DONALD DANFORTH
PLANT SCIENCE CENTER
DISCOVERY | COMMUNITY | IMPACT

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.

2016 Benefits Guide

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CONTACT INFORMATION

Contact Information		
Vendors	**Phone Number**	**Website**
UnitedHealthcare *(Medical)* Group Number: 707574	Call the toll-free number on the back of your ID card.	www.myuhc.com
MetLife *(Dental)* Group Number: 5922778	(800)ASK-4MET	www.metlife.com/mybenefits
UnitedHealthcare *(Vision)* Group Number: 707574	(800) 638-3120	www.myuhcvision.com
The Standard *(Life/Vol Life)* Group Number:	(800) 628-8600	www.standard.com
Chubb *(AD&D)* Group Number: 9906-44-80	(888) 987-5920	www.chubb.com/travelhelp/eb
The Standard *(STD/LTD)* Group Number:	(800) 368-2859	www.standard.com
The Standard *(Employee Assistance Program - EAP)*	(888) 293-6948	www.eapbda.com Login: standard6 Password: eap4u6
UHC *(Flexible Spending Account)*	(877) 311-7849	www.myuhc.com
Benefits Team	**Phone**	**Email**
Donald Danforth Human Resources Debbie Barron Patricia Ovca Vicky Wertich	(314) 587-1034 (314) 587-1031 (314) 587-1033	dbarron@danforthcenter.org povca@danforthcenter.org vwertich@danforthcenter.org
Consultant Rusty Besancenez Asha Kuhn	(314) 692-2249 (800) 844-4510	rbesancenez@cbiz.com akuhn@cbiz.com

ENROLLING IN THE PLANS

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

If you would like to make changes to your medical, dental and vision elections, you will need to complete an enrollment form, otherwise your current elections will remain unchanged. As well, if you are interested in enrolling in the Flex Plan, please make sure to enter your new election on an election form. Flex enrollments will not carry over to next year**.** If you would like to make changes or enroll in the Voluntary Life plan you will need to complete an enrollment form. All employees will need to complete a Beneficiary Form for The Standard. For 2016, there will be a $50/month surcharge to carry coverage for your spouse if they work and could elect coverage with their employer. If this is applicable, you will be asked to complete a form designating your spouse on your plan and acknowledging the surcharge. Please submit all forms to Human Resources. **All enrollment forms will need to be turned into HR no later than December 11, 2015.**

ELIGIBILITY

JOINING THE PLAN:

If you are a Danforth Center new employee, you are eligible for coverage immediately upon hire. You must submit your enrollment forms/applications and complete your enrollment within 30 days of the effective date. If you do not submit your enrollment information within 30 days of your effective date, you will need to wait until the next annual open enrollment to make your benefit elections.

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- Legal Spouse
- Natural and Adopted Children up to age 26
- Your Stepchildren
- Children placed in your custody for adoption
- Children under your legal guardianship
- Children under a qualified medical child support order
- Disabled children 26 years of age or older

Ineligible:

- Divorced or legally separated spouse
- Common law spouse
- Same or Opposite Sex Domestic Partners
- 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
- You or your spouse dies
- You become eligible for or lose Medicaid coverage
- You become eligible for Medicare

YOUR HEALTH PLAN OPTIONS

The Danforth Center knows your employee benefit package is extremely important to you. The Center understands benefits should meet you and your family's needs, as well as be affordable. In order to meet the needs of all Center employees, we offer you the choice between three medical plan options. Two of the medical plans are traditional PPO plans offering a copayment schedule for doctor visits and prescriptions. The Enhanced Plan offers a lower deductible and out of pocket cost as well as lower copayments. The Base Plan offers higher out of pocket expenses, however, the premium is lower. There is also an option to enroll in a Qualified High Deductible Health Plan (QHDHP). This plan does not have a copayment schedule for doctor visits and prescriptions. The services you receive under this plan go towards your annual deductible and out of pocket maximum. This option allows you to the opportunity to establish a tax favored Health Savings Account (H.S.A.). Please pay close attention to the details and costs associated with each plan in order to determine which plan best fits you and your family's needs.

PRE-TAX PREMIUM CONTRIBUTIONS

It is important to remember that all contributions for medical, dental, and vision premiums are paid on a pre-tax basis according to Section 125 of the IRS code. This means premiums will be deducted from your gross income. Taxes will then be applied to the remaining payroll amount.

Advocate4ME

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

Full Spectrum of Health Care Support

VIRTUAL VISITS

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

Conditions Commonly Treated Through a Virtual Visit

- Bladder Infection/Urinary Tract Infection
- Bronchitis
- Cold/Flu
- Diarrhea
- Fever
- Migraine/Headaches
- Pink Eye
- Rach
- 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 Base and Enhanced Plans and the deductible for the QHDHP.

RALLY

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

HOW TO FIND A PROVIDER

It's simple to look for a medical provider in your area:

1. Go to myuhc.com
2. Click on Find Physician, Laboratory or Facility on the right hand side of the page.
3. Select UnitedHealthcare Choice Plan as the plan name.
4. On the next screen you can personalize your search by zip code and physician type.

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MEDICAL INSURANCE

UnitedHealthcare Medical

Benefit Plan—Enhanced Plan	In Network	Out of Network
Deductible (calendar year)		
Single	$250	$500
Family	$500	$1,000
Coinsurance (plan pays/you pay)		
	100% / 0%	80% / 20%
Out of Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$3,500	$5,300
Family	$7,000	$10,000
Copayments		
Primary Physician Visit	$20 co-pay	Deductible, then you pay 20%
Specialist Physician Visit	$40 co-pay	Deductible, then you pay 20%
Preventive Care	Plan pays 100%	Deductible, then you pay 20%
Emergency Room Visit	$200 co-pay	$200 co-pay
Urgent Care Center Visit	$50 co-pay	Deductible, then you pay 20%
Prescription Drug Coverage		
Retail Pharmacy	$10/35/60	$10/35/60
Mail Order Pharmacy	$25/87.50/150	$25/87.50/150

2016 Employee Enhanced Plan Medical and Dental Contributions

Employee Deduction (for Medical and Dental per pay period)	Total	The Center Pays	Employee Monthly Cost	Employee Per Pay Period Cost	Employee Per Pay Period Cost with Spousal Surcharge
Employee	$540.10	$432.10	$108.00	$54.00	$54.00
Employee & Spouse	$1,130.83	$858.83	$272.00	$136.00	$161.00
Employee & Child(ren)	$1,046.13	$794.13	$252.00	$126.00	$126.00
Employee & Family	$1,593.21	$1,179.21	$414.00	$207.00	$232.00

MEDICAL INSURANCE

UnitedHealthcare Medical

Benefit Plan—Base Plan	In Network	Out of Network
Deductible (calendar year)		
Single	$1,000	$2,000
Family	$2,000	$4,000
Coinsurance (plan pays/you pay)		
	80% / 20%	60% / 40%
Out of Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$2,500	$5,000
Family	$5,000	$10,000
Copayments		
Primary Physician Visit	$20 co-pay	Deductible, then you pay 40%
Specialist Physician Visit	$40 co-pay	Deductible, then you pay 40%
Preventive Care	Plan pays 100%	Deductible, then you pay 40%
Emergency Room Visit	$200 co-pay	$200 co-pay
Urgent Care Center Visit	$50 co-pay	Deductible, then you pay 40%
Prescription Drug Coverage		
Retail Pharmacy	$10/35/60	$10/35/60
Mail Order Pharmacy	$25/87.50/150	$25/87.50/150

2016 Employee Base Plan Medical and Dental Contributions

Employee Deduction (for Medical and Dental per pay	Total	DDPSC Pays	Employee Monthly	Employee Per Pay	Employee Per Pay Period Cost with
Employee	$447.44	$393.44	$54.00	$27.00	$27.00
Employee & Spouse	$936.26	$776.26	$160.00	$80.00	$105.00
Employee & Child(ren)	$870.07	$722.07	$148.00	$74.00	$74.00
Employee & Family	$1,324.52	$1,060.52	$264.00	$132.00	$157.00

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MEDICAL INSURANCE

UnitedHealthcare Medical

Benefit Plan—QHDHP Plan	In Network	Out of Network
Deductible (calendar year embedded deductible*)		
Single	$2,600	$5,000
Family	$5,200	$10,000
Coinsurance (plan pays/you pay)		
	100% / 0%	70% / 30%
Out of Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$3,500	$10,000
Family	$7,000	$20,000
Copayments		
Primary Physician Visit	Deductible, then you pay 0%	Deductible, then you pay 30%
Specialist Physician Visit	Deductible, then you pay 0%	Deductible, then you pay 30%
Preventive Care	Plan pays 100%	Deductible, then you pay 30%
Emergency Room Visit	Deductible, then you pay 0%	In Network Deductible, then 0%
Urgent Care Center Visit	Deductible, then you pay 0%	Deductible, then you pay 30%
Prescription Drug Coverage		
Retail Pharmacy	Deductible then $10/35/60	Deductible & Coinsurance then $10/35/60
Mail Order Pharmacy	Deductible then $25/87.50/150	Deductible & Coinsurance then $25/87.50/150

2016 Employee QHDHP Plan Medical and Dental Contributions

Employee Deduction (for Medical and Dental per pay period)	Total	The Center Pays	Employee Monthly Cost	Employee Per Pay Period Cost	Employee Per Pay Period Cost with Spousal Surcharge
Employee	$431.85	$387.85	$44.00	$22.00	$22.00
Employee & Spouse	$903.52	$795.52	$108.00	$54.00	$79.00
Employee & Child(ren)	$840.44	$740.44	$100.00	$50.00	$50.00
Employee & Family	$1,279.30	$1,087.30	$192.00	$96.00	$121.00

*An **embedded** deductible means your plan contains two components, an individual deductible and a family deductible. Having two components to the deductible allows for each member of your family the opportunity to have the insurance policy cover their medical bills prior to the entire dollar amount of the family deductible being met. The individual deductible is embedded in the family deductible.

HEALTH SAVINGS ACCOUNT (HSA)

With the Election of the UnitedHealthcare Qualified High Deductible Health Plan (QHDHP) for your insurance coverage, you may also open an HSA.

What is an HSA?

A savings account set up by either you or your company where you can either direct pre-tax payroll deductions or deposit money to be used by you to pay for current or future medical expenses for you and/or your dependents. Once money goes into the account, it's yours forever - the HSA is in your name, just like a personal checking or savings account.

Why would I want an HSA?

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

In addition, The Danforth Center will contribute $500 towards the employee deductible and $1,000 towards the family deductible for 2016 into your HSA.

What Rules Must I Follow?

- You must be covered under a Q*ualified High Deductible Health Plan (QHDHP)* in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical *flexible* spending account (FSA).
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouses 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 a 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 and coinsurance first. This would include office visits that are not preventive, emergency room visits, and prescription drugs. You will, however, still have the opportunity to benefit from the discounts associated with using a network physician or facility.

What Else Do I Need to Know?

- The contribution limits for 2016 are $3,350 for Single and $6,750 for Family. You cannot put more than this amount in the account in a calendar year; you 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 subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled and/or qualify for Medicare, you can use the account for other purposes without paying the 20% penalty but you will pay income taxes.
- Donald Danforth has established accounts with Central Bank of Missouri so you can take advantage of payroll deductions on a pre-tax basis. An enrollment form is available if you are interested in establishing a Health Savings Account through Central Bank of Missouri.

Another advantage is that your account can grow over time.

Since the money always belongs to you, even if you leave the company, any unused funds carry over from year to year, so you never have to worry about losing your money. That means if you don't use a lot of healthcare services now, your HSA funds will be there if you need them in the future – even after retirement.

The HSA is also an investment opportunity.

With an HSA, your account can grow tax-free in an interest-bearing savings account, a money market account, a wide variety of mutual funds – or all three. Of course, your funds are always available if you need them for qualified healthcare expenses.

Generally, you can put enough in your HSA to cover most of your deductible.

The Qualified High Deductible Health Plan helps you pay for healthcare AFTER you meet the deductible. The annual contribution limit is based on IRS rules. In general, the total amount that goes in your account each year can't be more than the IRS annual contribution limit. If you're age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year.

You can spend only the money that is actually in your HSA.

If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as cash or personal check. You can request reimbursement after you have accumulated more money.

You can use your HSA for your spouse and dependents – even if they are not covered by your High Deductible Health Plan.

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

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, contact lenses and solution, and laser surgery
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs
- Physical therapy, speech therapy, and chiropractic expenses

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

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

YOUR HEALTH BENEFITS

Get the Most from Your Benefits

The Danforth Center offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

To get the most from your benefits during the year, try these tips:

- Ask your doctor for the generic equivalent of the brand-name drug prescribed
- Visit in network providers for your care

When to Use Primary Care, Convenience Care, Urgent Care, Lab Services, or Emergency Care

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.

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 www.myuhc.com.

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.

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.

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 www.myuhc.com.

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.

LAB SERVICES

If you require lab work consider having these services performed at **LabCorp.** If you choose to use Quest, services associated with the cost of your lab work will apply to the out of network deductible and coinsurance.

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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

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.

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.

PRESCRIPTION BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Anthem 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 The Center and potentially lower future renewal increases. Some prescription drugs are covered only if the physician obtains prior authorization from Anthem. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The Certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

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 www.healthcare.gov.

WOMEN'S PREVENTIVE CARE COVERAGE

Your health plan will provide first dollar coverage for certain women's preventive coverage without any cost sharing requirements (co-payment, coinsurance or deductible), when delivered by in network providers. This includes 100% coverage for FDA-approved tier 1 contraceptive methods for women when filled at an in network pharmacy.

DENTAL INSURANCE

MetLife Dental

Benefit/Service	In Network	Out of Network Benefit
Preventive	100%	100%
Basic	90%	80%
Major	60%	50%
Ortho (child only up to age 19)	50%	50%
Endodontics	90%	80%
Periodontics	90%	80%
Oral Surgery	90%	80%
Implants	Covered	Covered
Deductibles & Maximums		
Deductible Individual *	$25	$50
Deductible Family	$75	$150
Annual Maximum Per Person	$1,000	
Lifetime Orthodontia Maximum	$1,000	

*Does not apply to preventive services

Our dental plan is provided by MetLife. You will have coverage both in network and out of network. It is to your advantage to utilize a network dentist to take advantage of contracted fees. You will experience the deepest discounts when seeing an in network dentist. If you go out of network, you will be responsible for any amount exceeding MetLife's negotiated rates plus any deductible and co-insurance associated with your procedure.

To find a participating dentist in your elected plan, visit www.metlife.com/mybenefits.

Please note if you are not currently enrolled or if you chose not to enroll during your initial eligibility period, you will be subject to a 6 month waiting period on basic restorative services, a 12 month waiting period on all other basic services and a 24 month waiting period on major and orthodontia services if you chose to enroll at this time.

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VISION INSURANCE

UnitedHealthcare (UHC) Vision

Benefit/Service	In Network	Out of Network Benefit
Examination	$10 Co-pay	$40 reimbursement
Frequency of Service:		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses:	$25 Co-pay then:	Reimbursement:
Single	100%*	$40
Bifocal	100%*	$60
Trifocal	100%*	$80
Frames	*Covered 100% up to $50 Wholesale/$130 Retail	$45
Contacts:		Reimbursement
Necessary	Covered at 100%	$210
Cosmetic	$105 Allowance	$105

Our Vision benefit is provided by UnitedHealthcare. If you utilize an out of network provider, your benefit is based on a reimbursement schedule. Also, if you are considering Lasik surgery, there is a discount available. You can review a full list of providers at www.myuhcvision.com.

*With UnitedHealthcare Vision's frame benefit, all frames with a $50 wholesale cost or less are covered in-full at private practice providers. For any frame over $50 at private practice providers, the member pays the difference between the wholesale cost of the frame and the $50 allowance. Plan participants receive $130 retail frame allowance for frames purchased at a retail chain and for any frame above the $130 retail, the member

2016 Employee Vision Contributions

Vision Employee Cost	Employee Monthly Cost	Employee Per Pay Period Cost
Employee	$5.40	$2.70
Employee & Spouse	$9.94	$4.97
Employee & Child(ren)	$10.42	$5.21
Family	$15.60	$7.80

BASIC LIFE INSURANCE

All eligible employees receive Basic Life coverage. This coverage is provided by The Center at **no cost** to you. This coverage is administered through The Standard. This benefit provides two times your salary, up to a maximum of $150,000 of Life Insurance. Benefit reductions apply upon attaining certain age levels.

This plan offers Travel Assistance which helps you cope with emergencies when you travel more than 100 miles from home or internationally for trips of up to 180 days. It can also help you with non-emergencies, such as planning your trip. All services are available 24 hours a day, every day. Visit their website at https://members.uhcglobal.com/Standard/standard1.aspx or In the U.S., Canada, Puerto Rico, U.S. Virgin Islands, and Bermuda, call 800.527.0218. In other locations worldwide, call collect +1.410.453.6330.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

All eligible employees receive Basic AD&D coverage. This coverage is provided by The Center at **no cost** to you. This coverage is administered through Chubb.

VOLUNTARY LIFE INSURANCE

Your Voluntary Life is administered through The Standard. You must purchase voluntary life on yourself in order to purchase coverage for your spouse and dependent children. Benefit reductions apply upon attaining certain age levels.

EMPLOYEE COVERAGE

Employees can purchase a minimum of $10,000 in $10,000 increments, up to a maximum of $500,000 of coverage. The Guarantee Issue amount for newly eligible employees is $150,000.

VOLUNTARY LIFE EMPLOYEE CONTRIBUTION (per month)			
Age Band	Employee Rate per $1,000	Spouse Rate per $1,000	All Children Rate per
Under 25	$0.07	$0.13	$0.50
25-29	$0.07	$0.13	
30-34	$0.08	$0.14	
35-39	$0.11	$0.19	
40-44	$0.18	$0.31	
45-49	$0.26	$0.56	
50-54	$0.43	$0.92	
55-59	$0.75	$1.66	
60-64	$1.18	$2.03	
65-69	$1.85	$3.27	
70-74	$2.96	$3.27	
75+	$5.24	$3.27	

SPOUSE COVERAGE

Spousal coverage is available in $5,000 increments, with a minimum of $5,000 to a maximum of $250,000. The Guarantee Issue amount for newly eligible spouses is $20,000.

CHILDREN

A $10,000 benefit is available for purchase for your dependent children. This coverage is available from live birth to age 26.

Please note: If you are currently enrolled in the Mutual of Omaha plan you and your dependents have a onetime special enrollment opportunity, which allows you and your dependents to enroll or increase your elections by up to a maximum of $30,000 or up the guarantee issue amounts, without having to complete an Evidence of Insurability (EOI). If you are not currently enrolled, you can elect up to $30,000 without having to complete an EOI.

Annually at each open enrollment period, if you are covered under The Standard, you can increase your coverage amount by $30,000 up to the guarantee issue limit without providing Evidence of Insurability to The Standard. Spousal increases require Evidence of Insurability. If you do not have voluntary life coverage currently through The Standard you can apply during the annual enrollment period by completing an enrollment form and an Evidence of Insurability form. The Danforth Center will not deduct any amounts from your paycheck until The Standard has approved your application.

HOW TO CALCULATE VOLUNTARY PREMIUM								
$50,000 Elected Coverage	÷ 1,000 =	50 Units	X	$0.26 Rate * See Note	=	$13.00 Monthly Cost	*The premium calculation is based upon the life rate for an employee age 45.

Please note: If you and/or your dependents do not enroll during your initial enrollment period in the Voluntary Life you will be required to complete an Evidence of Insurability (EOI) form and be approved by The Standard before you are able to obtain coverage.

VALUE ADDED BENEFIT FROM THE STANDARD

LIFE SERVICES TOOLKIT

- **Estate-planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and healthcare agent forms.
- **Identity Theft Prevention:** Online resources help you learn how to thwart identity thieves and resolve issues if identity theft occurs.
- **Financial Planning:** Online tools help you confidently manage debt, calculate mortgage and loan payments, and take care of other financial matters.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help you and your family lead healthy lives.
- **Funeral Arrangements:** You can use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangement in advance.

SHORT TERM DISABILITY

Short term disability is intended to protect your income for a short duration in case you become ill or injured. The Center provides this benefit to you at **no cost.**

Beginning on the 8th day of an illness or injury, you are eligible to receive 60% of your weekly income, to a maximum of $1,900, through The Standard. The maximum benefit period is 12 weeks.

LONG TERM DISABILITY

Long Term Disability is intended to protect your income for a long duration. The Center provides this benefit to you at **no cost.**

After the 90th day of an illness or injury, you may be eligible for long term disability benefits through The Standard. The disability benefit is a monthly benefit and covers 60% of your monthly salary to a maximum of $8,000. This benefit may be paid to Social Security retirement age or until you no longer meet the definition of disability. You are considered disabled if you have a loss of duties in regards to your regular occupation due to an illness or injury. After 24 months, benefits continue if you cannot perform any gainful occupation for which you would be reasonably fitted.

RETIREMENT PLAN

As a not-for-profit organization, we are able to offer you participation in the Teachers Insurance and Annuity Association—College Retirement Equities Fund (TIAA-CREF) as our retirement plan. Unless you are classified as "part-time", i.e., scheduled to work less than 30 hours per week or are in a J-1 or F-1 visa status, The Danforth Center will contribute 3% of your compensation to the Plan regardless of whether you make pre-tax deferral contributions.

Employee Contribution	The Center Contribution
0%	3%
1%	2%
2%	3%
3%	4%
4%	5%

There is a three year vesting period attached to the portion contributed by The Center. If you choose to participate by contributing more than 4% of your annual salary, you may do so, however, 8% is the maximum contributed by The Center.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

We all experience times when we need a little help managing our personal lives. Your employer understands this and is providing the Employee Assistance Program (EAP) to covered employees in connection with your group insurance from The Standard, to offer support, guidance and resources to help you and your family find the right balance between your work and home life:

- Child care and elder care
- Alcohol and drug abuse
- Life improvement
- Grief and loss
- Difficulties in relationships
- Stress and anxiety with work or family
- Depression
- Identity theft and fraud
- Goal-setting
- Emotional well-being
- Financial and legal concerns
- Online will preparation

The above is just a small listing of the services offered. For more details visit their website at www.eapbda.com. This program is offered at **no cost** to you and your family members. Your program is here to support you through life's challenges and life's opportunities. Your communications with the EAP are always confidential.

Experienced master's-degreed clinicians will confidentially consult with you over the telephone and direct you to the solutions and resources you need. You may also receive referrals to support groups, community resources, a network counselor or your health plan. These services are available for covered employees, their dependents, including children to age 26, and all household members.

This plan offers 6 face-to-face visits.	**Available 24 hours a day, 365 days a year. Call their toll free number at 888.293.6948**	**www.eapbda.com Login ID: standard Password: eap4u**

CRITICAL ILLNESS AND ACCIDENT PROTECTION

Through Unum Insurance, employees may purchase critical accident coverage, which helps meet out of pocket expenses and extra bills associated with an accidental injury and is guaranteed issue with no health questions required during open enrollment. In addition, employees may also purchase critical illness protection, which helps offset effects of a catastrophic illness with a lump sum benefit if an insured is diagnosed with a covered critical illness, including cancer. This benefit may also be extended to spouses and dependents.

LIFETIME BENEFIT TERM LIFE INSURANCE WITH LONG TERM CARE (LTC) PROTECTION

Through Combined Insurance, employees may purchase permanent life insurance with premiums that are guaranteed to never increase. This plan also includes a provision for Long Term Care (LTC) insurance at 4% of your death benefit each month for up to 25 months, after a 90 day waiting period, and may be extended for an additional 50 months, after 100% of the base death benefit has been used for long term care, resulting in over 6 years of LTC coverage. During open enrollment only, current policy holders may increase their coverage without answering any health questions.

FLEXIBLE SPENDING ACCOUNT (FSA)

A Flexible Spending Account allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings. Open enrollment allows you the opportunity to enroll in and/or increase your election amounts for your Flexible Spending Account. Therefore, now is the time to gauge how much you utilize your benefits and how much money you spend in deductibles and copayments each year so that you can properly enroll in the FSA.

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

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

Carry Over Provision (**$500 Maximum**) - If you allocate money to a certain benefit during the plan year (1/1-12/31), you must use all the money for that benefit during the plan year (example; expenses have to be incurred but not necessarily paid for), with the exception of $500 under the Health Reimbursement Account.

What does this mean for you?

- **Up to $500 of your current plan funds can be carried over**
- **Greater flexibility and less guessing future expenses**

- **Does not change the maximum you can elect in a plan year**
- **A $500 election in a health FSA can be made without risk of losing funds at the end of the year**
- **No more rushing to spend down your unused funds at the end of the year**

You have 90 days past the plan year to turn expenses in for reimbursement. Any excess amount remaining for a particular benefit at plan year-end will be retained by the plan with the exception of $500. This program is administered by UnitedHealthcare. You must enroll/re-enroll in the plan to participate for the plan year January 1, 2016 – December 31, 2016.

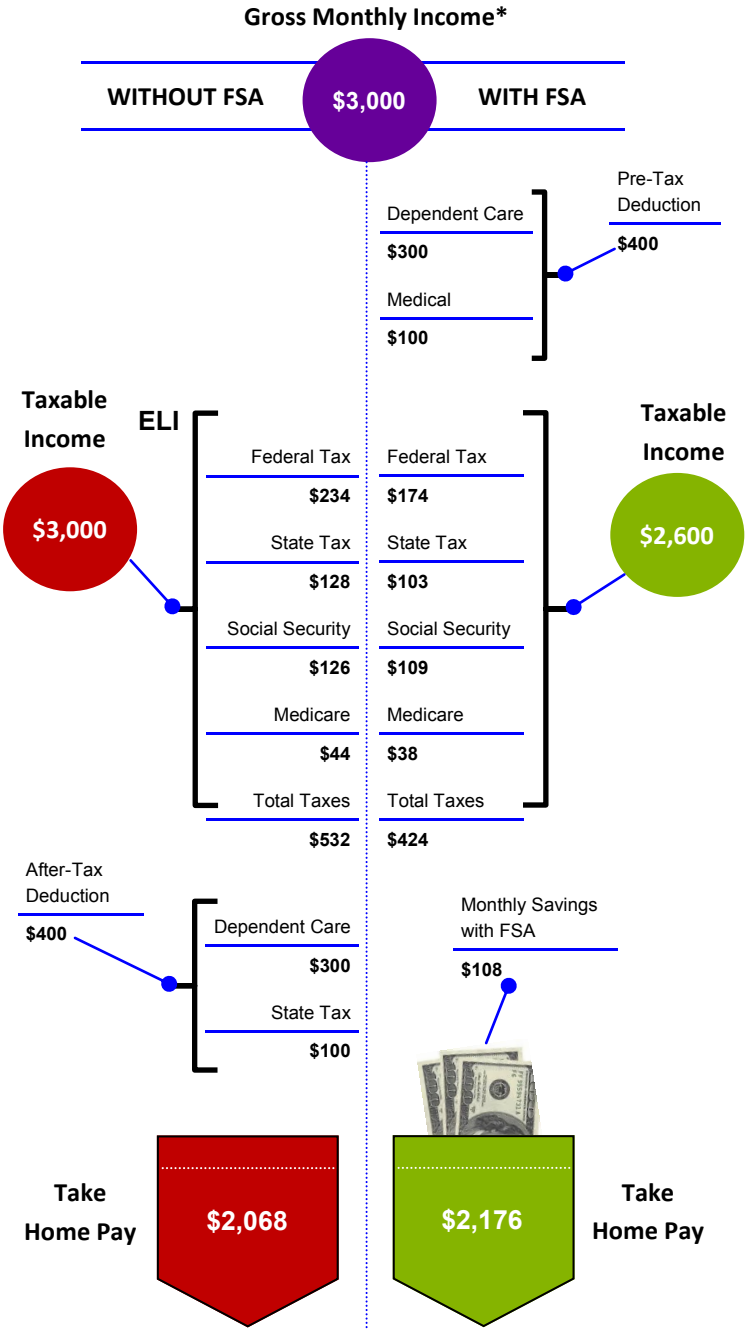
How the Medical Reimbursement FSA Works:

- Estimate health care expenses that are not covered by your health plan at all or a portion you have to pay when using your benefits (i.e. Co-pays, deductibles, coinsurance).
- Decide the amount you will spend and enroll in the Plan.
- The annual amount you select is available for reimbursement for qualified expenses.
- Use your debit card to pay for qualified expenses or send a reimbursement form and your receipts or statements to United Healthcare. In case of a paper claim a reimbursement check will be sent to you for the qualified expenses.
- The annual amount you elect will be spread out and deducted from your semi-monthly paycheck on a pre tax basis.

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

Donald Danforth Plan Science Center

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.

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

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

Submit completed form by December 11, 2015 to:

Vicky Wertich, Human Resources
975 N. Warson Road
St. Louis, MO 63132

The Donald Danforth Plant Science Center

SPOUSE/DOMESTIC PARTNER PREMIUM SURCHARGE

_____ _____
Employee Name (please print) **Department**

Effective January 1, 2016, the Danforth Center will add a **$50 monthly premium surcharge** to the Plan premiums for employees who elect to cover a spouse or domestic partner employed full-time outside of the Danforth Center who is eligible for health insurance through his or her own employer's plan. The premium surcharge will be in addition to the applicable Danforth Center health premium. Please complete the information on this affidavit relating to your spouse's/ domestic partner's employment outside of the Danforth Center.

Spouse/Domestic Partner Premium Surcharge	Yes	No
Is your Spouse or Domestic Partner employed outside of the Danforth Center on a full-time basis?	☐	☐
If yes, does your Spouse or Domestic Partner have health insurance available through his or her own employer?	☐	☐
Do you want to cover your Spouse or Domestic Partner under the Center's health plan?	☐	☐

I certify and warrant to the Danforth Center that all information on this spousal/domestic partner verification affidavit is true, correct and current as of the date signed. I agree to provide supporting documentation upon the request of the Danforth Center. I understand if I knowingly submit false information, my coverage may be terminated and I may be subject to disciplinary action up to and including termination of employment.

If indicated above, please remove my spouse/domestic partner from any health plan I am enrolled in for 2016.

_____ _____
Employee Signature ***Date***

UnitedHealthcare®
A UnitedHealth Group Company

FSA Enrollment Form

Please read all materials before completing this form.

Name _____
(PLEASE PRINT - LAST, FIRST, MIDDLE INITIAL)

Address _____
NUMBER STREET CITY STATE ZIP CODE

Social Security Number ___ – ___ – _____

Work Location _____

Health Care and Dependent Care Contributions

I elect to participate in the Flexible Spending Account plan for the upcoming plan period. I understand that I can contribute to my Health Care Account and to my Dependent Care Account each plan year (refer to your benefit book for minimum and maximum contribution amounts). I want the following **annual** amounts to be taken from my salary:

$ _____.00 Health Care Contribution
$ _____.00 Dependent Care Contribution
$ _____.00 TOTAL SALARY REDUCTION

Health Care — Automatic Reimbursement Authorization

☐ I authorize United HealthCare to make Automatic Reimbursement payments from my Health Care FSA for expenses submitted to, but not payable by, my medical plan. I certify that expenses to be automatically reimbursed through my FSA will be incurred by me (and/or my spouse and/or my eligible dependents) and will not be reimbursed by another plan. I (or we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) individual income tax return.

IMPORTANT: If you will have any expenses submitted to United HealthCare that may be payable by another carrier, you should not elect Automatic Reimbursement.

☐ I do not want Automatic Reimbursement.

Your Approval

I have read all the enrollment materials explaining this benefit. I understand that my contributions to each account can only be used to reimburse eligible expenses under each account and that I forfeit any funds remaining in my account at the end of the plan period.

I further understand that I cannot change my contributions unless I have a qualified family status change and that my salary reduction contributions will continue for the remainder of the plan period unless a qualified change is made. My Social Security benefits may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll reductions as contributions to my health and/or dependent care accounts as indicated above.

Signature _____ **Date** _____

ENROLLMENT WORKSHEET

Medical and Dental	Base	Base with Spousal Surcharge	Enhanced	Enhanced with Spousal Surcharge	QHDHP	QHDHP with Spousal Surcharge	My Per Pay Cost
Employee	$27.00	$27.00	$54.00	$54.00	$22.00	$22.00	
Employee & Spouse	$80.00	$105.00	$136.00	$161.00	$54.00	$79.00	
Employee & Child(ren)	$74.00	$74.00	$126.00	$126.00	$50.00	$50.00	
Family	$132.00	$157.00	$207.00	$232.00	$96.00	$121.00	
Vision							**My Per Pay Cost**
Employee	$2.70						
Employee & Spouse	$4.97						
Employee & Child(ren)	$5.21						
Family	$7.80						

Flexible Spending Account/Health Savings Account				My Monthly Cost
Medical Spending Account				
Limited Medical Spending Account				
Dependent Care Spending Account				
Health Savings Account				

Voluntary Life	My Monthly Cost
Employee	
$_____ ÷ 1,000 X $_____ = $_____	
Amount of Coverage / Unit Cost from Rate Table / Employee Monthly Cost	
Spouse	
$_____ ÷ 1,000 X $_____ = $_____	
Amount of Coverage / Unit Cost from Rate Table / Spouse Monthly Cost	

Voluntary Life	My Monthly Cost
Child(ren)	
$_____ ÷ 1,000 X $_____ = $_____	
Amount of Coverage / Unit Cost from Rate Table / Child(ren) Monthly Cost	

ENROLLMENT WORKSHEET

DEPENDENT PARTICIPATION DETAIL

Legal Name	SS#	Relationship	Gender	DOB	Medical Yes or No	Dental Yes or No	Vision Yes or No

BENEFICIARY INFORMATION

Basic Life Primary Beneficiary - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Basic Life Contingent Beneficiary - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Voluntary Life Primary Beneficiary - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Voluntary Life Contingent Beneficiary - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%

IMPORTANT NOTICES

SPECIAL ENROLLMENT NOTICE

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

NOTICE OF MATERIAL CHANGE (also Material Reduction in benefits)

The Donald Danforth Plant Science Center has amended The Donald Danforth Plant Science Center 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 Human Resources.

NOTICE OF PRIVACY PRACTICES

The Donald Danforth Plant Science Center 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 Human Resources.

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 Donald Danforth Plant Science Center.

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 in November 1st through January 31st.

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

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

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

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

More Information

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

MEDICAID CHIP NOTICE

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

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

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

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

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

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

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

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

1-866-444-3272
Menu Option 4, Ext 61565

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.hhs.gov

1-877-267-2323

MEDICARE PART D CREDITABLE COVERAGE.

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

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

United Healthcare has determined that the prescription drug coverage offered by Donald Danforth Plant Science Center 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 not be able to get this coverage back until open enrollment or you experience a qualifying event.

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

A notice will be provided to you prior to the October 15 Medicare open enrollment period. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)
TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at www.socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

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

GLOSSARY OF TERMS

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

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

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

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

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