The DESCO Group

2017 Employee Benefits Guide

CONTACT INFORMATION

MEDICAL, DENTAL & VISION Cigna	**Member Services:** **1.800.244.6224** **www.cigna.com**
COMPASS HEALTH COMPASS PROFESSIONAL HEALTH SERVICES	**Customer Service** **answers@compassphs.com** **www.compassphs.com** **1-800-513-1667**
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The DESCO Group	**Lynn Raga** **314-994-4075** **lraga@descogroup.com**

ELIGIBILITY

WHO CAN YOU ADD TO YOUR PLAN:

Medical, Dental, Vision & Life: Active Employees working 30+ hours per week, their spouse and dependents under the age of 26.

FREQUENTLY ASKED QUESTIONS

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

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

EXAMPLES OF QUALIFYING EVENTS?

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

CIGNA - Consumer Directed Health Plan with Health Savings Account

Benefit/Service	In-Network	Out-of- Network
Deductible Individual Family	 $2,600 $5,200	 $7,500 $15,000
Coinsurance	100%	70%
Out-of-Pocket Max - Individual - Family	 $6,250 $12,500	 $12,500 $25,000
Inpatient Hospital	100% After Deductible	70% After Deductible
Outpatient Hospital	100% After Deductible	70% After Deductible
Office Visit Copay: PCP/Specialist	After Deductible: $35/$70Co-Pay	70% After Deductible
Preventive Care	100%	70% After Deductible
Urgent Care	After Deductible: $100 Co-Pay	70% After Deductible
Emergency Room	After Deductible: $300 Co-Pay	In Network Deductible then $300 Co-Pay
Prescription Tier One Tier Two Tier Three Mail Order	<u>At Participating Pharmacies</u> AFTER DEDUCTIBLE: $10 Co-Pay $35 Co-Pay $60 Co-Pay $25/$87.50/$150 Co-Pay	

TDG will contribute $1,410 for Employee coverage and $2,820 for Employee plus dependents to the employee's HSA for the 2017 plan year.

COST PER PAY PERIOD

Employee Only	$31.04
Employee & Spouse	$65.17
Employee & Children	$60.52
Employee & Family	$94.66

The DESCO Group will continue to utilize Optum Bank for the Health Savings Account.

HEALTH SAVINGS ACCOUNT (HSA)

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

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

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

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

The HSA is established in your name. It is your bank account and can be taken with you if you change employers. Any money deposited into the account is your money. HSA accounts do <u>not</u> 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 Consumer Directed Health Plan. You can use HSA funds to pay for qualified expenses of your spouse and tax eligible dependents.

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

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

Facts about the HSA:

What is an HSA?

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

Why would I want an HSA?

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

What rules must I follow?

- You must be covered under a *Consumer Directed Health Plan (CDHP)* in order to establish an HSA.
- You cannot establish an HSA if you also have a medical *flexible* spending account (FSA).
- **You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a consumer directed 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 Consumer Directed Health Plan and a traditional PPO Plan?

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

What else do I need to know?

- Contributions are based on a calendar year. For 2017, contribution limits are $3,400 for Single and $6,750 for Family coverage. You cannot put more than this amount in the account; you can put less. Individuals who are age 55 or older can also contribute an additional $1,000 in catch up contributions per year. **Keep in mind when calculating your own contributions, you will need to factor in the amount that TDG contributes ($1,410 Individual/$2,820 Family).**
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services (medical, dental, vision and over-the-counter medically necessary items).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and is subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled, or upon account holder's death, the account can be used for other purposes without paying the 20% penalty.
- The savings account can be established with a variety of banking institutions, so you can take advantage of payroll deductions on a pre-tax basis.

Please note: the deductible applies to all services with the exception of wellness.

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

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

Please Note: if you elect to enroll in the CDHP 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.

FLEXIBLE SPENDING ACCOUNT (FSA)

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

Medical Flexible Spending 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. **If you contribute to a Health Savings Account and wish to enroll in the Flexible Spending Account, you must enroll in the "Limited" FSA as indicated below.**

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

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

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

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

ELIGIBLE EXPENSES

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

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

Three Convenient Ways to Manage Your Health Care

1. Create and account at www.myCigna.com. Features such as printing an ID card, managing claims, searching for providers and viewing benefits make healthcare a much better experience.
2. Get the full Cigna experience on the go - by using your tablet computer. Check your claims and benefits, use your health and wellness tools, get discounts on contact lenses and glasses. Coupons for health foods and much more.
3. Download Cigna's free app - just search for "myCigna" at the app store on your mobile device (Available for Apple & Android). Find doctors and urgent care centers, and get driving directions from wherever you are. You can also log in and view, email or fax an electronic version of your ID card.

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

Your Care Options & 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, 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.

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

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

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

To find an in-network Convenience Care Center near you, visit www.myCigna.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.

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.uhc.com.

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.

LAB SERVICES

If you require lab work consider having these services performed at Quest or LabCorp . When coded as preventive, the cost will be covered 100%.

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.

EMERGENCY ROOM

Some examples of emergency conditions may include the following:

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

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

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

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

Dental Insurance to Enhance your Smile....

Benefits	PPO	Out-of-Network
Deductible Individual Family	 $50 $150	 $50 $150
Coinsurance Diagnostic/Preventive (No Deductible) Basic Services Major Services	 100% 90% 60%	 100% 80% 50%
Endodontic (Root Canal) & Periodontic Services	90%	80%
Annual Maximum	$1,000 per person	
Child Orthodontic Benefit Lifetime Maximum	50% $1000	

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Bi-Weekly Employee Contribution

Employee	$10.88
Employee/Spouse	$22.01
Employee/Child(ren)	$25.20
Employee/Family	$35.92

See Clearly with Vision Insurance.....

Benefit/Service	In-Network	Out-of-Network
Exam Co-Pay	$10 Co-Pay	Up to $45
Frequency of Service: Exam Lenses Frames	 Every 12 months Every 12 months Every 24 months	
Lenses: Single Bifocal Trifocal Lenticular	$25 Co-Pay then: 100% 100% 100% 100%	 Up to $32 Up to $55 Up to $65 Up to $80
Frames	$25 Co-Pay, then: $130 Retail Allowance	Up to $45
Contacts: Necessary Cosmetic:	 Covered 100% $110 Retail Allowance	 Up to $210 Up to $98

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Voluntary Vision
Bi-Weekly Employee Contribution

Employee Only	$2.64
Employee/Spouse	$5.16
Employee/Child(ren)	$5.43
Employee/Family	$7.54

The DESCO Group provided Basic Life Insurance and AD&D

Effective January 1, 2017, the amount of your basic life insurance and AD&D will be equal to your annual salary rounded up to the next thousand up to a maximum of $250,000. Your DESCO provided life insurance will continue to increase as you receive merit increases or promotional increases.

There is NO action needed on your part to enroll in the basic life and AD&D.

Voluntary Supplemental Life Insurance

Beginning January 1, 2017, Associates are able to enroll in Voluntary Supplemental Life Insurance up to four times your ANNUAL salary.

Open enrollment will be the one time of year that you can enroll in the supplemental voluntary life insurance. You can enroll in up to two times your annual salary as guaranteed issue (no medical questions) up to a maximum of $240,000, and may request up to an additional three or four times your salary in life insurance up to a maximum of $480,000 by completing the Evidence of Insurability process.

Please note the amounts you choose during open enrollment will replace your current elections, which will expire on January 1, 2017.

Voluntary Supplemental Life Insurance (cont.)

The rates for supplemental life are as follows:

Cigna Supplemental Life Rates (Effective 1-1-17)	
Age	**Employee Rate per $1,000**
<20-24	$0.080
25-29	$0.080
30-34	$0.080
35-39	$0.110
40-44	$0.150
45-49	$0.260
50-54	$0.430
55-59	$0.640
60-64	$1.030
65-69	$1.800
70-99	$1.800

Spouse/Dependent Life Insurance

Associates currently have four options for spouse/dependent life insurance. No medical underwriting is needed to enroll in any of the spouse/dependent life plans. The four plans and their rates are enclosed below. During open enrollment associates will be permitted to enroll or make modifications to this benefit.

Option	Amount of Spouse/Children Coverage	Cost per Bi-Weekly Pay Period
Option 1	$5,000 spouse / $2,500 children	.94 per pay
Option 2	$10,000 spouse / $5,000 children	1.81 per pay
Option 3	$15,000 spouse / $7,500 children	2.81 per pay
Option 4	$20,000 spouse / $10,000 children	3.68 per pay

COMPASS
Healthcare Redefined.

HEALTHCARE STARTS WITH COMPASS.

YOUR LIFE JUST GOT SIMPLER.

Navigating healthcare these days seems impossible—unless you have Compass on your side. From finding doctors to getting cost estimates to solving billing problems, we're here to help. Your employer has partnered with us to serve as your personal healthcare advisor. So rely on your Compass Health Pro® consultant to make you an empowered healthcare consumer who takes control of healthcare costs. Our service is simple to use and available to you and your family.

UNDERSTAND INSURANCE BENEFITS

Receive guidance in understanding your benefits throughout the year.

PAY LESS FOR PRESCRIPTIONS

Let Compass compare medication prices and explore lower-cost options for you.

FIND A GREAT DOCTOR

Find highly rated doctors, dentists and eye care professionals in your area who meet your personal preferences and healthcare needs.

GET HELP WITH MEDICAL BILLS

Have your medical bills reviewed to make sure you are not overcharged.

SAVE MONEY ON MEDICAL CARE

Get price comparisons before receiving care. Depending on the doctor, hospital or facility, costs can vary by hundreds or thousands of dollars—even in-network.

answers@compassphs.com

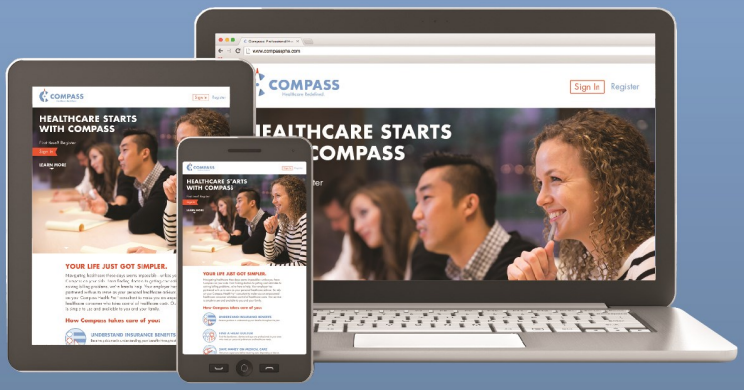
800.513.1667

Why should I contact my Health Pro?

1. Struggling to understand your medical and benefits plan? Let Compass help you understand how your plan actually works.
2. Moved recently or looking for a new provider? We'll find great doctors, dentists and eye care professionals for you and your family.
3. Need an annual physical? We'll locate the right doctor and set up your appointment.
4. Upcoming medical procedure? We'll estimate your out-of-pocket costs to ensure you pay a fair price.
5. Tired of overpaying for brand-name prescriptions? Let Compass research the most cost-effective options for the prescriptions you're taking.
6. Wondering if a medical bill is correct? We'll make sure you're not overbilled.

Your experience starts right now.

Your first step to simpler, smarter healthcare is to Get Connected. Complete your online profile at **member.compassphs.com.**



COMPASS
Healthcare Redefined.

Compass is your champion for simpler, smarter healthcare. It's what we mean when we say, "Healthcare Redefined."

These days, it's almost impossible to make sense of medical treatment options and costs. One hospital might charge $1,500 for an MRI, while another charges $500—in the same city. Challenges and inconsistencies exist throughout the system. That's why people turn to us.

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 Lynn Raga at 314-994-4075.

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

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 Lynn Raga.

NOTICE OF PRIVACY PRACTICES

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

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 The Desco Group.

What is the Health Insurance Marketplace?

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

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

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

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

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

More Information

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

MEDICAID CHIP NOTICE

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

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

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

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

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

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

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

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

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

MEDICARE PART D CREDITABLE COVERAGE.

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

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

Cigna has determined that the prescription drug coverage offered by *The Desco Group* 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 service are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services as required under the Affordable Care Act.

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

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

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

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

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

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

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

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

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

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