# 2015 Employee Benefits Guide

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the documents shall govern.

# 2015 Benefits Guide

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# Company Name

## CONTACT INFORMATION

# ENROLLING IN THE PLANS

### ENROLLING IN THE PLANS IS FAST AND EASY - HERE'S HOW:

# ELIGIBILITY

### WHO CAN YOU ADD TO YOUR PLAN:

**Eligible:**

**Ineligible:**

# FREQUENTLY ASKED QUESTIONS

### ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the re-enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 31 days of the qualifying event or you will have to wait until the next annual open enrollment period. Premiums and enrollment eligibility may change; see your Human Resources department for details.

### EXAMPLES OF QUALIFYING EVENTS?

- Your dependents or you lose health coverage because of loss of eligibility or loss of employer contributions
- You get married, divorced, or legally separated (with court order)
- You have a baby or adopt a child
- You or your spouse take an unpaid leave of absence
- You or your spouse dies
- Gain or loss of Medicaid entitlement
- You become eligible for Medicare

# PRE-NOTIFICATION INFORMATION

# Company Name

## MEDICAL INSURANCE

## ADVOCATE4ME

Advocate4Me is a consumer engagement program that provides UnitedHealthcare's members with a single point of contact to address your various health needs. By calling a single toll-free number, or using your preferred communication channel, members are connected with an Advocate who provides them with end-to-end support, "owning" their request until it's resolved. This service is offered at no charge to UnitedHealthcare members.

**Full Spectrum of Health Care Support**


## VIRTUAL VISITS

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy.

### Conditions Commonly Treated Through a Virtual Visit

- Bladder infection/Urinary
- Bronchitis
- Cold/Flu
- Diarrhea
- Fever
- Migraine/Headaches
- Pink Eye
- Rash
- Sinus Problems
- Sore Throat

### Access to Virtual Visits

Log in to **myuhc.com** and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit, you will pay the primary care visit copay for the UnitedHealthcare Base Plan and High Plans and the deductible for the QHDHP.

## Rally

Rally is a user-friendly digital experience on www.myuhc.com that will enhance you in a new way by using technology, gaming and social media to help you understand, learn and support you on your health journey. With the online Rally Health Survey, personalized missions, rewards and connections to wearables like Fitbit, Jawbone and more, it is easier for you to get motived to be healthier.


## SERVICES AND TOOLS AVAILABLE TO **(CARRIER NAME)** PARTCIPANTS

### LiveHealth Online

**Talk to a doctor anytime—365 days a year from the comfort of your own computer or mobile device.**

With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed *(as legally permitted in certain states)*.

**With LiveHealth Online, you get:**

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Private, secure and convenient online visits.

**How much does it cost?**

**The cost for an online doctor visit is just $49 if you don't have a health plan, if your plan doesn't cover online visits or if you haven't met your plan's deductible. If your health plan covers these visits, you may only owe the copay or coinsurance amount. Either way, you will always see what you owe before you begin a visit.**

**When to use LiveHealth Online?**

As always, you should call 911 with any emergency; otherwise, you can use LiveHealth Online whenever you have a health concern and don't want to wait. Some of the most common uses include:

- Cold and flu symptoms such as a cough, fever and headaches
- Allergies
- Sinus infections
- Family health questions

To get started, enroll for free at livehealthonline.com or on the app, and you're ready to see a doctor.

## Three Convenient Ways to Manage Your Health Care

1. Download Anthem's free app - just search for Anthem Blue Cross and Blue Shield at the app store on your mobile device. Find doctors and urgent care centers, and get driving directions from wherever you are. You can also log in and view, email or fax an electronic version of your ID card.
2. Get to Anthem's mobile site by going to anthem.com on your smartphone - and you'll get many of the same features of their app.
3. Get the full anthem.com experience on the go - by using your tablet computer. Check your claims and benefits, use your health and wellness tools, get discounts on contact lenses and glasses. Coupons for health foods and much more.

To log in on your smartphone, you must be registered on Anthem's secure member site and have a username and password. If you are an Anthem member but haven't registered, go to anthem.com from your computer and click *Register Now*.

## Your Care Options and When to Use Them

**PRIMARY CARE**

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

**CONVENIENCE CARE**

Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center that can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Walmart and Target, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out-of-pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/coinsurance.

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

**Convenience Care Center**

**Typical conditions that may be treated at a Convenience Care Center include:**

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

To find an in-network Convenience Care Center near you, visit anthem.com.

**URGENT CARE**

Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room. We do however, recommend that you seek routine

medical care from your primary care physician whenever possible.

URGENT CARE

**Typical conditions that may be treated at a Urgent Care Center include:**

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Small cuts
- Sore throats
- Rashes
- Preventive Screenings
- Back Pain or Strains

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

Services that are available for Urgent Care may vary per center. If you choose to use an urgent care center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the carrier's website at anthem.com.

**LAB SERVICES**

If you require lab work consider having these services performed at LabCorp . When coded as preventive, the cost will be covered 100%. If you choose to use Quest, services associated with the cost of your lab work will apply to the out-of-network deductible and coinsurance.

**EMERGENCY ROOM**

If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest emergency room or call 911. Emergency services are always considered at the in-network benefit level.

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to your or your loved one's bodily functions
- Serious dysfunction of any of your or your loved one's bodily organ or part

EMERGENCY ROOM

**Some examples of emergency conditions may include the following:**

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injuries
- Sudden weakness or trouble walking
- Large open wounds
- Sudden change in vision
- Spinal injuries
- Difficulty breathing

**This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergency medical condition, you should go to the nearest emergency room or call 911, even if your symptoms are not described here.**

If you obtain care at an emergency room, you will likely pay more out-of-pocket than if you were treated at your doctor's office, a Convenience Care Center or urgent care facility.

*If you receive treatment for an emergency in a non-network facility, you may be transferred to an in- network facility once the condition has been stabilized.

**Please Note: you may incur out-of-network expenses if you receive services from an out-of-network Emergency Room physician, pathologist, radiologist or anesthesiologist, even if the hospital is in-network.**

*Get the most out of your insurance by using in-network*

# HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is type of health care plan that involves a tax advantaged savings plan paired with a qualified high deductible health plan. There are two components to an HSA plan: the *qualified high deductible health plan* (required) and the *health savings account* (optional but encouraged).

The *qualified high deductible health plan (QHDHP)* will be designed within the specific regulations established by the IRS. It will consist of the underlying insurance benefits and will include deductibles, co-insurance amounts and costs for various benefits including how prescription drugs are covered. It is important to note that the deductible must be completely satisfied before the plan pays any benefits.

The *health savings account (HSA)* is optional but is recommended that participants fund this account. Individuals who place money in this account will enjoy the following tax advantages:

- Funds that go into the HSA are payroll deducted before taxes are taken so the employee's taxable income is reduced. Generally, you can deposit enough money each year to fund your deductible. Individuals who are age 55 or older are also allowed to contribute extra money into their account.
- Any earnings or investment income in the HSA is not taxed. This bank account can grow tax free.
- Any funds used for qualified health care expenses are not taxed. Additionally, once an individual becomes Medicare eligible, those funds can be used for other items without being taxed.

The HSA is established in your name. It is your bank account and can be taken with you if you change employers. Any money deposited into the account is your money. HSA accounts do not include the "use it or lose it" provision you would see with a flex spending account. Keep in mind that you can only spend money that is actually in your account. If your health care expenses are more than your HSA balance, you will have to pay the remaining cost in another manner such as cash, personal check, credit card, etc. Later, once you have accumulated the funds in your account, you can request reimbursement of what you've spent.

You can use your HSA funds for your spouse and dependents – even if they are not covered by your Qualified High Deductible Health Plan. You can use HSA funds to pay for qualified expenses of your spouse and tax eligible dependents for

You can use HSA funds for IRS-approved items such as...

- Doctor's office visits
- Hospitalization, urgent care, emergency room, etc.
- Dental services
- Eye exams, eyeglasses, contact lenses and solution, and laser surgery
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over the counter medications
- Physical therapy, speech therapy, and chiropractic expenses

**Facts about the HSA:**

**What is an HSA?**

A savings account set up by either you or your company where you can either direct pre-tax payroll deductions or deposit money to be used by you to pay for current or future medical expenses for you and/or your

dependents. Once money goes into the account, it's yours forever – the HSA is in your name, just like a personal banking account.

**Why would I want an HSA?**

Because you fund the HSA with pre-tax money, you are using tax-free funds for healthcare expenses you would normally pay for out-of-pocket using after-tax dollars. Your HSA contributions do NOT count toward your taxable income for federal taxes.

**What rules must I follow?**

- You must be covered under a Q*ualified High Deductible Health Plan (QHDHP)* in order to establish an HSA.
- You cannot establish an HSA if you also have a medical *flexible* spending account (FSA).
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare or Tricare.
- You cannot be claimed as a dependent under someone else's tax return.

**What is the difference between Qualified High Deductible Health Plan and a traditional PPO Plan?**

In a QHDHP, all services received, with the exception of preventive office visits, are applied to the deductible first. This would include office visits that are not preventive, emergency room visits, and prescription drugs. You will, however, still benefit from the discounts associated with using an in-network physician or facility.

**What else do I need to know?**

- Contributions are based on a calendar year. For 2015, contribution limits are $3,350 for Single and $6,650 for Family coverage. You cannot put more than this amount in the account; you can put less. Individuals who are age 55 or older can also contribute an additional $1,000 in catch up contributions per year.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services (medical, dental, vision and over-the-counter medically necessary items).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and is subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled, or upon account holder's death, the account can be used for other purposes without paying the 20% penalty.
- The savings account can be established with a variety of banking institutions, so you can take advantage of payroll deductions on a pre-tax basis.

**This type of health plan may be right for you if…...**

- You do not use a lot of medical services.
- You do not have a lot of prescription medications.
- You would like money in a savings account to pay for "Qualified Expenses" permitted under Federal Law. This includes most medical care, dental and vision services.
- You'd like a tax-advantaged savings account.
- You would like more control over your healthcare dollars.
- You would rather pay less in payroll deductions and you can afford the higher deductible.
- Please note: the deductible applies to all services

with the exception of wellness.

**More information about approved items, plus additional details about the HSA, is available on the IRS Website at www.irs.gov.**

**Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on the ineligible amount.**

Please Note: if you elect to enroll in the QHDHP and you establish a HSA you will not be eligible to participate in the FSA. You may establish a Limited Purpose FSA, which allows you to set aside pre-tax funds for dental and vision, but not for any expenses covered under the medical plan.

## DENTAL INSURANCE

## VISION INSURANCE

# BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

# VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

ABC Employer will continue to offer you the option of purchasing Voluntary Life/AD&D insurance for yourself, your spouse and your child(ren). This coverage will be provided to you through XXXX. You, the employee, must purchase Voluntary Life/AD&D in order to purchase for your spouse and dependent children. If you are currently enrolled in the Voluntary Life/AD&D plan, and you do not wish to make any changes, your current election will rollover to XXXXX. Your per paycheck contribution will not change.

Employees can purchase up to 5 times their salary, with a minimum of $10,000 in $10,000 increments up to a maximum of $500,000(anything over $100,000, will be subject to medical questions). Spousal coverage can be purchased in increments of $5,000 up to 50% of the employees election, with a minimum of $5,000 to a maximum of $250,000. (anything over $25,000 will be subject to medical questions). The spousal maximum has increased this year. Dependent children coverage can be purchased up to $10,000 ($1,000, $2,000, $4,000, $5,000, $10,000) if age 6 months to age 26 (regardless of student status). In addition, the voluntary life benefit carries and equal benefit of accidental death and dismemberment coverage (AD&D) for the employee and their dependents.

***Please note: If you did not enroll during your initial enrollment period in the Voluntary Life/AD&D you will be required to complete an Evidence of Insurability (EOI) form and be approved by XXXX before you are able to obtain coverage.***

Should you decide to leave ABC Employer have elected this coverage, you may have the option to convert your Voluntary Life/AD&D policy to an individual policy.

| VOLUNTARY LIFE/AD&D EMPLOYEE CONTRIBUTION (Rates are per month) | |
|---|---|
| **Age Band** | **Employee/Spouse Rate per $1,000*** |
| Under 25 | $.060 |
| 25-29 | $.060 |
| 30-34 | $.080 |
| 35-39 | $.095 |
| 40-44 | $.129 |
| 45-49 | $.197 |
| 50-54 | $.318 |
| 55-59 | $.527 |
| 60-64 | $.795 |
| 65-69 | $1.277 |
| 70-74 | $2.413 |
| 75+ | $2.413 |
| AD&D (employee) | $0.029 |
| AD&D (spouse) | $0.029 |
| Child Life | $0.240 |
| Child AD&D | $0.0510 |
| ***Spouse rates are based on the employees age.** | |

| HOW TO CALCULATE VOLUNTARY PREMIUM | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| $50,000 Elected Coverage | ÷ 1,000 = | 50 Units | X | $0.197 Rate * See Note | = | $9.85 Monthly Cost |
| *The premium calculation is based upon the life rate for an employee age 45. | | | | | | | | |

## BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

## VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

## SHORT TERM DISABILITY INSURANCE

ABC Employer will continue to offer this benefit to all eligible employees at no cost! Disability Insurance replaces a portion of your income if you are unable to work due to a disability resulting from an accident or illness. This coverage is provided through XXXXX.

Short Term Disability coverage begins 7 days after an accident or illness and pays you a weekly benefit up to specified limits. The maximum benefit period is 90 days.

Long Term Disability coverage begins after 90 days of disability (elimination period) and pays you a monthly benefit up to specified limits. This benefit may be paid to age 65 or until you no longer meet the definition of disability. Disability is defined as either the inability to perform your own occupation or any gainful occupation which you would be reasonably fitted considering education, training, and experience, depending on the length of your disability. Disability, as defined, assumes a loss of income. You must be under the care of a doctor. Please refer to the plan summary for detailed information on this plan.

## LONG TERM DISABILITY INSURANCE

## VOLUNTARY SHORT TERM DISABILITY INSURANCE

## VOLUNTARY LONG TERM DISABILITY INSURANCE

# WORKSITE BENEFIT PROGRAM

## DISABILITY INCOME POROTECTION

Employees may insure themselves so in the event an illness or injury would cause an absence from work, a percentage of lost income could be paid to you for necessary living expenses. There is a choice of elimination and benefit periods, allowing you to tailor this important benefit to your budget.

## ACCIDENT EXPENSE BENEFIT

This plan helps offset unexpected medical expenses that result from off the job accident related expenses such as ambulance, emergency room, fractures, dislocations, hospitalization including intensive care, accidental death or dismemberment, out-of-pocket costs and many more items.

## WHOLE LIFE

Whole Life is a guaranteed level premium life insurance plan which accumulates cash value and lasts for life. You may cover yourself, spouse or children. Benefits are paid in addition to any other life insurance you or other family members may be covered under. In addition to life insurance, there are benefits for adult day care, inpatient resident care and a terminal illness benefit.

## CITICAL ILLNESS

This benefit provides cash payments in the event of a heart attack, bypass surgery, stroke, loss of sight/speech/ hearing, severe burns, coma, organ transplant, occupational HIV, kidney failure and permanent paralysis. It also pays $XX tax-free cash each year for any insured that has a covered health screening exam.

## SUPPLEMENTAL HEALTH

This plan helps offset copayments and deductible of some hospital stays, outpatient surgeries, diagnostic and emergency room visits not covered by most major medical plans. This coverage is available to you as well as your family members.

## CANCER ASSISTANCE

This program provides funds for necessary treatment. Tax free lump sum policy benefits are available for you, spouse and children.

## EMPLOYEE ASSISTANCE PROGRAM (EAP)

## CALL A DOCTOR

## COMPASS

# FLEXIBLE SPENDING ACCOUNT (FSA)

A Flexible Spending Account allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings. Open enrollment allows you the opportunity to enroll in and/or increase your election amounts for your Flexible Spending Account. Therefore, now is the time to gauge how much you utilize your benefits and how much money you spend in deductibles and copayments each year so that you can properly enroll in the FSA. In accordance with Health Care Reform, the maximum contribution in the Medical Reimbursement Account is $2,550. And depending on how your limited-purpose FSA plan is set up, you may be able to carry over up to $500 of unused funds to the following plan year.

**Medical Reimbursement Account** (**$2,550 Maximum**) - This account allows employees the opportunity to pay for medical expenses not covered by insurance with pre-tax dollars. This means the amount you elect for the year comes out of your paycheck in equal deductions **before** the federal government takes their taxes out. Many employees use this account for deductible amounts, copayments, eyeglasses, etc.

**Dependent Care Reimbursement Account** (**$5,000 Maximum**) - This account allows employees the opportunity to pay for qualified child/dependent care expenses with pre-tax dollars. In most cases, there is substantially more tax savings with this plan than there is with the "tax credit" that you get when doing your tax return. It is best to discuss your options with your tax advisor if you have any concerns.

**Limited Flexible Spending Account** (**$2,550 Maximum**)- A limited-purpose health flexible spending account (referred to as a limited-purpose FSA) is much like a typical, general-purpose health FSA. However, under a limited-purpose FSA, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents.

IRS rules do not allow you to contribute to a health savings account (HSA) if you are covered by any non-qualifying health plan, including a general-purpose health FSA. By limiting FSA reimbursements to dental and vision care expenses, you (or your spouse) remain eligible to participate in both a limited-purpose FSA and an HSA. Participating in both plans allows you to maximize your savings and tax benefits.

And depending on how your limited-purpose FSA plan is set up, you may be able to carry over up to $500 of unused funds to the following plan year.

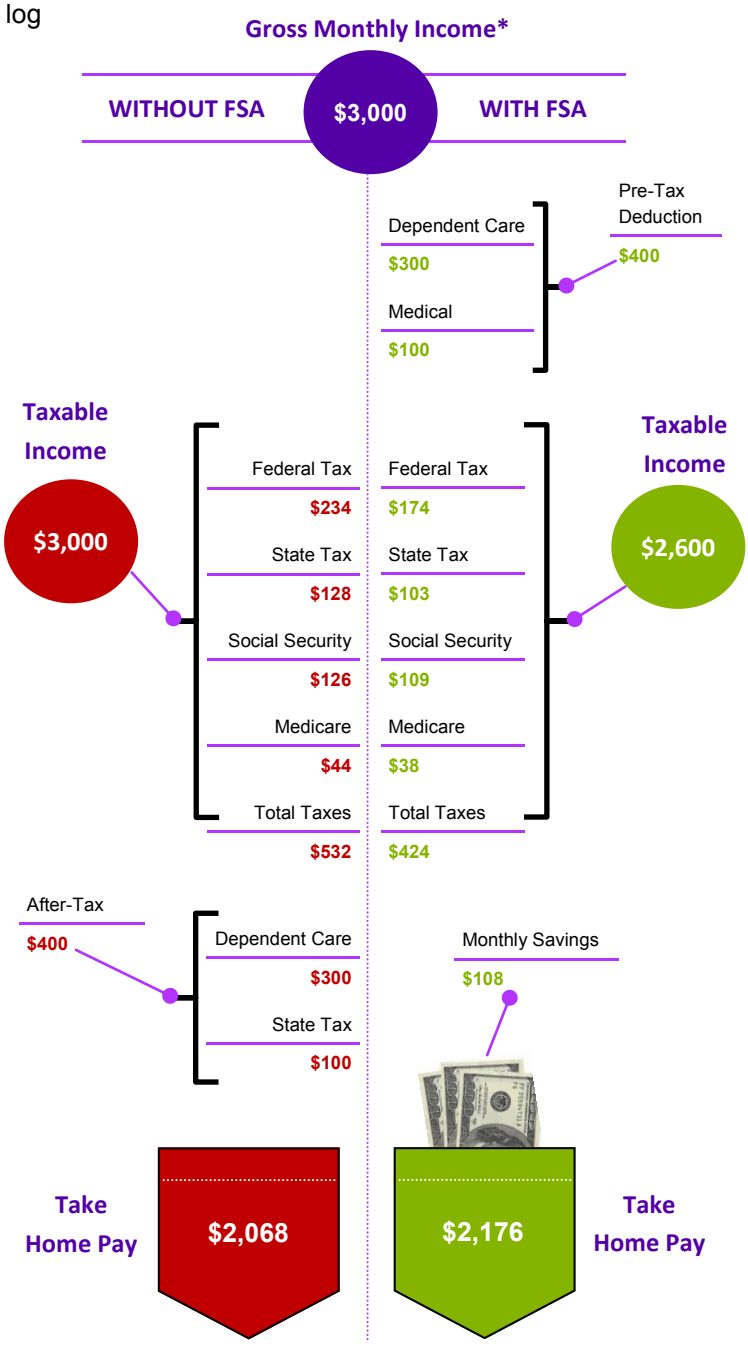
(Optional)

Getting reimbursed is easy! You can either use your debit card for approved medical expenses or you can fax in your receipts to CBIZ along with a claim form and receive a reimbursement check. The fax number is (877) 634-6236. You can also mail claims to CBIZ Flex, 2797 Frontage Rd NW, Suite 2000, Roanoke, VA 24017. The phone number is (800) 815-3023, Option 4.

**Remember...you may still be required to submit your receipts even if you choose to use the debit card**. The IRS requires your FSA Vendor to substantiate expenses that do not match your copayments exactly. Please

respond to all requests for receipts promptly. This will prevent CBIZ from temporarily turning off your debit card until the requested information is received. Feel free to log on to www.myplans.cbiz.com to review your Flexible Spending Account balance.

## How will a flexible spending arrangement save you money?




* This is an example and for illustration purposes only. Taxes are not exact and will vary.

### ELIGIBLE EXPENSES

Below is a partial list of eligible expenses that can be reimbursed from a Section 125 Medical Account. Other out-of-pocket expenses may qualify.

| | | |
|---|---|---|
| Alcoholism treatment | Ambulance | Artificial limbs |
| Braces | Chiropractors | Coinsurance and co-payments |
| Contact lens solution | Contraceptives | Crutches |
| Deductible amounts | Dental expenses | Dentures |
| Dermatologists | Diagnostic expenses | Laboratory fees |
| Eyeglasses, including exam fee | Handicapped care and support | Nutrition counseling |
| Hearing devices and batteries | Hospital bills | Orthopedic shoes |
| Licensed osteopaths | Licensed practical nurses | Prescription drugs |
| Orthodontia | Obstetrical expenses | Psychologist expenses |
| Oxygen | Podiatrists | Smoking cessation programs |
| Prescribed vitamin supplements | Psychiatric care | Surgical expenses |
| Routine physical | Seeing-eye dog expenses | |
| Sterilization and reversals | Substance abuse treatment | |

## RETIREMENT

# Company Name

## ENROLLMENT WORKSHEET

| Medical | Plan 1 | Plan 2 | Plan 3 | Plan 4 | Monthly Cost |
|---|---|---|---|---|---|
| Employee | $ | $ | $ | $ | |
| Employee & Spouse | $ | $ | $ | $ | |
| Employee & Child(ren) | $ | $ | $ | $ | |
| Family | $ | $ | $ | $ | |

| Dental | Plan 1 | Plan 2 | Plan 3 | Plan 4 | Monthly Cost |
|---|---|---|---|---|---|
| Employee | $ | $ | $ | $ | |
| Employee & Spouse | $ | $ | $ | $ | |
| Employee & Child(ren) | $ | $ | $ | $ | |
| Family | $ | $ | $ | $ | |

| Vision | Plan 1 | Plan 2 | Plan 3 | Plan 4 | Monthly Cost |
|---|---|---|---|---|---|
| Employee | $ | $ | $ | $ | |
| Employee & Spouse | $ | $ | $ | $ | |
| Employee & Child(ren) | $ | $ | $ | $ | |
| Family | $ | $ | $ | $ | |

| Health Savings Account (HSA) | | | | | Monthly Cost |
|---|---|---|---|---|---|
| If participating, what is your monthly contribution? *(Yearly Maximums: Individual $3,350; Family $6,650 and if you are 55 or older, you can make "catch-up" contributions of an additional $1,000 per year.)* | | | | | |

| Medical Flexible Spending Account | | | | Monthly Cost |
|---|---|---|---|---|
| If participating, what is your monthly contribution? *($2,550 Yearly Maximum)* | | | | |

| **Limited Flexible Spending Account** (with an HSA) | | | | Monthly Cost |
|---|---|---|---|---|
| If participating, what is your monthly contribution? *($2,550 Yearly Maximum)* | | | | |

| Dependent Care Flexible Spending Account | | | | Monthly Cost |
|---|---|---|---|---|
| If participating, what is your monthly contribution? *($5,000 Yearly Maximum )* | | | | |

# ENROLLMENT WORKSHEET

| VOLUNTARY LIFE/AD&D EMPLOYEE CONTRIBUTION (Rates are per month) | |
|---|---|
| **Age Band** | **Employee/Spouse Rate per $1,000*** |
| Under 30 | $.048 |
| 30-34 | $.056 |
| 35-39 | $.071 |
| 40-44 | $.100 |
| 45-49 | $.150 |
| 50-54 | $.230 |
| 55-59 | $.402 |
| 60-64 | $.572 |
| 65-69 | $.918 |
| 70+ | $1.735 |
| AD&D | $0.017 |
| Child Life | $0.240 |
| Child AD&D | $0.510 |
| ***Spouse rates are based on the employees age** | |

**Employee**

$_____ ÷ 1,000 X $_____ = $_____

Amount of Coverage | Unit Cost from Rate Table | Employee Monthly Cost

**Spouse**

$_____ ÷ 1,000 X $_____ = $_____

Amount of Coverage | Unit Cost from Rate Table | Spouse Monthly Cost

**Child(ren)**

$_____ ÷ 1,000 X $_____ = $_____

Amount of | Unit Cost from | Child(ren)

# Company Name

## ENROLLMENT WORKSHEET

### DEPENDENT PARTICIPATION DETAIL

| Legal Name | SS# | Relationship | Gender | DOB | Medical Yes or No | Dental Yes or No | Vision Yes or No |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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### BENEFICIARY INFORMATION

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|---|---|---|---|
| **Basic Life Primary Beneficiary(s) - Total Must Equal 100%** | | | |
| Name | SS# | Relationship | % |
| Name | SS# | Relationship | % |
| **Basic Life Contingent Beneficiary(s) - Total Must Equal 100%** | | | |
| Name | SS# | Relationship | % |
| Name | SS# | Relationship | % |
| **Voluntary Life Primary Beneficiary(s) - Total Must Equal 100%** | | | |
| Name | SS# | Relationship | % |
| Name | SS# | Relationship | % |
| **Voluntary Life Contingent Beneficiary(s) - Total Must Equal 100%** | | | |
| Name | SS# | Relationship | % |
| Name | SS# | Relationship | % |

# IMPORTANT NOTICES

## SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact *Name of Contact* at *Phone Number.*

## WELLNESS PROGRAM DISCLOSURE

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program call *Name of Contact* at *Phone Number* and we will work with you to develop another way to qualify for the reward.

## WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular co-pays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

## NOTICE OF MATERIAL CHANGE (also Material Reduction in benefits)

*Company Name* has amended the *Name of Benefit Plan* benefit plan. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you need a copy, please submit your request to *Name of Contact*.

## NOTICE OF PRIVACY PRACTICES

The *Name of Plan* is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting *Name of Contact*.

## MARKETPLACE OPTIONS

### HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

**General Information**

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by *Name of Company*.

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1st through January 31st.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**

You may qualify to save money and lower your monthly premium. Savings depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an offer of health coverage from your employer which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

**More Information**

New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

## MEDICAID CHIP 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 on the DOL website provided 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)**.

**Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums:** **http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf**

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.hhs.gov
1-877-267-2323

**MEDICARE PART D CREDITABLE COVERAGE.**

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plan provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

*Carrier* has determined that the prescription drug coverage offered by *Name of Plan or Plans* is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

A notice will be provided to you prior to the October 15 Medicare open enrollment period. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at www.socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

**MEDICARE PART D NON-CREDITABLE COVERAGE.**

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plan provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

*Carrier* has determined that the prescription drug coverage offered by *Name of Plan or Plans* is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug cost if you join a Medicare drug plan. You may also pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

You can keep your current coverage, however, because your coverage under this plan is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if an when you join a drug plan.

If you lose your current non-creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan. You may be subject to higher premium (a penalty) to join a Medicare drug plan because you did not have creditable coverage.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

A notice will be provided to you prior to the October 15 Medicare open enrollment period. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at www.socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

# GLOSSARY OF TERMS

**Coinsurance** – Your share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. The plan pays any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

**Copays** – A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care, or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

**Deductible** – The amount of money you pay before service are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services as required under the Affordable Care Act.

**Emergency Room** – Services you receive from a hospital for any serious condition requiring immediate care.

**Lifetime Benefit Maximum** – All plans are required to have an unlimited lifetime maximum.

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

**Network Provider** - A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

**Out-of-Pocket Maximum** – The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance, and co-pays are included in the out-of-pocket maximum.

**Preauthorization** – A process by your health insurer or plan to determine if any service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval, or precertification.

**Prescription Drugs** – Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail Order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

**Preventive Services** – All services coded as Preventive must be covered 100% without a deductible, coinsurance, or copayments.

**UCR (Usual, Customary and Reasonable)** – The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

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