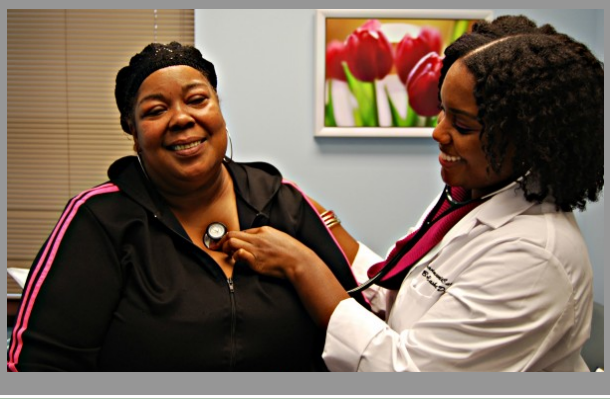
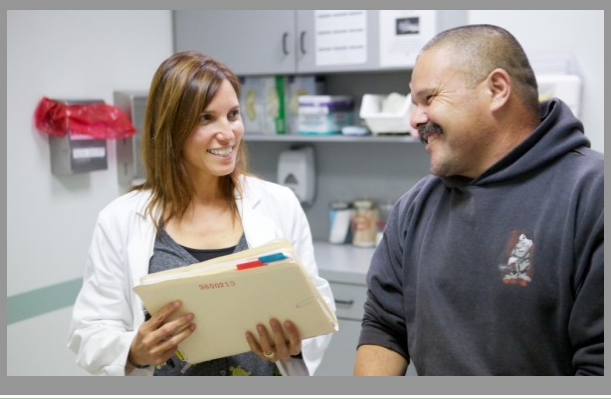
Amanda Luckett Murphy Hopewell Center

BETTY JEAN KERR People's HEALTH CENTERS

People's COMMUNITY ACTION CORPORATION

2016 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.

Table of Contents

People's Health Centers/Hopewell Center/PCAC

Contact Information

Contacts		
Vendors	**Member Services**	**Website / Email**
Medical: *UnitedHealthcare* Policy Number:	Please refer to the number on the back of your ID card	myuhc.com
Voluntary Dental: *UnitedHealthcare* Group Number:		myuhc.com
Vision: *Vision Benefits of America (VBA)* Group Number: 3376	800.432.4966	visionbenefits.com
Life / AD&D: *Cigna* Group Number: FLX965917	800.732.1603	cigna.com
Voluntary Life: *Cigna* Group Number: FLX965918	800.732.1603	cigna.com
Long-Term Disability: *Cigna* Group Number: LK964018	800.732.1603	cigna.com
Flexible Spending Account (FSA): *CBIZ Flex*	800.815.3023 Fax: 800.584.4185	myplans.cbiz.com
Employee Assistance Program (EAP): *H&H Associates*	800.832.8302	hhhealthassociates.com
Benefits Team	**Phone**	**Email**
People's Health Centers: *Carole Colich - Benefits*	314.367.7848	ccolich@phcenters.com
CBIZ Benefits & Insurance Services: *Asha Kuhn - Sr. Account Manager* *Rusty Besancenez - Sr. Account Executive*	314.692.2249 314.692.5834 314.995.5501	akuhn@cbiz.com rbesancenez@cbiz.com

Reasons to Call	Who to Call
Claims Questions	Carrier / CBIZ
Identification Cards / Numbers	Carrier / CBIZ
Pre-Certification	Carrier
Provider Directories	Carrier Websites
If Drug Prescription is Denied	Provider / Doctor
Payroll Issues / Status Changes / Miscellaneous Issues	People's Health Centers

How to use this resource sheet for questions regarding a medical claim:

1. First, contact Member Services,
2. If issue still unresolved, contact Asha Kuhn at CBIZ Benefits & Insurance Services, Inc. for assistance.

Understanding Your Plan Options

Employees of People's Health Centers/Hopewell Center/ PCAC who meet eligibility requirements are offered an employee benefit package which includes Medical, Voluntary Dental, Vision, Basic Life / Accidental Death & Dismemberment (AD&D), Supplemental Life / AD&D, an Employee Assistance Program and Voluntary Worksite plans.

People's Health Centers/Hopewell Center/PCAC offers four medical plans administered by UnitedHealthcare. The Bronze plan offers the lowest premium, but it has a high deductible, and here are no copayments with this plan. The Gold Plan and Enhanced Plan options offer higher benefits with copayments for a higher premium. The Qualified High Deductible Health Plan (QHDHP), has a higher deductible with lower premiums and gives you the option to contribute to a Health Savings Account (HSA).

The dental plan also offers two options through UnitedHealthcare. Both options are Preferred Provider Organization (PPO) plans which offers you the choice to utilize an in network provider or go outside of the network. Utilizing an in network provider offers you greater savings through contracted fees and lower out-of-pocket expenses. If you elect to utilize a non-participating dentist, the benefits are paid based on UnitedHealthcare's maximum allowance. You may experience balance billing and higher out-of-pocket expenses.

Vision benefits are offered through Vision Benefits of America (VBA). The plan also offers a network of providers where you will receive the best benefits. Expenses incurred by utilizing a non-network vision provider will be reimbursed at a limited schedule based upon the services you receive.

Basic Life / AD&D is offered to employees at no cost. You may elect additional Supplemental Life for yourself and your eligible dependents at a cost based upon the amount you elect and your current age.

This Benefit Guide provides a brief summary of all People's Health Centers/Hopewell Center/PCAC benefit plans along with the rates based upon the coverage you select. You will also find notices and other important information in this guide.

WHAT CAN I DO TO KEEP MY MEDICAL COSTS DOWN?

Use Network doctors and facilities

- Check myuhc.com to find network providers near you.
- Ask your provider if they are contracted in-network with UnitedHealthcare.
- Before you have any procedures, be sure to talk to your doctor or the facility to which you are referred to be sure they are in-network.
- If you are balance-billed by an out-of-network provider, contact them and ask if they will lower the charge if you set up a payment plan.

Understand your benefits

- Always review your health plan documents to fully understand your benefits. If you are not sure, contact UnitedHealthcare's customer service at the phone number on the back of your ID card.
- Go online at myuhc.com. Click on the "Benefits & Coverage" menu, then click on "Coverage Documents".

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

Eligibility

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- Your legal spouse
- Your or your spouse's child who is under age 26
- Legally adopted child or a child placed for adoption
- Child for which you or your spouse is the legal guardian
- A disabled child who is unmarried and over age 26
- A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court order.

Ineligible:

- A common law spouse
- Domestic Partner
- Divorced or legally separated spouse
- Foster Children
- Sisters, brothers, parents, or in-laws, grandchildren, etc.

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 30 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
- Death of an insured member
- Gain or loss of Medicaid entitlement
- You become eligible for Medicare

HOW ARE NEWBORNS COVERED?

People's Health Centers/Hopewell Center/PCAC's medical plan covers newborns for up to the first 4 days. Coverage is based upon the Federal law, The Mother's and Newborns' Health Protection Act. This law requires coverage for a 48-hour inpatient hospital stay for natural birth or 96-hour inpatient stay for cesarean section. If coverage beyond the 48 or 96 hours is wanted, the newborn must be enrolled within the first 30 days. If the medical coverage for a newborn is elected under a spouse's plan, coordination of benefits will take place which will determine if the People's Health Centers/ Hopewell Centers/PCAC or a spouse's plan will be the primary payer.

WHAT IF I USE AN OUT-OF-NETWORK PROVIDER?

It is important to ask if your medical provider is a participant of the UnitedHealthcare Network. If your provider is not a participating provider, your claim may be processed based upon what Medicare allows. Non-network claims may be based upon 175% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service. Non-network benefits are then applied to the eligible charges. This means you may be balance-billed for non-eligible charges.

Ask the provider about their fees before you receive services

- You can ask about fees before you receive services or pharmacy benefits. Contracted fees are not the same for all providers. You have the right to ask before you receive services so you are aware of what your expenses will be. This may not always be possible, however, when it is...ask.
- To estimate and compare costs, you can also go online at myuhc.com and look for the Cost Estimator Tool.

Health Care Coverage Options: COBRA and Its Alternatives

Selecting the right health care coverage option is important when facing an employment transition. We know how complex healthcare coverage can be, especially with the recent introduction of the Affordable Care Act.

The Affordable Care Act did not eliminate COBRA or change the COBRA rules. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work.

The question then becomes whether or not taking COBRA is a better choice than purchasing a new policy through an insurance exchange and applying a federal subsidy if eligible.

- **COBRA coverage may be more expensive than a new individual policy through the health insurance exchanges.**

  This is because if a COBRA policy is continued, the employee has to pay both their share of the premium and the employer's contribution. If the policy is rich with benefits and the employer has been paying a significant portion of the premium, chances are the full premium will be higher than other health insurance coverage options through the health exchanges.

- **Rather than take COBRA, the Affordable Care Act provisions allow low-income individuals to get coverage at a lower cost because of their potential eligibility for federal subsidies.**

  These subsidies are designed for people who earn between 100 percent and 400 percent of the Federal Poverty Line, or about $23,850–$95,400 for a family of four or $11,670–$46,680 for an individual. If an employee's income is under these limits, it will probably be more cost effective to purchase a new policy and receive the subsidies to help pay the premium.

WHY IS CBIZ SELECTQUOTE BEING OFFERED?

SelectQuote Benefit Solutions, through its partner CBIZ, will help you understand your choices and guide you through the options related to healthcare coverage to help you find a plan that best suits your needs. This service available to anyone seeking additional health care options and there is no additional cost associated with this service.

KEEPING YOUR HEALTH CARE AFFORDABLE

As the healthcare marketplace evolves, we are committed to providing you access to affordable, high quality healthcare options. Get started today to make the most of this benefit for you and your family.

GETTING STARTED

Review your options at cbiz.selectquotebenefits.com or call at 1-855-801-5742.

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 the toll-free number on the back of your ID card, 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 Tract Infection
- Bronchitis
- Cold/Flu
- Diarrhea
- Fever
- Migraine/Headaches
- Pink Eye
- Rash
- Sinus Problems
- Sore Throat
- Stomach Ache

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 Gold and Enhanced Plans and the deductible for the QHDHP and Bronze Plans.

Rally

Rally is a user-friendly digital experience on 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.

Medical Insurance

UHC - Bronze Plan

Features	In-Network	Non-Network
Deductible (individual / family)	$5,000 / $10,000	$10,000 / $20,000
Coinsurance	80%	60%
Out-of-Pocket Maximum* (individual / family)	$6,000 / $12,000	$15,000 / 30,000
Office Visit PCP and Specialist	Deductible / Coinsurance	Deductible / Coinsurance
Preventive Benefits	$0	Deductible / Coinsurance
X-Ray and Lab	Deductible / Coinsurance	Deductible / Coinsurance
Inpatient Hospital	Deductible / Coinsurance	Deductible / Coinsurance
Outpatient Surgery	Deductible / Coinsurance	Deductible / Coinsurance
Urgent Care	Deductible / Coinsurance	Deductible / Coinsurance
Emergency Room	Deductible / Coinsurance	70% after Deductible
Retail Pharmacy	$10/35/60	
Mail Order Pharmacy (90 day supply)	$25/87.50/150	

***Out-of-Pocket Maximum—** All deductibles, coinsurance and copays apply toward the out-of-pocket maximum.

The goal of this plan is to provide medical coverage after the participant meets a high deductible. Before coverage under this plan begins, a significant deductible must be met. This plan offers the lowest payroll deductions but requires the participant to pay more of the initial cost of medical expenses than the other plans. This plan does offer covered preventive benefits at no charge to the participant.

UHC - Gold Plan

Features	In-Network	Non-Network
Deductible (individual / family)	$2,500 / $5,000	$5,000 / $10,000
Coinsurance	80%	50%
Out-of-Pocket Maximum* (individual / family)	$5,500 / $11,000	$9,000 / 18,000
Office Visit Co-pay PCP and Specialist	$25/50	Deductible / Coinsurance
Preventive Benefits	$0	Deductible / Coinsurance
X-Ray and Lab	100%	Deductible / Coinsurance
Inpatient Hospital	Deductible / Coinsurance	Deductible / Coinsurance
Outpatient Surgery	Deductible / Coinsurance	Deductible / Coinsurance
Urgent Care	$50	Deductible / Coinsurance
Emergency Room	$200	
Retail Pharmacy	$10/35/60	
Mail Order Pharmacy (90 day supply)	$25/87.50/150	

***Out-of-Pocket Maximum—** All deductibles, coinsurance and copays apply toward the out-of-pocket maximum.

The goal of this plan is to provide medical coverage at a reasonable price. Deductibles, co-insurance and out-of-pocket maximums are not as expensive under this plan when compared to the Bronze Plan but not as rich as the Enhanced Plan. This plan has slightly higher payroll deductions but has lower out-of-pocket costs for medical expenses. This plan also offers covered preventive benefits at no charge to the participant.

People's Health Centers/Hopewell Center/PCAC

UHC - Qualified High Deductible Plan (QHDHP) with Option to Establish a Health Savings Account

Features	In-Network	Non-Network
Deductible (non-embedded) (individual / family)	$3,500 / $6,850	$7,000 / $14,000
Coinsurance	90%	70%
Out-of-Pocket Maximum* (individual / family)	$4,500 / $6,850	$11,000 / 22,000
Office Visit Co-pay PCP and Specialist	Deductible / Coinsurance	Deductible / Coinsurance
Preventive Benefits	$0	Deductible / Coinsurance
X-Ray and Lab	Deductible / Coinsurance	Deductible / Coinsurance
Inpatient Hospital	Deductible / Coinsurance	Deductible / Coinsurance
Outpatient Surgery	Deductible / Coinsurance	Deductible / Coinsurance
Urgent Care	Deductible / Coinsurance	Deductible / Coinsurance
Emergency Room	90% after Deductible	90% after Deductible
Retail Pharmacy	Deductible Applies Then $10/30/50	
Mail Order Pharmacy (90 day supply)	Deductible Applies Then $25/75/125	

***Out-of-Pocket Maximum—** All deductibles, coinsurance and copays apply toward the out-of-pocket maximum.

The goal of this plan is to provide medical coverage along with a tax advantaged savings account. Deductibles are similar to the Gold Plan but the co-insurance is 90% after the deductible is met. This plan has the second lowest payroll deductions of all 4 medical options. The HSA has the ability to utilize a tax advantaged savings account for medical expenses. This plan also offers covered preventive benefits at no charge to the participant.

UHC - Enhanced Plan

Features	In-Network	Non-Network
Deductible (individual / family)	$1,000 / $2,000	$2,000 / $4,000
Coinsurance	90%	70%
Out-of-Pocket Maximum* (individual / family)	$3,000 / $6,000	$5,000 / 10,000
Office Visit Co-pay PCP and Specialist	$20/40	Deductible / Coinsurance
Preventive Benefits	$0	Deductible / Coinsurance
X-Ray and Lab	100%	Deductible / Coinsurance
Inpatient Hospital	Deductible / Coinsurance	Deductible / Coinsurance
Outpatient Surgery	Deductible / Coinsurance	Deductible / Coinsurance
Urgent Care	$50	Deductible / Coinsurance
Emergency Room	$200	
Retail Pharmacy	$10/35/50	
Mail Order Pharmacy (90 day supply)	$25/87.50/150	

***Out-of-Pocket Maximum—** All deductibles, coinsurance and copays apply toward the out-of-pocket maximum.

The goal of this plan is to provide richer medical coverage with a higher payroll deduction. Deductibles, co-insurance and out-of-pocket maximums are much lower under this plan when compared to the Gold or Bronze Plans. This plan has a higher payroll deductions but has lower out-of-pocket costs for medical expenses. This plan also offers covered preventive benefits at no charge to the participant.

Health Condition	2016 Medical Plans			
	Bronze	Gold	HSA	Enhanced
Wellness Visit	$0	$0	$0	$0
Chest Cold (Office Visit to Primary Care Physician)	Satisfy $5,000 deductible then 20% of remaining charges up to $6,000	$25 copay	Satisfy $3,500 deductible then 10% of remaining charges and RX copays up to	$20 copay
Routine Pregnancy	Satisfy $5,000 deductible then 20% of remaining charges up to $6,000	Satisfy $2,500 deductible then 20% of remaining charges up to $5,500	Satisfy $3,500 deductible then 10% of remaining charges and RX copays up to	$1,000 deductible then 10% of charges up to $3,000
Hysterectomy	Satisfy $5,000 deductible then 20% of remaining charges up to $6,000	Satisfy $2,500 deductible then 20% of remaining charges up to $5,500	Satisfy $3,500 deductible then 10% of remaining charges and RX copays up to	$1,000 deductible then 10% of charges up to $3,000
Breast Cancer	Satisfy $5,000 deductible then 20% of remaining charges up to $6,000	Satisfy $2,500 deductible then 20% of remaining charges up to $5,500	Satisfy $3,500 deductible then 10% of remaining charges and RX copays up to	$1,000 deductible then 10% of charges up to $3,000
Severely Broken Bone	ER: Satisfy $5,000 deductible then 20% of all remaining charges up to $6,000 (including Rx copays)	ER: $200 copay Office Visit follow up: $25 or $50 copay up to $5,500	ER: Satisfy $3,500 deductible then 10% of remaining charges and RX copays up to $6,850	ER: $200 copay Office Visit follow up: $20 or $40 copay up to $3,000

Employee Cost Per Month for Medical Insurance

Employee Deduction	Bronze Plan	Gold Plan	QHDP	Enhanced Plan
Employee	$89.12	$208.51	$136.65	$306.62
Employee & Spouse	$612.48	$859.62	$710.87	$1,043.25
Employee & Child(ren)	$499.98	$719.66	$587.44	$884.91
Employee & Family	$1,028.23	$1,376.85	$1,167.02	$1,628.42

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 a 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.
- 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 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 a 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 a 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 a HSA.
- You cannot establish a HSA if you also have a medical *flexible* spending account (FSA).
- You cannot set up a 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. The employee contribution levels for 2016 are $3,350 for single coverage and $6,750 for family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year. The employee cannot put more than this amount in the account; but can put less.
- 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 **Central Bank of Missouri**, so you can take advantage of payroll deductions on a pre-tax basis.

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

- 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 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.

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, Wal-mart 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.

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.

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.

To find an in-network Convenience Care Center near you, visit our website at myuhc.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 myuhc.com.

LAB SERVICES

If you require lab work please check to be sure the provider you are going to is in-network. Example, Lab Corp is a network provider and Quest is not. Utilizing

Quest will cause your benefits to be paid at the non-network level.

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

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.

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.

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.

PRESCRIPTION DRUG BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by UnitedHealthcare and approved before they're covered. This process, called ***prior authorization***, helps ensure drugs are used as recommended by The FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost you less
- Restrictions for use with very specific conditions

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for People's Health Centers/Hopewell Centers/PCAC and potentially lower future renewal increases.

Some prescription drugs are covered only if the physician obtains prior authorization from UnitedHealthcare. In addition, coverage for some drugs is provided in limited quantities and duration.

PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at healthcare.gov. Another important website to review preventive care information is cdc.gov/vaccines.

People's Health Centers/Hopewell Center/PCAC

Dental Insurance

UHC Plan Designs

Features	Buy-Up Plan		Base Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible:	$75	$75	$50	$50
Family Deductible:	$225	$225	$150	$150
Diagnostic/ Preventive	100%	100%	100%	80%
Basic Services	90%	80%	80%	60%
Major Services	60%	50%	50%	50%
Orthodontia	50% Adult & Child(ren)	50% Adult & Child(ren)	50% Child(ren) Only	50% Child(ren) Only
Orthodontia Lifetime Max.	$1,000/Adult & Child (ren)		$1,000/Child(ren) Only	
Annual Maximum	$1,000/person		$1,000/person	

Monthly Employee Cost for Dental

Coverage	Buy-Up Plan	Base Plan
Employee	$27.80	$26.42
Employee & Spouse	$62.73	$60.70
Employee & Child(ren)	$63.18	$59.93
Employee & Family	$98.52	$93.90

Orthodontia will only be offered to children under the Base Plan and adults and children under the Buy-Up Plan. You will experience the deepest discounts when seeing an In-Network dentist. To find a provider in your area, please go to myuhc.com.

Vision Insurance

VBA Plan Design

Benefits/Service	In-Network	Out-of-Network
Examination Co-pay	$0	$40 Reimbursement
Frequency of Service: Exam Contacts (in lieu of glasses) Lenses Frames	 Every 12 Months Every 12 Months Every 12 Months Every 24 Months	
Lenses: Single Bifocal Trifocal	$20 Co-Pay then: 100% 100% 100%	Reimbursed up to: $40 $60 $80
Frames	100% $125-$150 Retail	$50
Contact Lenses: Necessary Cosmetic	 UCR $160	Reimbursed up to: $320 $160

Monthly Employee Cost for Vision

Coverage	Cost
Employee	$5.75
Employee + 1	$10.95
Employee & Family	$15.00

If you are considering Lasik, there is a discount available through TLC Lasik Eye Centers or Qualsight. As well, hearing aid discounts are available through Beltone. To find a provider in your area, please go to visionbenefits.com and click on " Search for Provider". When making the appointment you should notify the VBA Provider that VBA is your insurance carrier. There are no ID cards needed for this benefit.

Basic Life and AD&D

People's Health Centers/Hopewell Center/PCAC provides this benefit at no cost to you and is delivered through Cigna. This protection will gives 2 X salary of life insurance for all eligible employees up to specified limits. This also carries an equal benefit of accidental death and dismemberment coverage. Please make sure to have the name and social security number for your beneficiaries on hand when you enroll. Benefit reductions apply upon attaining certain age levels.

Voluntary Life

Voluntary Life, offered by Cigna, allows you the opportunity to purchase additional life insurance on yourself and your dependents. Employees must purchase voluntary life in order to purchase coverage for your spouse and dependent children.

Please note: If you choose not to enroll in the Voluntary Life plan during your initial eligibility period, you will be required to complete an Evidence of Insurability (EOI) form and be approved by Cigna before you are able to obtain coverage.

Newly eligible employees, spouses, and/or children can purchase additional life insurance up to the guarantee issue amount without completing an EOI. Please note the spouse rate will be based on the employee age, not the age of the spouse.

Voluntary Term Life Insurance	
Employee	$10,000 increments up to a maximum of $500,000. Guarantee Issue - $100,000
Spouse	$5,000 increments up to a maximum of the lesser of 50% of the employee election or $250,000. Guarantee issue - $25,000 Please note that you must elect optional coverage for yourself if you wish to elect coverage for your spouse.
Child(ren)	$5,000 increments up to $10,000 per child. Guarantee issue - $10,000 Please note that you must elect optional coverage for yourself if you wish to elect coverage for your child(ren).
Reduction Schedule	65% at age 65 50% at age 70
Accelerated Death Benefit	Up to 75% of supplemental life amount, or $150,000

Voluntary Life Rates

Per $1000 of Coverage Per Month Spouse Rates are Based Upon Employee's Age		
Age	Employee	Spouse
Under Age 25	$0.06	$0.06
25-29	$0.07	$0.07
30-34	$.0.08	$.0.08
35-39	$0.11	$0.11
40-44	$0.17	$0.17
45-49	$0.29	$0.29
50-54	$0.48	$0.48
55-59	$0.78	$0.78
60-64	$0.97	$0.97
65-69	$1.69	$1.69
70-74	$2.73	$2.73
Over 74	$4.22	$4.22
Child Rate	$0.20 per $1,000	Regardless of # of Children

HOW TO CALCULATE VOLUNTARY PREMIUM

$\frac{\$50{,}000}{\text{Elected Coverage}} \div 1{,}000 = \frac{50}{\text{Units}} \times \frac{\$.29}{\text{Rate}} = \frac{\$14.50}{\text{Per Month}}$

* See Note

*The premium calculation is based upon the life rate for an employee age 45.

Long-Term Disability

People's Health Centers/Hopewell Center/PCAC offers this benefit to all eligible employees at no cost to you! 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 Cigna.

Coverage begins after 180 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.

Flexible Spending Accounts (FSAs)

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.

TYPES OF ACCOUNTS

MEDICAL REIMBURSEMENT ACCOUNT: This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription drug expenses that are not covered under your insurance program or that of your spouse. You may also cover dependent health care expenses through the account even if you choose single coverage. The total amount of your annual pledge is available to you up front thus reducing the risk of a large out-of-pocket expense at any one time during the plan year. Be aware that with the Section 125 Medical Account, any unused portion of the account at the end of the plan year is forfeited. You cannot establish the FSA if you also contribute to a Health Savings Account (HSA).

DEPENDENT CARE REIMBURSEMENT ACCOUNT: This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and individuals, as long as the caregiver is not a child of yours under age 19 or anyone you can claim as a dependent for tax purposes. Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. Either may be better, depending on your personal situation. You may not use both. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

Maximum Contributions	
Section 125 Medical Account	$2,550
Dependent Care Expense Account	$5,000

ACCOUNT STATEMENTS

You may request a full statement of your accounts at any time by calling or sending a written request to CBIZ. You can also manage your account by logging onto myplans.cbiz.com to view account balances, view the expenses that have been paid, and see any other account information.

HOW THE ACCOUNT WORKS

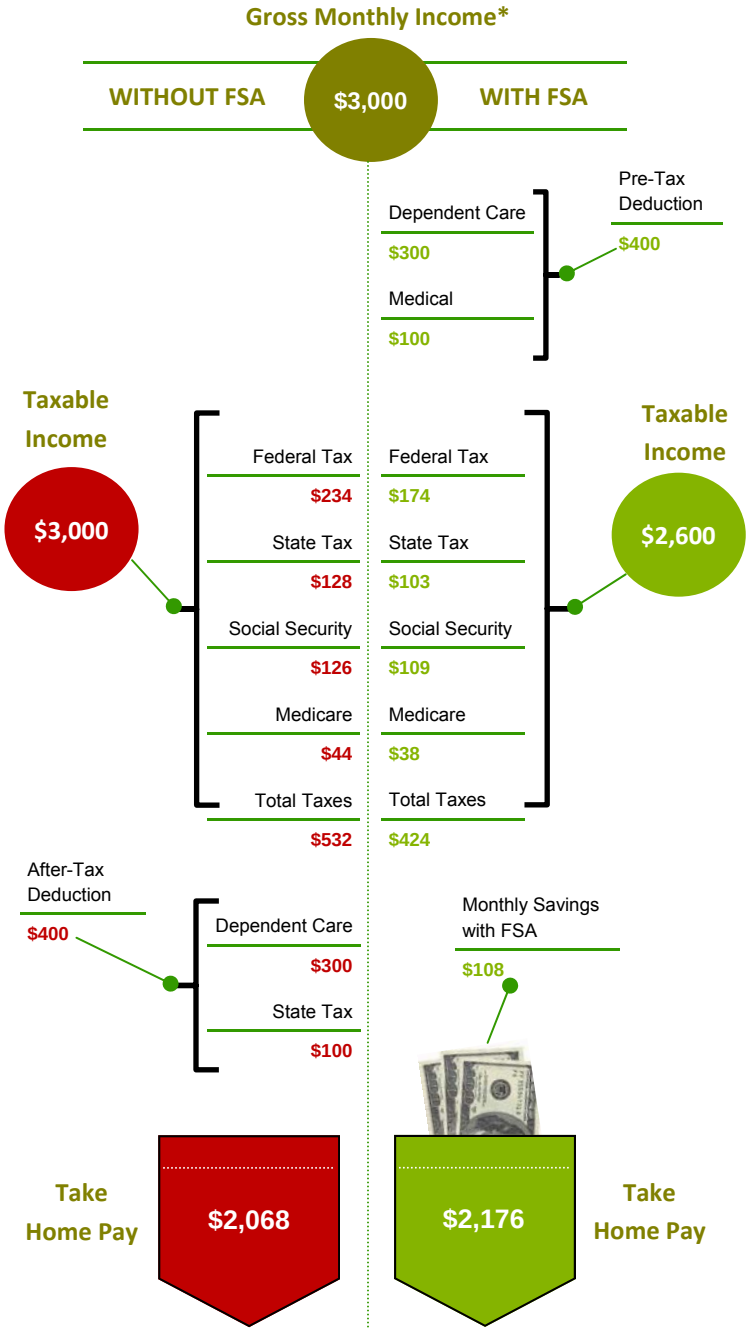
When you have eligible expenses not covered under the health insurance plan, such as copayments and deductibles, you can utilize your CBIZ FSA Debit Card for payment from your Section 125 Medical Account. You may also submit a FSA claim form with your receipt and a reimbursement payment will be issued to you directly.

When you have dependent care expenses, you may complete a dependent care claim form and submit it to CBIZ with a receipt from your child care provider. A reimbursement payment is issued to you directly. Please note, the receipt for your child care provider must include the name, address, and federal tax identification number or social security number of the provider. **You can submit claims through the website at: myplans.cbiz.com, or you can submit claims by sending a claim to: CBIZ Flex, 2797 Frontage Road, Roanoke, VA 24017**

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

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

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.

People's Health Centers/Hopewell Center/PCAC

Employee Assistance Program

Through our Employee Assistance Program (EAP) contract with our service provider, H&H Associates, you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

Our EAP benefit offers confidential, short-term counseling for personal and family issues at no cost to you. The EAP provides short-term, confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns. The EAP also provides the following services to help you balance work and home life:

- Managing stress and change
- Family and relationship concerns
- Parenting issues
- Care management for aging parents
- Identifying school/college resources
- Depression and grief
- Work performance issues
- Health and wellness issues
- Lifestyle weight management
- Budgeting and debt management
- Substance abuse
- Locating child and elder care resources
- Emotional and personal conflicts
- Legal concerns
- Retirement issues
- Financial planning

H&H is an independent firm that specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. H&H professionals answer calls 24 hours a day, seven days a week. H&H's telephone number is 314-845-8302 or 1-800-832-8302. When you call the EAP, an H&H representative will answer any questions you have and set up an appointment for you. Please visit the H&H website for additional information at hhhealthassociates.com.

How to Get Covered in the Missouri Health Insurance Marketplace

What is the Missouri Health Insurance Marketplace?

The Missouri Health Insurance Marketplace is a website where you can compare and buy the health insurance plan that's right for you. The Marketplace opens November 1, 2015, with health insurance coverage starting January 1, 2016.

Can I use the Marketplace?

Anyone can use the Marketplace to see their insurance options. The Missouri Health Insurance Marketplace is designed to help individuals and families get affordable health coverage.

How to apply

You can buy insurance through the Missouri Health Insurance Marketplace November 1, 2015, through January 31, 2016. The process will be simplified – you only need to fill out one application to get coverage and financial help. **You can apply online, by phone or in person.**

Help using the Marketplace

If you have questions, need help selecting a health plan or completing your application you can:

Talk to someone in person. Navigators and Certified Application Counselors are trained people who can answer questions and help you fill out your application in person. Find help near you at **www.covermissouri.org** or call **1-800-466-3213** (available Oct. 15) to set up an appointment with a trained assister.

Get Covered: Follow these steps to find the right health insurance plan for you and get covered.

Visit www.healthcare.gov

Create an account

Give your name, address and other basic information to get started.

Fill out the application

Provide more information about you and your family, such as household size, income and other information to see your plan options.

Compare

Review health insurance plans side-by-side and see if you qualify for lower premiums. Then, choose the plan that best meets your needs.

Pay your premium

Pay your first monthly premium (cost of your health insurance) and begin using your new health coverage.

Call the toll-free Marketplace call center, open 24 hours a day, seven days a week. Call **1-800-318-2596** (TTY 1□855-889-4325). You can have a live online chat at **www.healthcare.gov**. Spanish-speaking individuals can use **www.cuidadodesalud.gov**.

Talk to an agent or broker. Insurance agents and brokers can also help you find, choose and buy coverage. It is important to note that agents and brokers can receive money from a health insurance

Getting Financial Help in the Marketplace

What is the Health Insurance Marketplace?

The Missouri Health Insurance Marketplace is a website where you can compare insurance plans and pricing that best fit your budget and health care needs. You can use the Marketplace if you are an individual or family who doesn't have access to affordable coverage through work. **The Marketplace opens on November 1, 2015, with health insurance coverage starting January 1, 2016.**

How can I get financial help in the Marketplace?

If you use the Missouri Health Insurance Marketplace, you may be able to save money on your health insurance.

Premium tax credits and cost-sharing reductions are available to help make health care more affordable. These financial help options use a sliding scale, so families making less money pay a smaller amount for health insurance and care.

You'll see if you can get financial help and how much you can save when you fill out your Marketplace application.

If you don't make enough to get financial help, you may qualify for Medicaid. You can use the Missouri Health Insurance Marketplace to find out.

Premium Tax Credits

Premium tax credits can lower the amount you pay for your health insurance plan. The value of the tax credit depends on how much money you make and how many people are in your family. In general, the less money you make, the larger your tax credit will be. This amount can go up or down based on changes in your job status, size of your family, or marital status. There are two ways to use the tax credit:

1. **TAKE IT NOW:** You can choose to take your tax credit "in advance." This allows you to lower your premiums every month. Your tax credit will be paid directly to your insurance plan on a monthly basis. When you file your taxes, you'll report that you already used your tax credit.
2. **TAKE IT LATER:** If you choose this option, you'll pay your full premium each month. When you file your taxes, you'll subtract your premium tax credit from any taxes you owe. If you don't owe taxes, you'll get a bigger refund.

Do I qualify for a premium tax credit?

- **You can't get affordable health insurance through your job.**
- **You don't have Medicare.**
- **You have household income between 100% and 400% of the Federal Poverty Level.**
  (Find the income range for your family size in this chart to see if you qualify)
- **You use the Missouri Marketplace to buy coverage.**

*Income Level (100% – 400%)**			
Family Size	*Yearly*	*Monthly*	*Hourly*
1	$11,770 – $47,080	$981 – $3,923	$5.66 – $22.63
2	$15,930 – $63,720	$1,328 – $5,310	$7.66 – $30.63
3	$20,090 – $80,360	$1,674 – $6,697	$9.66 – $38.63
4	$24,250 – $97,000	$2,021 – $8,083	$11.65 – $46.63
5	$28,410 – $113,640	$2,368 – $9,470	$13.66 – $54.63
6	$32,570 – $130,280	$2,714 – $10,857	$15.66 – $62.63

Cost-Sharing Reductions

Cost-sharing reductions are a discount that lowers the amount of money you pay out of your own pocket for health care. You can lower your out-of-pocket costs if your income is at or below 250% of the poverty level and you use the Missouri Marketplace.

Do I qualify for lower out-of-pocket costs?

- **You receive a premium tax credit.**
- **You choose to buy a silver-level health plan through the Missouri Marketplace.**
- **You have household income at or below 250% of the Federal Poverty Level.**
  (Find the income level for your family size in this chart to see if you qualify)

Income Level (250%)*

Family Size	Yearly	Monthly	Hourly
1	$29,425 or less	$2,452.08 or less	$14.15 or less
2	$39,825 or less	$3,318.75 or less	$19.15 or less
3	$50,225 or less	$4,185.42 or less	$24.15 or less
4	$60,625 or less	$5,052.08 or less	$29.15 or less
5	$71,025 or less	$5,918.75 or less	$34.15 or less
6	$81,425 or less	$6,785.42 or less	$39.15 or less

**Based on the 2015 Federal Poverty Income Levels.*

To Learn More

If you need help figuring out if you can get financial help or qualify for Medicaid, you can:

- **Talk to someone in person.** Navigators and Certified Application Counselors are trained people who can answer questions and help you fill out your application in person. They're required to provide fair and accurate information. Find help near you at **www.covermissouri.org** or call **1-800-466-3213** (available Oct. 15) to set up an appointment with a trained assister. You can also use the Plan Comparison Tool on **www.covermissouri.org** to explore your health care plan options.

- **Call the toll-free Marketplace call center**, open 24 hours a day, 7 days a week. Call 1-800-318-2596 (TTY 1-855-889-4325). You can have a live online chat at **www.healthcare.gov**. Spanish-speaking individuals can use **www.cuidadodesalud.gov**.

- **Talk to an agent or broker.** Insurance agents and brokers can also help you find, choose and buy coverage. It is important to note that agents and brokers can receive money from a health insurance company for enrolling people into their plans.

www.covermissouri.org Published September 2015

Understanding Health Insurance and Plan Choices in the Marketplace

Most Americans are now required to have health insurance or pay a penalty. The Missouri Health Insurance Marketplace gives Missourians a way to compare plans and buy health insurance.

What is health insurance?

Health insurance helps you pay for medical care and can protect you from high health care costs, like emergency room visits or hospital stays after a car accident. These health care bills can add up quickly and often cause people to go into debt or even bankruptcy.

There are important things to look at when buying health insurance:

The health services the plan covers.
How much you'll pay for the plan – monthly premiums.
How much you'll pay for things like doctor visits or prescription medicine – cost-sharing.

What does it cover?

New health insurance plans must cover a minimum set of core benefits called essential health benefits, which include:

- Ambulatory services, like visits to your doctor's office.
- Emergency services.
- Hospitalizations, usually round-the-clock care for people in the hospital.
- Maternity and newborn care for pregnant women, new moms and their babies. This includes breastfeeding pumps and well-baby visits.
- Mental health and substance use disorder services, including counseling to treat depression and alcohol abuse.
- Prescription medicine.
- Rehabilitation and habilitative services. These may include physical therapy, occupational therapy or walkers.
- Laboratory services, like blood tests your doctor uses to diagnose and treat you.
- Preventive services and chronic disease management to help prevent and control health conditions. Services may include:
- Cancer screenings and checkups.
- Programs to help you quit smoking.
- Pediatric services for kids and babies, including dentist visits and eye exams.

Some health plans may cover additional health services. It's important to know that insurance companies may limit how much they'll pay for these "nonessential benefits." For example, your plan could limit how much it will pay for your dental care each year or over your lifetime, because dental care for adults is not considered an essential health benefit.

How does health insurance work?

Health insurance helps pay for the cost of medical care by reducing the amount you personally pay when you have medical needs. The amount you pay depends on your specific health insurance plan. Most health plans use a combination of the following:

- **PREMIUMS** – A premium is a set amount you pay for your health insurance plan, usually paid every month. You pay your premium even if you don't receive medical care that month.
- **DEDUCTIBLES** – A deductible is the amount of money you pay for health care services before your insurance plan begins to pay for covered health services. For example, if your health insurance plan has a $1,000 deductible, you must pay $1,000 for medical care before your insurance will start paying. A deductible may not apply to all health services, such as preventive care.
- **CO-PAYMENT** – A co-payment, also called a co-pay, is a fixed amount you'll pay for medical services. For example, you may pay $25 every time you visit your doctor. Your health plan will pay the rest of the cost for that visit.
- **COINSURANCE** – Coinsurance is where you pay a percentage of the cost for a covered health service. For example, if your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%, you'd pay $20. Your health insurance plan pays the rest.
  The coinsurance percentage depends on your specific insurance plan.

How much does health insurance cost?

Insurance plans in the Missouri Health Insurance Marketplace fall into four categories based on how the costs of care are shared between you and the insurance company. The categories are: Bronze, Silver, Gold and Platinum. All health plans in the Marketplace will cover the same set of essential health benefits.

Each health plan may have different costs, even if they are in the same category. In general, the more you're willing or able to pay for each health care service you use, the lower your premium will be.

To make an appointment to speak with a trained assister, call **1-800-466-3213** (available Oct. 15) or use the scheduling tool on **www.covermissouri.org**. Call the toll-free Marketplace call center, open 24 hours a day, seven days a week. Call **1-800-318-2596** (TTY 1□855-889-4325). Online: **www.healthcare.gov** for English or **https://cuidadodesalud.gov** for Spanish. **Talk to an agent or broker.** Insurance agents and brokers can also help you find, choose and buy coverage. It is important to note that agents and brokers can receive money from a health insurance company for enrolling people into their plans.

www.covermissouri.org

Published September 2015

What Individuals and Families Need to Know About the Marketplace

What is the Missouri Health Insurance Marketplace?

The Missouri Health Insurance Marketplace is a website where you can compare and buy an insurance plan to fit your budget and health care needs. You can use the Marketplace if you are an individual or family who doesn't have access to affordable coverage through work. **The Marketplace opens on November 1, 2015, with health insurance coverage starting January 1, 2016, if you enroll by December 15. The Marketplace closes on January 31, 2016.**

How does the Marketplace work?

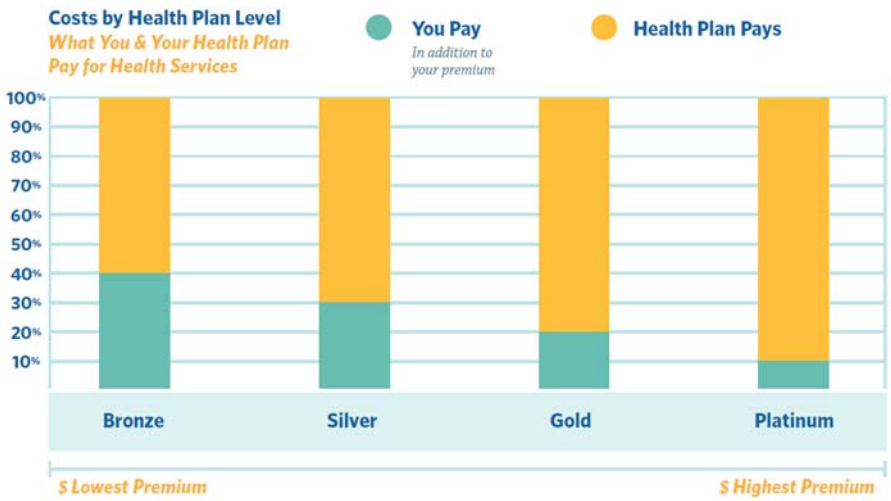
It's a lot like travel websites where you can compare prices and buy hotel or plane tickets. In the Missouri Health Insurance Marketplace you can compare prices and buy quality, affordable health insurance. Private insurance companies offer the health plans sold in the Marketplace.

- On The Missouri Health Insurance Marketplace website you can:
- Compare health insurance plans.
- Get the cost of health insurance plans before you buy.
- Find out if you can get financial help – most people will qualify for some financial assistance.
- See if you qualify for Medicaid, a public health insurance program.
- Buy a health insurance plan that best meets your needs.

Choosing a plan in the Marketplace

When you go to the Missouri Health Insurance Marketplace, you'll have the choice of four types of plans. All health plans will cover the same essential health benefits.

Each health plan may have different costs, even if they're the same type of plan. In general, the more you're willing or able to pay for each health care service you use, the lower your premium will be.



What kind of financial help can I get?

If you use the Missouri Health Insurance Marketplace, you may be able to save money on health insurance.

Premium tax credits will lower how much you pay for your health plan. Cost-sharing reductions will lower how much you spend out of your own pocket for covered health services. This financial help uses a sliding scale, so families making less money pay a smaller amount for health insurance and health care.

You'll see if you can get financial help and how much you can save when you fill out your Marketplace application. **The Missouri Health Insurance Marketplace opens November 1, 2015. Insurance coverage and financial help start on January 1, 2016.**

If you don't make enough to get financial help, you may qualify for Medicaid. You can use the Missouri Health Insurance Marketplace to find out.

How do I get covered?

You can buy insurance through the Missouri Health Insurance Marketplace November 1, 2015, through January 31, 2016. The process will be simplified – you only need to fill out one application to get coverage and financial help. **You can apply online, by phone or in person.**

To learn more

If you have questions, need help selecting a health plan or completing your application, there are several types of help available. You can:

- **Talk to someone in person.** Navigators and Certified Application Counselors are trained people who can answer questions and help you fill out your application in person. They're required to provide fair and accurate information. Find help near you at **www.covermissouri.org** or call **1-800-466-3213** (available Oct. 15) to set up an appointment with a trained assister. You can also use the Plan Comparison Tool on **www.covermissouri.org** to explore your health care plan options.

- **Call the toll-free Marketplace call center**, open 24 hours a day, 7 days a week. Call 1-800-318-2596 (TTY 1-855-889-4325). You can have a live online chat at **www.healthcare.gov**. Spanish-speaking individuals can use **www.cuidadodesalud.gov**.

- **Talk to an agent or broker.** Insurance agents and brokers can also help you find, choose and buy coverage. It is important to note that agents and brokers can receive money from a health insurance company for enrolling people into their plans.

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 a special enrollment or obtain more information, contact Human Resources Department.

Notice of Material Change (also Material Reduction in Benefits)

People's Health Centers/Hopewell Center/PCAC has amended the People's Health Centers/Hopewell Center/ PCAC's Health Benefits 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 the Human Resources Department.

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 copays, 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 Privacy Practices

People's Health Centers/Hopewell Center/PCAC 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 your Human Resources Department.

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2015. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form in January 2016. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee for the premium tax credit.

You'll need a 1095 form to complete your annual Federal tax return.

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 People's Health Centers/Hopewell Center/PCAC.

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 also 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 **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 **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 **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: 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
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
cms.hhs.gov
1-877-267-2323

Medicare Part D Credible 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 plans provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

UnitedHealthcare has determined that the prescription drug coverage offered by People's Health Centers/ Hopewell Center/PCAC 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.

This information is provided for the Medicare open enrollment period which begins on October 15. 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 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 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).

Glossary of Terms

Coinsurance – The plan's 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. You pay 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 copays 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.