THIS BENEFIT IS PAID ENTIRELY BY THE CITY OF PALM COAST

Life Coverage

Life insurance protects your family or other beneficiaries in the event of your death. The death benefit helps replace the income you would have provided and can help meet important financial needs. It can help pay your mortgage, rent, run your household, send your children to college, pay off debts, etc. The City of Palm Coast provides eligible employees basic life insurance up to one year's base salary with SunLife at no cost. The City of Palm Coast also provides eligible employees the option to enroll in voluntary life insurance with SunLife at a group rate (located on the next page).

The following are attached to this group term life insurance policy:

- *Waiver of premium*
- *Accelerated life benefit*
- *Portability*

Summary of Voluntary Life Insurance

If you chose to enroll in voluntary life insurance, you may also insure your spouse and eligible dependent children up to the age of 21. A summary of your life insurance coverage is listed in the table below, if you should have questions on this policy see your SunLife Financial Certificate of Benefits.

Summary of Insurance	
Guaranteed Issue	$100,000.
Minimum Benefit Amount	$10,000.
Maximum Benefit Amount	7X annual salary, not to exceed $500,000.
Increments of…	$10,000.
Spouse Coverage	
Spouse Guarantee Issue	$30,000.
Increments of…	$5000.
Child(ren) Coverage	
Age 14 days to 25 years	$10,000 *minimum and maximum*

Employee/Spouse Monthly Cost:

If your age is...	Your cost for each $1,000 of supplemental life is...
<25	$0.060
25-29	$0.060
30-34	$0.070
35-39	$0.090
40-44	$0.110
45-49	$0.170
50-54	$0.260
55-59	$0.550
60-64	$0.630
65-69	$0.940
70-74	$2.300
75 +	$3.200

Additional Information

- **Age reduction scale:**
  65% of original amount at age 70
  50% of original amount at age 75
- **Age-bracketed premiums:**
  Premiums increase on plan anniversary after you enter next 5 year age group
- **Evidence of Insurability form**
  Is required for employees who do not enroll during their initial eligibility period or who want to increase coverage or add dependent coverage at Open Enrollment

Dependent Children Monthly Cost:

If your coverage level is...	Your cost for each $1,000 of supplemental life is...
Child Life	$0.166

How to figure your voluntary life cost per paycheck:

1. Indicate your elected benefit amount (EBA)
2. Divide EBA by $1,000
3. Enter age rate from cost table
4. Multiply Step 2 by Step 3
5. Multiply Step 4 by 12 then divide by 24 to calculate your cost per paycheck

Employee Assistance Program (EAP)

With New Directions' comprehensive EAP services, employees and their dependent family members can successfully identify and resolve a wide range of issues at no cost. EAP experts and tools can help individuals address almost any issue, to include some of the following:

Behavioral Consultation

* Relationship and family challenges
* Stress
* Depression
* Work and life coaching
* Substance Abuse

Legal and Financial Consultation

* Divorce
* Landlord/Tenant
* Tax/IRS/Social Security
* Criminal Charges
* Bankruptcy
* Landlord/Tenant Issues

⇒ 6 Visits/Consultations vs. 3 with other EAP

⇒ Florida Blue Network

◊ Resources available 24/7 365 days per week

◊ Call 800-624-5544 or visit ***ndbh.com***

City Retirement Plans 401(a)

Provided by Empower Retirement

Empower Retirement administers the City of Palm Coast Retirement Plan. The City of Palm Coast makes the following contributions to the 401(a) City Retirement Plan for employees, depending on their job classification. Employees do not contribute to this plan. Employees elect their investment choice and can direct their funds into one or more investment options.

City Contributions	
Special Risk Employees	17.5%
Directors	13%
General Employees	10%

VESTING

Vesting refers to the percentage of employer contributions a participant is entitled to receive upon distribution from the Plan. Employer contributions to the Plan, plus any earning they generate, are vested as follows:

General Employees and Directors

Years of Service	Vesting Percentage
1 Year	20%
2 Years	40%
3 Years	60%
4 Years	80%
5 Years	100%

Special Risk Employees

Years of Service	Vesting Percentage
1 Year	10%
2 Years	20%
3 Years	30%
4 Years	40%
5 Years	50%
6 Years	60%
7 Years	70%
8 Years	80%
9 Years	90%
10 Years	100%

Withdrawals-401(a) City Retirement Plan

Withdrawals may be made from your 401(a) City Retirement Plan upon one of the following qualifying events as defined by the IRS:

-Retirement -Separation from Service -Total Disability

-Attainment of age 59 1/2 -Death of participant

Please see Plan documents for special rules that may pertain to fire personnel. Ordinary income taxes will apply to each withdrawal.

City Retirement Plans 457(b)

Provided by Empower Retirement

ICMA-RC Services

The Deferred Compensation Plan offered through Empower Retirement and/or ICMA-RC is a benefit available to both full and part-time employees. Through Payroll Deduction, you make pre-tax contributions to your 457(b) Deferred Compensation Plan. You may direct your money into one, or a variety of investment options. Traditional and Roth options are offered.

The maximum contribution amount to the 457(b) plan is as specified by the IRS. For 2018, it is $18,500. For employees 50 years or older, there is a catch-up provision that allows an additional contribution of $6,000. per year.

YOU CAN ENROLL IN THE PLAN AT ANY TIME DURING THE YEAR. Please notify HR whenever you make a change online.

Withdrawals may be made from your 457(b) Deferred Compensation Plan upon one of the following qualifying events; as defined by the IRS:

- Retirement
- Separation from service
- Total Disability
- Unforeseeable Emergency (subject to Plan Limitations)
- Attainment of age 70 1/2
- Death of Participant

Please see Plan documents for special rules that may pertain to Fire personnel.

Loans may be taken from the 457(b) plan, up to 50% of contributions or $50,000. whichever is less. For more

Understanding Your Financial Wellness Benefit

What is Financial Wellness?

- Its a position of health, not wealth
- An ongoing process, not an event
- Controlling your money and not letting it control you
- Eliminating stress by having a plan in place
- Maintaining a proper balance between spending and saving
- Having the knowledge, peace and confidence to make informed, financial decisions

How do I get Involved?

the participant effect

888-968-9168
Call us! We'll provide you resources to begin your financial wellness journey!

www.meetme.so/enrollTPE
Schedule a time to meet one-on-one. Getting started is quick and simple.

Email
Let us know you are interested! We will contact you with more information about financial wellness and your next steps

kmccoy@theparticipanteffect.com

Scan Here!
Scan the QR reader to schedule a time that works with your schedule.

Tuition Reimbursement

In an effort to improve service to the citizens of the City of Palm Coast and to encourage employees to enhance their productivity and efficiency in their current position and/or which may contribute to advancement and promotional potential, the City of Palm Coast may provide tuition reimbursement according to the following procedures.

Employees who request Tuition Reimbursement, ***must agree to remain in the employ of the City for at least one year*** following completion of the coursework for which they are being reimbursed. ***Employees who separate from employment during this period shall reimburse the City the amounts paid under this policy.*** Each semester, employees must complete a Tuition Reimbursement Program Application and Agreement to Work Form to be eligible for benefits.

This program may be amended or terminated at any time. Reimbursement shall be limited, subject to the availability of funds. The city will reimburse tuition related expenses only. Reimbursement will not be made for books, fees including internet, labs, travel, equipment, etc.

WHO IS ELIGIBLE

- Full-time City employees who have been employed at least one year.

WHAT SCHOOL CAN I ATTEND

- Employee must enroll in an institution accredited by one of the regional associations recognized by the US Department of Education.
- Course work must be related to either the employee's current position or prepare the employee for promotional opportunities within the City.

WHAT COURSES ARE REIMBURSABLE

- Both academic and technical courses.*
- Bachelor and Masters Degree Courses.**
- Community college courses, correspondence courses, and internet courses.

* - Technical Courses for Water Treatment Plant Only

**The city will reimburse for only (1) Masters degree program and will not reimburse for Doctorate level work.

Technical or other course work	Bachelors Degree Program	Masters Degree Program
Pass = 100%	A = 100%	A = 100%
Fail =0%	B = 75%	B = 50%
	C = 50%	C or Below = 0%
	Below C = 0%	

Tuition Reimbursement

Cont'd

REIMBURSEMENT

The City will reimburse employees only to the extent that they are not reimbursed through other programs (i.e., Federal, State or Local aid as well as paid leave, state fire supplemental pay, etc.). No employee will receive tuition funds greater than those actually incurred by the employee. The City will reimburse employees attending private colleges based on the average annual resident rate established by the State of Florida (figures available through Florida Department of Education) for undergraduate or graduate credit hours in the State of Florida Public University System. Employees attending colleges or technical schools that are on the quarter hour or other hourly system will be converted to semester hours for the purpose of reimbursement. The City will not reimburse payment for required textbooks, travel, equipment or other related fees.

APPLICATION PROCESS

In order to be eligible for tuition reimbursement the **employee must complete and submit the signed, Tuition Reimbursement Program Application and the Statement to Work Form** to the Human Resources Department.

IMPORTANT

- The employee must attach a copy of the itemized bill, clearly indicating tuition costs and other expenses from the school, along with a receipt showing the class has been paid. The receipt and the itemized bill can be one in the same if the bill shows how the payment was made.
- The employee must attach a copy of their grades.
- The tuition reimbursement package must be submitted to the Human Resource Department within thirty (30) days after completion of the course. Requests not received within this timeframe will be dependent upon availability of funds.

Annually the City Council shall establish a budget for the fiscal year based on availability of funds for the tuition reimbursement program.

No employee will receive more than 12 credit hours per semester at the current annual average rate. Where there are insufficient funds to cover all approved applications, funds will be disbursed equitably to all applicants, however, not to exceed an amount equal to the cost of 12 credit hours per semester.

Please contact the Human Resources Department for credit hour rates.

FOR ASSISTANCE

Should you have a benefit or claims question, refer to the table below for the appropriate provider. Be sure to have your insurance identification card available when you make your call.

Company/Provider	Group #	Telephone	Website
BLUE CROSS BLUE SHIELD OF FLORIDA Medical	51470	800.352.2853	www.bcbsfl.com
SUNLIFE Dental, Disability, Life	Dental 5482522 Life & Disability 246804	800.247.6875	www.sunlife.com
HUMANA Vision	791259	866-537-0229	www.members.humana.com
NEW DIRECTIONS EAP	City of Palm Coast	800-624-5544	www.ndbh.com
Empower Retirement 401(a) 457(b)	98496-01 98496-02	800.701.8255	www.empower-retirement.com
ICMA RETIREMENT 457(b) RHSA	306140 800699	800.326.7272	www.icmarc.org
AFLAC Therese Raimondo		912.269.0476	Therese.raimondo@us.aflac.com

Special Enrollment Rights Notice

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 towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your 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.

Special enrollment rights also may exist in the following circumstances:

- ⇒ If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- ⇒ If you or your dependents become eligible for a State premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.
- ⇒ If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Note: The 60 day period for requesting enrollment applied only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applied to most special enrollments.

Women's Health & Cancer Rights Act of 1998

The Women's Health and Cancer Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies.

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 was performed;
- ⇒ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ⇒ Prostheses; and
- ⇒ Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance amounts applicable to other medical and surgical benefits provided under the health plan offered by your employer.

Health Insurance Portability and Accountability Act (HIPAA) Notice

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

This Information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of such an event.
If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at (312)353-0900.
If you have any questions about this notice or the law, please contact your Plan Administrator at the number or location provided in your benefits booklet or Summary Plan Description.
Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

Notice of Privacy Practices: Plan administrators, clearinghouses, business associates, and health care providers that transmit health information electronically or use electronic health records may not redistribute or unlawfully use electronic health records without permission from the insured. The insured may request information on how their electronic records are distributed, how frequently they are distributed, and who they are distributed to by contacting the U.S. Department of Health and Human Services.

Notice of Breach of Unsecured PHI: If a breach in protected health information (PHI) was to occur you should receive notice of the breach without unreasonable delay in no less than 60 days of the discovery from the entities mentioned above (plan administrators, providers, etc.)

Health Insurance Marketplace Coverage Notice

The Health Insurance Marketplace is available to assist you as you evaluate health insurance options for you and your family. This notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer. The Marketplace is designed to help you find private health insurance and compare private health insurance options. You may also be eligible for a new kind of tax credit under section 36B of IRS code that could potentially lowers your monthly premium. If the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes. More information on the health insurance Marketplace may be found at https://www.healthcare.gov

Notice of Rescission

(a) *Prohibition on rescissions* - (1) A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual):

I. performs an act, practice, or omission that constitutes fraud
II. makes an intentional misrepresentation of material fact,

as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

A rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose.

A cancellation or discontinuance of coverage is not a rescission if -

I. The cancellation or discontinuance of coverage has only a prospective effect;
II. The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRApremiums) towards the cost of coverage;
III. The cancellation or discontinuance of coverage is initiated by the individual (or by the individual's authorized representative) and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or
IV. The cancellation or discontinuance of coverage is initiated by the exchange pursuant (the insured).

Michelle's Law

Michelle's Law protects a postsecondary student from losing full-time student status under an employer's medical coverage if the student is (i) a dependent child of a participant or beneficiary under the terms of the plan; and (ii) enrolled in a plan on the basis of being student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence from school. A dependent covered under the law is entitled to the same benefits as if the dependent continued to be enrolled as a full-time student. The law also recognizes that changes in coverage (whether due to plan design or a subsequent annual enrollment election) pass through to the dependent for the remainder of the medically necessary leave of absence.

Mental Health Parity & Addiction Equity Act 2008 (MHPAEA)

Under the MHPAEA, the financial requirements and treatment limits that group health plans and health insurance issuers apply to mental health or substance use disorder benefits generally cannot be more restrictive than those applicable to medical and surgical benefits. If a plan covers mental health and substance use disorder, MHPAEA provides medical and surgical benefits and mental health and substance use disorder benefits. MHPAEA it must comply with the federal parity requirements.

The MHPAEA contains the following parity requirements:
The financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket limits) applicable to mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.

Treatment limitations (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of coverage) must also comply with the MHPAEA's parity requirements. Non-quantitative treatment limitations (such as medical management standards, formulary design and determinations of usual, customary or reasonable amounts) are subject to a separate parity requirement.

If medical and surgical benefits are offered on an out-of-network basis, a plan or issuer must also offer mental health and substance use disorder benefits on an out-of-network basis.

Newborn's and Mothers' Health Protection Act

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).

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Cobra provides eligible individuals and their dependents who would otherwise lose group health coverage as a result of a qualifying life event with an opportunity to continue group health coverage for a limited time period under certain circumstances such as:

- Voluntary or involuntary job loss
- Reduction in the hours worked
- Transition between jobs
- Death
- Divorce
- And other qualifying life events

If you are entitled to elect COBRA coverage, you will have 60 days (starting on the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage.

Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by groups with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

The duration of COBRA extends from the date of the qualifying event for a limited period of 18 or 36 months. The length of time depends on the type of qualifying life event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

COBRA Continuation coverage may be terminated earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis
- The employer ceases to employ any group health plan
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage;
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of open enrollment period. For more information on alternatives to COBRA coverage reach out to your HR Representative or Plan administrator.

Contact your plan administrator or Human Resources to determine how COBRA is administered at your workplace.

CHIP Model Notice

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 January 31, 2017. Contact your State for more information on eligibility.

State– Specific Medicaid Contact information (Continued)		
State	**Phone**	**Web Address**
Alabama	1-855-692-5447	www.myalhipp.com
Alaska	1-866-251-4861	http://myakhipp.com/
Arizona	1-855-432-7587	https://www.azahcccs.gov/Members/GetCovered/Categories/KidsCare.html
Arkansas	1-855-692-7447	https://www.myarhipp.com
California	1-8775437669	https://www.insurekidsnow.gov/state/ca/index.html
Colorado	1-800-221-3943	www.healthfirstcolorado.com/
Connecticut	1-855-805- 4325	https://www.insurekidsnow.gov/state/ct/index.html
Delaware	1-800-996-9969	http://www.dhss.delaware.gov/dss/dhcp.html
Florida	1-877-357-3268	http://flmedicaidtplrecovery.com/hipp/
Georgia	1-404-656-4507	https://dch.georgia.gov/medicaid
Hawaii	1-877-628-5076	https://www.insurekidsnow.gov/state/hi/index.html
Idaho	1-877-456-1233	http://healthandwelfare.idaho.gov/Medical/Medicaid/IdahoHealthPlanforChildren/tabid/219/Default.aspx
Illinois	1-866-311-1119	https://www.insurekidsnow.gov/state/il/index.html
Indiana	1-800-403-0864	http://www.in.gov/fssa/hip/ Or Http://www.indianamedicaid.com
Iowa	1-8883469562	http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Kansas	1-785-296-3512	http://www.kdheks.gov/hcf/
Kentucky	1-800-635-2570	http://www.chfs.ky.gov/dms/default.htm
Louisiana	1-888-695-2447	http://new.dhh.louisiana.gov/index.cfm/subhome/1/n/331
Maine	1-800-442-6003	http://www.maine.gov/dhhs/ofi/public-assistance/index/html
Maryland	1-855-642-8572	https://mmcp.dhmh.maryland.gov/chp/pages/Home.aspx
Massachusetts	1-800-462-1120	http://www.mass.gov/eohhs/gov/departments/masshealth/
Michigan	1-855-275-6424	https://www.mibridges.michigan.gov/access/
Minnesota	1-800-657-3739	http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Mississippi	1-601-359-6050	http://msdh.ms.gov/msdhsite/_static/41,0,96.html
Missouri	1-573-751-2005	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

State– Specific Medicaid Contact information		
State	**Phone**	**Web Address**
Montana	1-800-694-3084	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Nebraska	1-855-632-7633	http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Nevada	1-800-992-0900	https://dwss.nv.gov/
New Hampshire	1-603-271-5218	http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
New Jersey	1-609-631-2392-Medicaid 1-800-701-0710-Chip	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
New Mexico	1-855-637-6574	https://www.insurekidsnow.gov/state/nm/index.html
New York	1-800-541-2831	https://www.health.ny.gov/health_care/medicaid/
North Carolina	1-919-855-4100	http://dma.ncdhhs.gov/
North Dakota	1-844-854-4825	http://www.nd.gov/dhs/services/medicalserv/medicaid/
Ohio	1-800-324-8680	https://www.insurekidsnow.gov/state/oh/index.html
Oklahoma	1-888-365-3742	http://www.insureoklahoma.org
Oregon	1-800-699-9075	http://healthcare.oregon.gov/Pages/index.aspx
Pennsylvania	1-800-692-7462	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Rhode Island	1-401-462-5300	http://www.eohhs.ri.gov/
South Carolina	1-888-549-0820	https://www.scdhhs.gov/
South Dakota	1-888-829-0059	http://dss.sd.gov/
Tennessee	1-877-543-7669	https://www.insurekidsnow.gov/state/tn/index.html
Texas	1-800-440-0493	http://gethipptexas.com/
Utah	1-877-543-7669	Medicaid-https://medicaid.utah.gov/
Vermont	1-800-250-8427	http://www.greenmountaincare.org/
Virginia	Medicaid-1-800-432-5924 Chip-1-855-242-8282	Medicaid/Chip-http://www.coverva.org/programs_premium_assistance.cfm
Washington	1-800-562-3022 Ext. 15473	http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
West Virginia	1-877-598-5820	http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Wisconsin	1-800-362-3002	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Wyoming	1-307-777-7531	https://wyequalitycare.acs-inc.com/