2017 Your Benefits

Your Well-being is Our Focus

Place Logo Here

Welcome!

We recognize the important role that employee benefits play in your overall compensation. As such, XYZ Company continues to make every effort to target the best quality benefit plans for our employees and their families. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family, and this program is designed to assist you in providing for the health, well being, and financial security of you and your covered dependents. Helping you understand the benefits XYZ Company offers is important to us and that is why we have created this Employee Benefits Guide.

Inside

Benefits Guide Overview

XYZ Company is proud to be able to offer a high quality menu of benefit choices and the freedom to select coverage that will fit your needs and your budget. This Guide provides a good explanation of the benefits available to you and your family. At this time, you may elect to enroll in the benefit programs offered. Options selected during this enrollment period will remain in place until August 31, 2018 unless you or your dependents experience a qualified life event (See next page).

Coverage Summary and Contact Information

Additional details on your benefits, Benefit Summaries, Summary of Benefits and Coverage (SBCs) and Summary Plan Descriptions (SPDs) are available through Human Resources. Also, if you wish to ask a benefit question or correspond directly with the insurance company relative to a personal matter including a claims inquiry or assistance with locating a network provider, see contact information below.

Benefit	Who Pays for Coverage?	Carrier Name	Phone or Email
Medical Insurance	**XYZ Company and You**	**Anthem Blue Cross Blue Shield (Anthem/BCBS)**	**800.922.6621**
Dental Insurance	**XYZ Company and You**	**Anthem/BCBS**	**866.956.8604**
Vision Insurance	**You**	**Anthem/BCBS (Blue View Vision)**	**866.723.0515**
Basic Life Insurance	**XYZ Company**	**Anthem**	**Phone: 800.813.5682**
Basic Accidental Death & Dismemberment Insurance	**XYZ Company**		**Fax: 800.850.0017**
Supplemental Employee and Dependent Life Insurance	**You**		**Email: Lifeanddisabiityclaims @anthem.com**
Short-Term Disability Insurance (STD)	**XYZ Company**	**Anthem**	**Phone: 800.813.5682**
Short-Term Disability Buy-Up Insurance (STD Buy-Up)	**You**		**Fax: 800.850.0017**
Long-Term Disability Insurance (LTD)	**XYZ Company**		**Email: Lifeanddisabiityclaims @anthem.com**

Employee Eligibility

All active, part-time and full-time employees regularly scheduled to work 30 hours or more per week are eligible to participate in XYZ Company benefit plans.

Dependent Eligibility

You must enroll yourself in order to enroll your spouse or any dependents. Upon your enrollment, you must provide your dependent's information (name, date of birth, Social Security number, relationship, gender and address) in order to enroll them and you may be asked to provide verification for your dependent(s) such as a birth or marriage certificate. Your dependents can include the following:

- Your legal spouse (not legally separated, divorced or common-law)
- Your domestic partner as defined by XYZ Company
- Your children to age 26 including biological children, legally adopted children and step children - coverage extends to the end of the month in which your child turns 26
- Your unmarried children of any age who are dependent upon you for support and incapable of supporting themselves due to disability or illness

Healthcare Reform

You may have heard about the new health insurance marketplaces. Individuals who are not offered qualified healthcare coverage through their employer may be eligible for government subsidies to help pay for health insurance premiums for plans purchased in these marketplaces (based on income level and number of dependents).

To find out more about the new insurance marketplaces, visit healthcare.gov.

Coverage Effective Date and Election Changes

If you are a new hire, your benefits are generally effective on the 1st of the month following 60 days of employment. Enrolled dependents are effective on the same day you become effective. Enrollment outside your initial eligibility date may result in a delay in your effective date or ineligibility until the next plan year. XYZ Company's plan year is September 1 through August 31 with an annual enrollment period that typically begins in late summer.

According to IRS guidelines, the benefit coverage you elect to pay for on a pre-tax basis - such as medical, dental and vision coverage - must stay in effect for the entire plan year. However, you may be able to change your benefits during the year if you experience a qualified life event. Qualified life events include, but are not limited to:

- Marriage, divorce, legal separation or annulment
- Birth, adoption or placement for adoption of an eligible child
- Death of a dependent
- Change in your spouse's or child's employment status that affects eligibility for benefits
- Dependent reaching the age of ineligibility for coverage under your plan (age 26)

If you experience a qualifying event and wish to enroll or make a change in benefits, you must request the enrollment or change no later than 30 days after the event occurs in order to qualify. All election changes must be consistent with the qualifying event. For example, if you give birth to a child during the year, you may add your child to the medical plan but you could not cancel your vision coverage for yourself.

To request special enrollment, or obtain additional information, see Human Resources.

Unless you experience a qualifying event, Open Enrollment may be your only opportunity to make benefit elections for the year.

Medical Insurance – Anthem Blue Cross Blue Shield (Anthem/BCBS)

XYZ Company offers **three** medical plan options through Anthem Blue Cross Blue Shield (Anthem/BCBS). One plan is a Health Maintenance Organization (HMO), one is an Open Access Point of Service (POS) and one is a Traditional PPO (PPO). The PPO, with its national network best serves employees who reside outside Connecticut.

Features of all medical options:

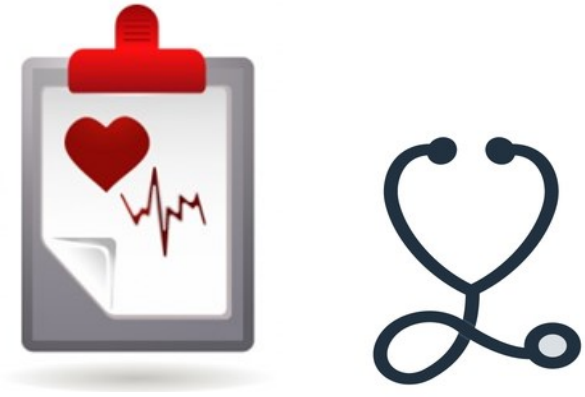
- Preventive health care services from a network provider are covered at 100% and are not subject to a deductible or copay.
- Care from an Anthem/BCBS network Primary Care Physician or Specialist is offered at a copay.
- Prescriptions filled at an Anthem/BCBS network pharmacy are covered at a copay based upon drug tier/category.
- All copays and the deductible amounts apply towards the out-of-pocket maximum. The POS and PPO have separate out-of-pocket maximums for in and out-of-network services meaning in-network copays don't apply towards the out-of-network out-of-pocket limit and vice versa.
- For each covered person, the deductible is limited to the plan "Individual" deductible. If you elect to cover yourself and at least one more family member, your total deductible expenses for all family members will not exceed the "Family" deductible. Any combination of covered family members can meet the family deductible.
- Any licensed provider can provide services; however, you will receive a much greater benefit by going to a network provider with a negotiated relationship with Anthem/BCBS. The HMO covers services received from network providers only.
- All plans utilize the Anthem/BCBS Essentials formulary for prescription drugs.

Features of the HMO Plan:

- Offers coverage only when care is received from a BCBS network provider or contracted pharmacy.
- Non-preventive health care expenses, not covered by a copay (inpatient hospitalization for instance), are subject to the calendar year deductible. Once you meet the deductible, under the HMO, you pay nothing additional because the plan pays 100% (you have a 0% coinsurance). However, copays for subsequent covered services and prescription drugs may continue to accumulate towards the out-of-pocket limit. Once you have satisfied the out-of-pocket maximum, the insurance company covers 100% of any covered expense for you and/or your family members for the rest of the plan year.

Features of the POS and PPO Plans:

- All copays for in-network non-preventive health care expenses (and including prescription drugs) accumulate towards the in-network out-of-pocket maximum. If you satisfy the out-of-pocket limit, the insurance company covers 100% of any covered expense for you and/or your family members for the rest of the plan year.
- All non-emergency health care expenses from an out-of-network provider are subject to the calendar year deductible before the insurance company pays any portion of the expense. Once you meet the deductible, you pay only a percentage of the covered expense (your coinsurance) and no more than the out-of-pocket maximum. If you reach the out-of-network out-of-pocket limit, the insurance company covers 100% of any covered expense for you and/or your family members for the rest of the plan year.



MEDICAL PLANS

PLAN NAME	HMO	POS		PPO	
Eligibility	CT Residents	CT Residents		All Employees	
Benefits	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Office Visits	$0; Plan pays 100%	0%; Plan pays 100%	50%*	0%; Plan pays 100%	50%*
Primary Care Office Visit	$30	$30	50%*	$30	50%*
Specialist Office Visit	$45	$45		$45	
Individual Deductible ***(per calendar year)***	$3,000	$0	$2,000	$0	$2,000
Family Deductible ***(per calendar year)***	$6,000	$0	$6,000	$0	$6,000
Coinsurance	Plan pays 100%	Plan pays 100%	Plan pays 50%	Plan pays 100%	Plan pays 50%
Individual Out of Pocket Maximum ***(Includes deductible and rx expenses)***	$7,150	$7,150	$21,450	$7,150	$21,450
Family Out of Pocket Maximum ***(Includes deductible and rx expenses)***	$14,300	$14,300	$42,900	$14,300	$42,900
Lifetime Maximum	Unlimited	Unlimited		Unlimited	
Inpatient Hospital	0%*	$500/day; $2,000 max/stay	50%*	$500/day; $2,000 max/stay	50%*
Outpatient Surgery	0%*	$100/occurrence (freestanding); $500/occurrence (hospital)		$100/occurrence (freestanding); $500/occurrence (hospital)*	
Advanced Imaging Services ***(MRI, MRA, CAT, CTA, PET and SPECT Scans)***	$75/occurrence; $375 max per year	$75/occurrence; $375 max per year	50%*	$75/occurrence; $375 max per year	50%*
Emergency Room	$200/occurrence; waived if admitted	$150/occurrence; waived if admitted		$150/occurrence; waived if admitted	
Ambulance	$225/occurrence	$225/occurrence		$225/occurrence	
Urgent Care Visit	$75	$75	Not Covered	$75	Not Covered
Retail Prescription Drugs^ *(30-day supply)*					
Tier 1 - Generic	$5	$5		$5	
Tier 2 - Preferred Brand	$20	$20		$20	
Tier 3 - Non-Preferred Brand/Specialty	$35	$35		$35	
Mail Order Prescription Drugs^ *(90-day supply)*					
Tier 1 - Generic	$5	$5		$5	
Tier 2 - Preferred Brand	$40	$40		$40	
Tier 3 - Non-Preferred Brand/Specialty	$70	$70		$70	

*Coinsurance or copay applies after Deductible is met; ^Anthem/BCBS Essentials formulary applies effective September 1, 2017

MEDICAL PLANS

The XYZ Company medical benefits are insured by Anthem Blue Cross Blue Shield. Connecticut employees may select one of the plans (Base, Buy-Up, or PPO) or waive coverage altogether. Out of state employees can enroll in the PPO plan or waive coverage.

For enrolled members

Register on the anthem.com website and:

-Find in network providers and facilities
-Track claims and account activity
-Review prescription drug costs
-Get answers to coverage questions
-Compare plan options and features
-Find health advice
And much more

Follow these easy steps to locate a doctor, hospital or health facility participating with Anthem.

- Go to www.anthem.com
  Click on "Find a Doctor"
- Follow the prompts

To Search for HMO Providers

In the Select a plan/network drop down box, select "Blue Care Health Plan (Local Network Only)" under the Medical (Employer Sponsored) heading.

To Search for POS Providers

In the Select a plan/network drop down box, select "Blue Care Health Plan (With Extended Network)" under the Medical (Employer Sponsored) heading.

To Search for PPO Providers

In the Select a plan/network drop down box, select "Century Preferred" under the Medical (Employer Sponsored) heading.

MEDICAL PLANS

How do I know which medical plan is right for me?

Unsure which medical plan option is the best fit for your needs? Take a moment to review the utilization scenarios below. The top scenario represents a low to average utilizer and the bottom scenario represents a high utilizer. While the examples below represent an employee, earning between $40,000 and $100,000 with employee only coverage, the impact would be similar at other tiers of coverage (employee + 1 or family) and other earnings levels. The charts below illustrate projected total annual cost under each plan option.

While the difference in total expense may not be great between the plan options illustrated below, there is a difference in coverage. The HMO offers coverage only for in-network services, however, true emergencies incurred outside the network will be paid at the HMO in-network level. The POS and PPO plans offer out-of-network coverage for non-emergency services as well which may provide additional flexibility for you or your family members. The PPO has the largest network offering nationwide coverage.

Employee Only - earning $40K - $100K/year	HMO (CT only)	POS (CT only)	PPO (All Employees)
Claim Activity	**Your Cost**	**Your Cost**	**Your Cost**
6 Regular Office Visits	$180	$180	$180
Preventive Office Visits	$0	$0	$0
1 Specialty Office Visits	$45	$45	$45
4 Mail Order Prescriptions (all Preferred)	$160	$160	$160
1 Urgent Care Visit	$75	$75	$75
TOTALS	**$460**	**$460**	**$460**
Employee Annual Contributions	$1,601	$1,743	$1,766
	$2,061	**$2,203**	**$2,226**

Employee Only - earning $40K - $100K/year	HMO (CT only)	POS (CT only)	PPO (All Employees)
Claim Activity	**Your Cost**	**Your Cost**	**Your Cost**
6 Regular Office Visits	$180	$180	$180
Preventive Office Visits	$0	$0	$0
1 Specialty Office Visits	$45	$45	$45
4 Mail Order Prescriptions (all Preferred)	$160	$160	$160
1 Inpatient Hospitalization (5 day stay)	$3,000	$2,000	$2,000
TOTALS	**$3,385**	**$2,385**	**$2,385**
Employee Annual Contributions	$1,601	$1,743	$1,766
	$4,986	**$4,128**	**$4,151**

DENTAL PLANS

The Anthem dental plan allows you to visit any dentist you would like—in or out-of-network. Visiting an in-network dentist, however, assures you that you will not be balance billed for any charges beyond Anthem's negotiated fees.

Select "Find a Dental Provider" on the Anthem homepage and select the "Anthem Dental Complete" option in the Dental Providers column.

Dental Coverage - Anthem Blue Cross Blue Shield		
Type of Plan	**Passive PPO**	
	In-Network	**Out-of-Network**
Deductible	Single: $50 Family: $150	Single: $50 Family: $150
Annual Benefit Maximum Per Individual	$1,500	$1,500
Preventive Services *(Oral exam, Cleaning, X-rays)*	100%	100%*
Basic Services *(Fillings, Oral surgery, Root canals)*	80% after Deductible	80% after Deductible*
Major Services *(Crowns, Dentures, Bridges)*	50% after Deductible	50% after Deductible*
Orthodontia *(children to age 19)*	Covered at 50%; $1,000 Lifetime Benefit Maximum	

*Subject to Usual, Customary and Reasonable charges (90th percentile)

VISION PLANS

Anthem Blue View Vision offers complete, high quality vision care to XYZ Company employees. The plan includes benefits for eye exams, frames, eyeglasses and contact lenses. In addition, members receive discounts for Lasik surgery and additional frames and lenses.

Select "Find a Vision Provider" from the homepage and select the "Blue View Vision" option under the Vision Providers column.

Vision Coverage - Blue View Vision Anthem Blue Cross Blue Shield		
Network Providers Include: *JC Penneys, LensCrafters, Sears, Pearle Vision,Target and more*	**Network**	**Out of Network Services**
Eye Exam	**Once every calendar year**	
	$10 Co-Pay	Reimbursed up to $48
Prescription Lenses	**Once every calendar year**	
Single	$25 Co-Pay	Reimbursed up to $36
Bifocal	$25 Co-Pay	Reimbursed up to $54
Trifocal	$25 Co-Pay	Reimbursed up to $69
Progressive	$25 Co-Pay, then balance not to exceed $65.	N/A
Frames	**Once every two calendar years**	
	Up to $130 Allowance, 20% discount on any balance	Reimbursed up to $64
Contact Lenses *(in lieu of glasses)*	**Once every calendar year**	
	$130 Allowance, 15% discount on additional charges (no discount for disposable lenses) *Standard Lens Fitting*: Member pays up to $55 *Speciality Lens Fitting*: Member receives10% discount	Reimbursed up to $105 Lens Fitting: Not Covered

CONTRIBUTIONS

Medical Insurance - Employee Weekly Contributions			
Blue Care Basic HMO (Connecticut Residents Only)	**Annual Target Compensation Over $100,000**	**Annual Target Compensation between $40,000 and $99,999**	**Annual Target Compensation Less than $40,000**
Employee Only Coverage	$39.18	$31.20	$16.93
Employee + 1 Coverage	$84.17	$67.25	$36.53
Family Coverage	$105.71	$84.65	$45.70
Blue Care Buy Up POS (Connecticut Residents Only)	**Annual Target Compensation Over $100,000**	**Annual Target Compensation between $40,000 and $99,999**	**Annual Target Compensation Less than $40,000**
Employee Only Coverage	$42.64	$33.96	$18.55
Employee + 1 Coverage	$91.55	$72.27	$39.52
Family Coverage	$114.93	$91.78	$49.88
Century Preferred PPO (All Employees)	**Annual Target Compensation Over $100,000**	**Annual Target Compensation between $40,000 and $99,999**	**Annual Target Compensation Less than $40,000**
Employee Only Coverage	$43.09	$34.43	$18.78
Employee + 1 Coverage	$92.70	$74.15	$40.20
Family Coverage	$116.27	$93.19	$50.32

Dental Insurance - Employee Weekly Contributions			
Anthem Blue Cross Blue Shield Dental	**Annual Target Compensation Over $100,000**	**Annual Target Compensation between $40,000 and $99,999**	**Annual Target Compensation Less than $40,000**
Employee Only Coverage	$0.00	$0.00	$0.00
Employee + 1 Coverage	$2.75	$2.75	$2.75
Family Coverage	$5.25	$5.25	$5.25

Vision Insurance - Employee Weekly Contributions			
Anthem Blue View Vision	**Annual Target Compensation Over $100,000**	**Annual Target Compensation between $40,000 and $99,999**	**Annual Target Compensation Less than $40,000**
Employee Only Coverage	$1.75	$1.75	$1.75
Employee + 1 Coverage	$3.06	$3.06	$3.06
Family Coverage	$4.90	$4.90	$4.90

LIFE AND AD&D

Your Life, Accident and Disability Coverage is an important part of your comprehensive benefits package. This coverage provides financial protection for you and your family in the event of death, illness, or serious accident. The Life, Accident, and Disability Coverage is insured by Anthem.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

XYZ Company provides the Basic Life and AD&D benefit to all full time employees at no cost to you.

The ***Basic Life insurance benefit is 1 times your Annual Earnings up to a $100,000 maximum***. Benefits are reduced by 35% at the age of 70, and 50% at the age of 75.

AD&D insurance provides additional benefits to you and/or your beneficiary if you suffer loss of life or limb due to an accident. The ***Basic AD&D benefit is 1 times your Annual Earnings up to a $100,000*** **maximum**.

BASIC SHORT TERM DISABILITY

XYZ Company provides company paid Short Term Disability insurance that begins on your 8th day of disability due to illness or accident. The program replaces ***60% of your weekly earnings to a weekly maximum of $300 for up to 12 weeks***. You also have the option to purchase additional Short-Term Disability insurance. The ***Buy-Up Option increases the weekly benefit to a $1,000 Maximum***. Both the programs offer a return to work incentive which may allow you to earn more than 60% of your pre-disability earnings while you are partially disabled and if you are able to work in some reduced capacity. See the plan Certificate for details.

BASIC LONG TERM DISABILITY

XYZ Company provides company paid Long Term Disability insurance that begins on the 91st day of disability for approved claims. The Long Term Disability benefit replaces ***60% of your monthly earnings up to $4,000 per month***. The benefit can last until your Social Security Normal Retirement Age (SSNRA) should you continue to meet the disability definition.

LIFE AND AD&D

In addition to the Basic Life and AD&D benefit that XYZ Company provides at no cost, employees can purchase Supplemental Life and AD&D insurance for themselves as well as spouses and dependent children. In order to elect coverage for a spouse or child, employees must enroll in the life coverage themselves.

Employees can also elect the Buy-Up Short-Term Disability option and can increase their weekly disability benefit. The Buy-Up option is available to employees with normal salaries in excess of $500 per week.

The Supplemental Life and Buy-Up Short-Term Disability plans are guaranteed at initial eligibility only. If you previously waived the coverage and would like to elect during a subsequent open enrollment, you must complete an Evidence of Insurability form and be approved by the insurance company.

Supplemental Life and AD&D Coverage		
Employee	Increments of $10,000 up to lesser of 5 Times Annual Earnings or $300,000 Guaranteed Issue: $80,000 (only guaranteed at initial enrollment)	
Spouse	Increments of $5,000 up to lesser of $50,000 or 100% of Employee benefit Guaranteed Issue: $25,000 (only guaranteed at initial enrollment)	
Dependent Child(ren)	Increments of $1,000 up to $10,000 : 14 days to 21 years (or 25 years if full time student)	
Benefit Reduction	The Life and AD&D benefit will reduce to 65% of the original benefit amount when the enrollee attains age 70, 45% of the original benefit amount when the enrollee attains age 75, and 30% of the original benefit amount when the enrollee attains age 80.	
Supplemental Life Rates	***Age***	***Monthly Employee Rate (per $1,000)***
Rates are determined by employee age as of September 1, 2017.	< 30	$0.06
	30-34	$0.07
	35-39	$0.10
	40-44	$0.15
	45-49	$0.24
	50-54	$0.41
	55-59	$0.66
	60-64	$0.88
	65-69	$1.38
	70-74	$2.41
	75 or over	$4.19
Dependent Child(ren) Life Rates	$0.16 per $1,000	
Supplemental AD&D Rates	$0.03 per $1,000 (for Employee/Spouse) $0.04 per $1,000 (for Dependent Children)	
Weekly Cost	To calculate weekly cost: 1) Choose coverage amount per plan details above. 2) Divide this amount by 1000. 3) Multiply by the appropriate age banded rate above. 4) Multiply by 0.23. Example: $20,000 ÷ 1000 = $20 x .15 (for 42 year old employee) = $3.00 per month x .23 = $0.69 per week	
Buy Up Short Term Disability		
Amount of Benefit	60% of weekly earnings to a $1,000 maximum	
When Benefits Begin	8th Day of Accident / 8th Day of Sickness	
Benefit Duration	12 weeks	
Weekly Cost	To calculate weekly cost: 1) Multiply weekly earnings by 60%. 2) Divide this amount by 10. 3) Multiply by the weekly rate of .0415. Example: $800 x 60% = $480 ÷ 10 = $48 x .0415 = $1.99 per week	

2017 Health Plan Notices

* Women's Health and Cancer Rights Act of 1998

Your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or co-pays that are appropriate and consistent with other benefits under your plan.

* The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

MANDATED NOTICES

Important Notice from XYZ Company About
Your Prescription Drug Coverage and Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of cover age set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

XYZ Company has determined that the prescription drug coverage offered by Anthem Blue Cross Blue Shield is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current XYZ Company coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current XYZ Company coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with XYZ Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through XYZ Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	08/01/2017
Name of Entity/Sender:	XYZ Company
Contact--Position/Office:	
Address:	
Phone Number:	

MANDATED NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

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KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300

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SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	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
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, 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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

☐ **I have other coverage** ☐ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name _____	☐ Dependent has other coverage	☐ Another reason
Name _____	☐ Dependent has other coverage	☐ Another reason
Name _____	☐ Dependent has other coverage	☐ Another reason
Name _____	☐ Dependent has other coverage	☐ Another reason

_____ _____

Employee Name – Please Print **Employee Social Security Number**

_____ _____/_____/_____

Employee Signature **Date**

MANDATED NOTICES

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

MANDATED NOTICES

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
5. Employer address	6. Employer phone number	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email addres	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - X Some employees. Eligible employees are:
    Full Time Employees who work at least 30 hours per week.

- With respect to dependents:
  - X We do offer coverage. Eligible dependents are:
    - Legal Spouses
    - **Children up to age 26 to include: natural born children, step children, legally adopted children, grandchildren if employee has court ordered power of attorney. Handicapped dependent children are also eligible beyond age 26.**
  - ☐ We do not offer coverage.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

MANDATED NOTICES

Michelle's Law

NOTICE OF EXTENDED COVERAGE TO PARTICIPANTS COVERED UNDER A GROUP HEALTH PLAN

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

The Plan currently permits an employee to continue a child's coverage if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child* means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- *Medically necessary leave of absence* means a leave of absence or any other change in enrollment:
    - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury
    - which is medically necessary
    - and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

NOTES

Place Logo Here

Disclaimer: This Benefit Guide provides a brief summary of the benefits available under XYZ Company Benefit Program. In the event of any discrepancy(ies) between this summary and any Plan Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. XYZ Company reserves the right to modify or eliminate these benefits at any time and for any reason.