CENTERSTAGE

BENEFITS PLAN OVERVIEW 2016/2017

WELCOME

CenterStage takes pride in offering a comprehensive and competitive benefits package to its employees. CenterStage, through all of its benefit partners, offers you a benefit program that allows choice and flexibility. Through this program you can choose the benefits that are best for you and your family.

Please take the time to review all of the plan options available to you prior to making your selections. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet you and your family's needs throughout the year.

Options selected during open enrollment remain in place for the full plan year. Options selected upon hire remain in place through the end of the plan year in which you are hired.

The Internal Revenue Service *(IRS)* states that eligible employees may only make elections to the plan once a year at open enrollment. Medical, Dental, and Vision benefit choices are binding through June 30th of each year. The following circumstances are the ONLY reasons you may change your benefits during the year:

Marriage	***Death of a Spouse***
Divorce	***Death of a Dependent***
Birth & Adoption	***Loss of Dependent Status***
Loss of Spouse's job where coverage is maintained through a spouse's plan	

These special circumstances, often referred to as life event changes, will allow you to make plan changes at any time during the year in which they occur. For any allowable changes, you must inform Human Resources within 30 days of the event to avoid lapse in coverage. All other changes are deferred to open enrollment.

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Medical Benefits aetna

CenterStage's medical options are designed to provide you and your family with access to high quality healthcare. There are two medical plan options which are available through Aetna. The first Aetna option is an HNO Only plan and the second is an HNO HSA Comp plan.

The medical options cover a broad range of healthcare services and supplies, including prescriptions, office visits and hospitalizations. The plans differ when it comes to how they share costs with you. Please refer to the summary on Page 2 for specific details on each medical plan option. www.aetna.com.

In addition, the Affordable Care Act offers plans that you may select on your own. However no cost sharing is provided through CenterStage. www.healthcare.gov

www.marylandhealthconnection.gov

Eligibility: First day of the month following date of employment.

Available to All full time benefit eligible employees, their qualified dependents, domestic partners and their qualified dependents. Please note: Coverage for domestic partners and their dependents will be deducted on a post tax basis. **(under IRC §152)** Employees will also need to show proof of domestic partnership by completing the Affidavit provided by the HR Department.

This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this brochure and the official plan documents, the language of the official plan document shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future to meet Internal Revenue Service rules or otherwise as decided by CenterStage.

Medical Benefits Description

Benefits Description	Aetna HNO Only		Aetna HNO HSA Comp	
	In-Network	*Out-Of-Network*	*In-Network*	*Out-Of-Network*
Employer Contribution to Health Savings Account	N/A	N/A	$185 (pro-rated)	
Lifetime Maximum	Unlimited		Unlimited	
Out-Of-Pocket Maximum Individual Family	$4,000 $8,000	N/A N/A	$3,000 $6,000	N/A N/A
Deductible Individual Family	$1,000 $2,000	N/A N/A	$1,500 $3,000	N/A N/A
Coinsurance	80% / 20%	N/A	100% / 0%	N/A
Preventive Care	Covered in full	Not covered	Covered in full	Not covered
Primary Office Visit	$30 copay	Not covered	$20 copay after deductible	Not covered
Specialist Services	$50 copay	Not covered	$30 copay after deductible	Not covered
Emergency Room	$150 copay (waived if admitted)	Paid as In-Network	$150 copay after deductible	Paid as In-Network
Inpatient Hospital Services	20% after deductible	Not covered	$250 copay per admission after deductible	Not covered
Outpatient Surgery	20% after deductible	Not covered	Covered in full after deductible	Not covered
Lab & Pathology Services	Covered in full	Not covered	$30 copay after deductible	Not covered
X-Ray Services Routine Radiology/Diagnostic MRI/MRA, CT, PET Scans	$50 copay $100 copay	Not covered Not covered	$30 copay after deductible $100 copay after deductible	Not covered Not covered
Routine Mammography	Covered in full	Not covered	Covered in full	Not covered
Routine Eye Exam *(once every year)*	Covered in full	Not covered	Covered in full	Not covered
Durable Medical Equipment	20%	Not covered	20% after deductible	Not covered
Prescription Drug *(including oral contraceptives)* Generic Brand Formulary Mail Order (2x retail)	$15 copay $35 copay $60 copay $30 / $70 / $120 copay	Not covered Not covered Not covered Not covered	$15 copay $35 copay $60 copay $30 / $70 / $120 copay	Not covered Not covered Not covered Not covered

**see Aetna benefit summary for more details*

Health Savings Account (HSA)

A Health Savings Account (HSA) is a savings account used for setting aside pre-tax dollars in order to pay for qualified medical, dental, or vision expenses.

The HSA account is located at Wells Fargo Bank. The account earns interest and may incur fees.

To open an HSA, you must participate in Aetna's HNO HSA Compatible Plan.

If you open an HSA while at CenterStage, the company makes an annual contribution to the account. This amount is $185.00 (prorated).

For calendar year 2016, the maximum you can contribute (through payroll deductions) is $3,350 for Individuals and $6,750 for Families. In 2017, the Single amount increases to $3,400.

You are the owner of the account. If you leave CenterStage, the account stays with you. It is always yours.

You cannot contribute to both a Medical FSA and an HSA Health Savings Account in the same year. You cannot contribute to an HSA if you have a balance in a Healthcare FSA. See other limitations and more details at the website below:

www.wellsfargo.com/HSA

Glossary of Health Coverage and Medical Terms

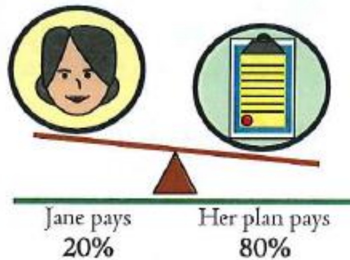
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs (see your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document).
- **Bold blue** text indicates a term defined in this Glossary.
- See Page 5 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense", "payment allowance" or "negotiated rate". If your **provider** charges more than the allowed amount, you may have to pay the difference (see **Balance Billing**).

Appeal: A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing: When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

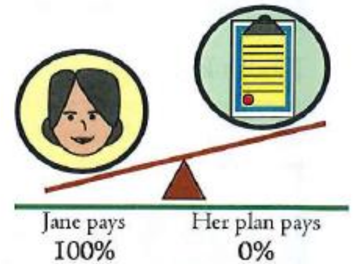
Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. See examples on how co-insurance works on page 5.



Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Durable Medical Equipment (DME): Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an **emergency medical condition**.

Emergency Room Care: **Emergency Services** you get in an emergency room.

Emergency Services: Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or **plan**.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment: A fixed amount (for example $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

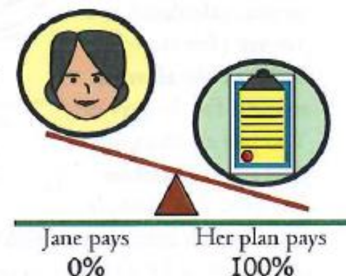
Network: The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider: A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or it your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance: The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment: a fixed amount (for example, $30) you pay for covered health care services from providers who to ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit: The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



Physician Services: Health care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage: **Health insurance** or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

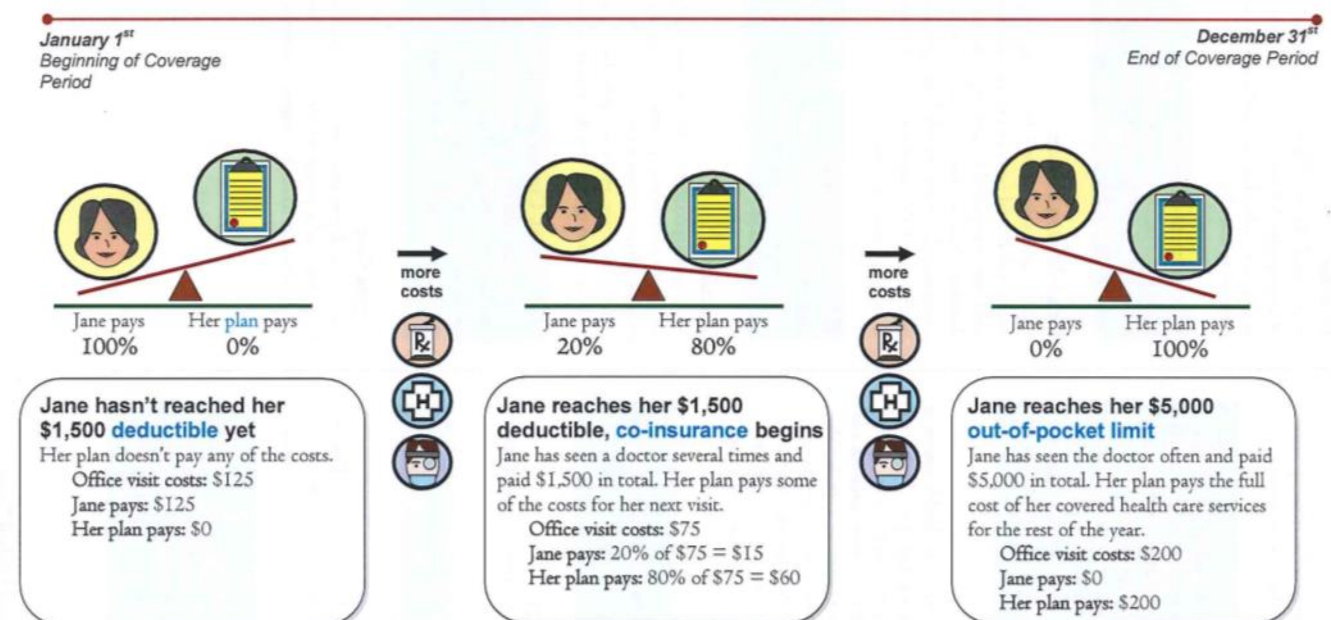
Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.



Health Savings Accounts (HSA)

If you enroll in Centerstage's **Aetna HNO HSA** plan, you may be eligible to open a Health SavingAccount (HSA). HSA's are individual, tax-advantaged savings accounts used to cover health expenses. You may use funds in your HSA to reimburse yourself for out-of-pocket health plan expenses. Distributions from your HSA are tax-free if used to pay for eligible medical, dental, vision, and prescription drug expenses for yourself or a covered family member (Dependents over age 19 must be able to be claimed on your Federal tax return).

Who is eligible to open an HSA?

In order to open an HSA, you must meet the following requirements:

- You must be enrolled in the qualified high deductible health plan known as the **Aetna HNO HSA** plan
- You cannot be claimed as a tax dependent by another individual
- You cannot be enrolled in any other health plan coverage including Medicare, military coverage, a spouse's plan, or a health care flexible spending account (FSA)

How much can I contribute to an HSA?

Each year, the IRS sets a limit on the maximum amount that can be deposited into an HSA. The accounts can be funded by the employer, employee or a combination of employer and employee funds. The chart below summarizes the total maximum contribution that an employee can contribute.

If you are 55 or older as of 12/31/2016, you can contribute an additional $1,000.

	Total Annual HSA Maximum	Centerstage 2016/17 Contribution	Maximum You May Contribute
Individual	**$3,350**	**$185**	**$3,165**
Employee + One Child	**$6,750**	**$185**	**$6,565**
Employee + Spouse	**$6,750**	**$185**	**$6,565**
Employee + Family	**$6,750**	**$185**	**$6,565**

How do I contribute to the HSA?

You may open an HSA through the financial institution that partners with Aetna, which is Wells Fargo. If you elect to contribute to the account, your contributions will be made through pre-tax payroll deductions each pay period up to the maximum amounts shown above. The more you contribute the better prepared you will be to cover your out-of-pocket expenses. You may only contribute to the HSA as long as you remain eligible to do so (see requirements above).

Reminder: The maximum amount that you may contribute to your HSA account is based upon the type of coverage you carry for the health insurance. Ex: Individual health insurance = employee only maximum ($3,050)

Dental Benefits

UNITED CONCORDIA DENTAL

Good Dental health is important to your overall well being. At the same time, we all need different levels of dental treatment. We are offering a dental PPO plans through United Concordia. The PPO dental plan provides affordable coverage based on the type of services obtained – Preventive, Basic or Major.

Under this plan, you may obtain covered services from any dentist. However, if an out-of-network provider is used, reimbursement is based on UCCI's usual and customary reasonable charge.

You can visit www.ucci.com to find a dentist. Centerstage is part of the **Advantage Plus** network. See United Concordia benefit summary for more details.

Dental Benefits Description	Concordia Preferred Plan In Network	 Out of Netwrok
Deductible ***(applies to Basic & Major services)*** Individual Family	 $50 $150	 $50 $150
Preventive Services Oral Exams, Full Mouth X-Rays, Fluoride Treatments, Lab Work & Tests, Teeth Cleaning, Periodontal Maintenance	100%	100%
Basic Services Fillings, Endodontics-Root Canal, Periodontics, Oral Surgery, General Anesthesia, Pulp Capping	90%	80%
Major Services Inlays & Onlays, Crowns, Dentures, Bridges	60%	50%
Orthodontic Services	50% ($1,000 Maximum)	
Annual Maximum	$1,500 *Per Year*	

Vision Benefits

All employees are eligible to sign up for Vision Coverage. Participants get an exam, lenses, frames and contacts once every 12 months. Contact Lenses are in lieu of lenses and frames

Benefits Description	Vision Plan *In-Network*
Eye Exam & Refraction	$10 *Every 12 months*
Vision Lenses	$25 *Every 12 months*
Frames	$130 allowance *Every 12 months*
Contact Lenses	Conventional/disposable: $130 allowance *Every 12 months* Medically necessary: $0 copay *Every 12 months*

Participants have the option of receiving care from a network or out-of-network provider; however, if you use a non-network provider you will incur higher out-of-pocket expenses.

You can visit www.e-nva.com to find a provider in your area. See NVA benefit summary for more details.

Basic Life and Accidental Death & Dismemberment Insurance

All employees receive Basic Life Insurance in an amount that equals two times your annual base salary to a maximum of $60,000. Accidental Death and Dismemberment Insurance pays a benefit that varies with the type of loss or accident. These benefits are paid for by CenterStage and provided by Aetna. www.aetna.com

Long Term Disability

Your long-term disability (LTD) benefit provides you with a source of income in the event that you are not able to work due to an accident, illness or injury. CenterStage provides LTD benefits to all employees at no cost to the employee.

Your LTD benefit equals 60% of your monthly base earnings up to a maximum benefit of $5,000 per month. This benefit has a 90-day elimination period. Age at disability determines benefit period; see Summary Plan Description for details.

www.aetna.com

Flexible Spending Accounts *(FSA)*

CenterStage allows you to defer a portion of your pay though payroll deduction into Flexible Spending Accounts. The money that goes into an FSA is deducted on a pre-tax basis, which means it is taken from your pay before Federal and Social Security taxes are calculated. Because you do not pay income taxes on money that goes into your FSA, you decrease your taxable income.

It is important that you estimate carefully. If you do not use all of the money in your accounts by the end of the plan year, Federal law may require you to forfeit a portion of your unused balances. You have up to 3-1/2 months after the plan year ends *(October 15th)* to submit qualified expenses for reimbursement incurred during the prior year.

CenterStage's FSA program features several plans. You can choose one or all of them.

Healthcare FSA: The maximum you can set aside is $1,500 per year. You cannot change your election until the end of June. **Unused funds in the account at the end of June are forfeited.**

Dependent Care FSA: The maximum you can set aside is $5,000 per year. You can stop or change your election at any time.

Parking/Transportation FSA: The maximum you can set aside is $255 per month for Parking. The maximum you can set aside is $255 per month for Transit. You can stop or change your election at any time. Unused funds in the account at the end of June are rolled over.

You cannot combine funds in the various accounts. For example, parking funds cannot be used to pay a medical bill.

There are two options to pay for your qualified expenses:

1. CBIZ can issue you a debit card ("prepaid benefits card") which you would use to pay providers directly.
2. You pay for the expenses up front and request reimbursement from CBIZ by check or direct deposit.

Please visit www.myplans.cbiz.com or call (800)-815-3023, Option 4.

Compliance Notices

The following are federally required notices related to your QHS Benefits Program.

Women's Health and Cancer Rights Act

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Maternity and Newborn Length of Stay

Under federal law, group health plans and health coverage issuers offering group coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery; or
- Less than 96 hours following a cesarean section.

They may also not require that a provider obtain authorization from the plan or coverage issuer for prescribing a length of stay not in excess of those periods. The law generally does not prohibit an attending provider of the mother or newborn (in consultation with the mother) from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Special Enrollment Rights Under HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides the following special enrollment rights. If you do not enroll for medical coverage for yourself and your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan, as long as you request enrollment within 31 days after your other coverage ends. You will need to provide proof that your other coverage had ended.

In addition, if you have a new dependent as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as long as you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Notice of Health Information Privacy Practices

The privacy of your medical information is important to us. As a participant in a medical plan sponsored by QHS, you may receive a HIPAA Privacy Notice. The HIPAA Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

For more information about our privacy practices or for additional copies of the HIPAA Privacy Notice, please contact us using the information provided.

Contact:	Human Resources
Address:	700 North Calvert Street Baltimore, MD 21202
Phone:	(410) 986-4000

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's summary plan description or contact the plan administrator.

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a qualifying event, as listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if covered under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an associate, you will become a qualified beneficiary if you lose your coverage under the plan because your hours of employment are reduced or your employment ends for any reason other than your gross misconduct.

If you are the spouse or dependent child of an associate, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- The associate dies;
- The associate's hours of employment are reduced;
- The associate's employment ends for any reason other than his or her gross misconduct;
- The associate becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The associate becomes divorced or legally separated; or
- If you are a dependent child, you stop being eligible for coverage under the plan as a "dependent child".

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying even has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the associate, commencement of a proceeding in bankruptcy with respect to the employer, or the associate's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan administrator of the qualifying event.

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

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary…

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is death of the associate, the associate's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the associate's hours of employment, and the associate became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the associate lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 19-month period of continuation coverage.

If your family experiences another qualifying event while receiving 18 months of continuation coverage, your spouse and dependent children can get up to 19 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to your spouse and any dependent children receiving continuation coverage if the associate or former associate dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If you have questions about your plan or your COBRA continuation coverage rights, refer to the contact listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Associate Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

In order to protect your family's rights, you should keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

For more information about Medicare prescription drug plans, visit www.medicare.gov. Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Notice of Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of key health benefits under QHS' medical plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit on key health benefits under the plan are eligible to enroll in the plan during open enrollment. For more information contact Benefits, HR at (410) 822-0697.

Preventive Services and the Affordable Care Act

Under the affordable care act, you an your family may be eligible for some important preventive services which can help you avoid illness and improve your health - at no additional cost to you. What this means for you:

If your plan is subject to these new requirements, you would not have to pay a co-payment, co-insurance, or any deductible to receive preventive health services, such as recommended screenings, vaccinations, and counseling. For example, depending on your age, you may have free access to such preventive services as:

- Blood pressure, diabetes, and cholesterol tests;
- Many cancer screenings, including mammograms and colonoscopies;
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use;
- Routine vaccinations against diseases such as measles, polio, or meningitis;
- Flue and pneumonia shots;
- Counseling screening, and vaccines to ensure health pregnancies;
- Regular well-baby and well-child visits, from birth to age 21

Some Important Details:

- If your health plan uses a network of providers, be aware that health plans are only required to provide these preventive services through an in-network provider. Your health plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.
- Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.
- To know which covered preventive services are right for you - based on your age, gender, and health status - ask your health care provider.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low -Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

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, 2015. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid

Website: http://www.in.gov/fssa
Phone: 1-800-889-9948

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 800-657-3629

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

Website: http://www.oregonhealthykids.gov
En Espanola: http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT– Medicaid

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

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid

Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: http://www.health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

NOTES

CENTERSTAGE