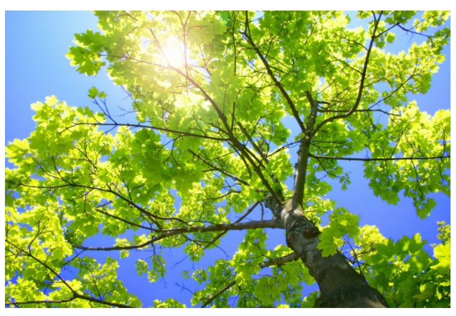
Benefit Plan Overview

Plan Year January 1, 2018 through December 31, 2018

Welcome!



AbsoluteCARE takes pride in offering a comprehensive and competitive benefits package to full-time employees. AbsoluteCARE, through all of its benefit partners, offers you a benefit program that allows choice and flexibility. Employees are eligible for all health benefits, beginning on the first of the month following one month of full time employment.

It is important that you take the time to review all of the plan options available to you. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet you and your family's needs throughout the year.

Options selected upon hire remain in place through the end of the plan year (Dec 31st). New employees have thirty (30) days from their date of hire to select benefits. Employees who do not elect benefits within thirty (30) days may do so during the next available annual open enrollment period. Options selected during annual open enrollment remain in place for the full plan year.

The Internal Revenue Service *(IRS)* states that eligible employees may only make elections to the plan once a year at open enrollment. Historically, AbsoluteCARE has held Open Enrollment in the month of November, for a January 1st effective date. This means that all benefit choices are binding through December 31st of each year. The following circumstances are some examples of reasons you may change your benefits during the year (please see HR for a complete list):

Marriage	Death of a Spouse
Divorce	Death of a Dependent
Birth & Adoption	Loss of Dependent Status
Loss of Spouse's job where coverage is maintained through a spouse's plan	

These special circumstances, often referred to as qualified events, or life status changes, will allow you to make plan changes at any time during the year in which they occur. For any allowable changes, you must inform the Human Resources Department within 30 days of the event to avoid lapse in coverage. All other changes are deferred to open enrollment.

Medical Benefits

The AbsoluteCARE medical options are designed to provide you and your family with access to quality and affordable healthcare, nation-wide. Three plans are available through UnitedHealthcare to provide the employees of AbsoluteCARE more flexibility and savings in their medical coverage options.

All plans are open access, so no referral is required for specialty care. The medical options cover a broad range of healthcare services and supplies, including prescriptions, office visits and hospitalizations. The plans differ when it comes to how they share costs with you. Please refer to the summary on page 2 for specific details concerning plan design. You may also find more information by visiting www.umr.com.

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Medical/Rx Benefits Description

Medical Plan Design	UMR Choice Plus HMO HSA $1,500		UMR Choice Plus PPO HSA $1,500		UMR Choice Plus $5,000 Gap Plan Option	
Deductible:	In Network Only		In Network	Out of Network	In Network	Out of Network
- Single	$1,500		$1,500	$4,000	$5,000	$7,500
- Family	$3,000		$3,000	$8,000	$10,000	$15,000
Out of Pocket Maximum:						
- Single	$3,000		$3,000	$6,000	$6,250	$15,000
- Family	$6,000		$6,000	$12,000	$12,500	$30,000
Coinsurance:	100%		90%	70%	100%	80%
Office Visits:						
- Preventive Care	Covered in full		Covered in full	Ded, then 30%	Covered in full	Ded, then 20%
- Primary Care Physician	Ded, then covered in full		Ded, then 10%	Ded, then 30%	Ded, then covered in full	Ded, then 20%
- Specialist	Ded, then covered in full		Ded, then 10%	Ded, then 30%	Ded, then covered in full	Ded, then 20%
- Lab and x-rays	Ded, then covered in full		Ded, then 10%	Ded, then 30%	Ded, then covered in full	Ded, then 20%
Hospitalization:						
- Inpatient	Ded, then covered in full		Ded, then 10%	Ded, then 30%	Ded, then covered in full	Ded, then 20%
- Outpatient	Ded, then covered in full		Ded, then 10%	Ded, then 30%	Ded, then covered in full	Ded, then 20%
- Emergency Room (waived if admitted)	Ded, then covered in full		Ded, then 10%	Ded, then 10%	Ded, then covered in full	Ded, then 20%
Prescription Drugs:	OPTUM	AbsoluteCare	OPTUM	AbsoluteCare	OPTUM	AbsoluteCare
- Generic	$10 copay	$0 copay	$10 copay	$0 copay	$10 copay	$0 copay
- Brand	$35 copay	$17.50 copay	$35 copay	$17.50 copay	$35 copay	$17.50 copay
- Brand Non-Formulary	$60 copay	$30 copay	$60 copay	$30 copay	$60 copay	$30 copay
* Speciality	$100 copay	$50 copay	$100 copay	$50 copay	$100 copay	$50 copay
- Mail Order	2.5x retail	2 x AbsoluteCare	2.5x retail	2 x AbsoluteCare	2.5x retail	2 x AbsouluteCare
Employee Per Pay Contribution	UMR Choice Plus HMO HSA $1,500		UMR Choice Plus PPO HSA $1,500		UMR Choice Plus $5,000 Gap Plan Option	
	Discount	Smokers	Discount	Smokers	Discount	Smokers
- Employee	$50.00	$75.00	$25.00	$50.00	$0.00	$25.00
- Employee/Spouse	$230.00	$155.00	$320.00	$345.00	$175.00	$200.00
- Employee/Child (ren)	$175.00	$200.00	$265.00	$290.00	$130.00	$155.00
- Family	$425.00	$450.00	$565.00	$590.00	$350.00	$375.00
HSA	Yes		Yes		No	
FSA	Limited FSA Plan Only		Limited FSA Plan Only		Yes	
GAP	No		No		Yes	

AbsoluteCare Pharmacy

Discounted Copays when you purchase your prescriptions at AbsoluteCare Pharmacies (1/2 of the OPTUM rx copays)

Locations in Atlanta & Baltimore (Greenbelt members may use Baltimore pharmacy via mail service)

Employee Contributions

Plans	2017 Non-Smoking Discount 24 Pays	2017 No Discount 24 Pays	2018 Non-Smoking Discount 24 Pays	2018 No Discount 24 Pays
HMO/HSA 1500				
Employee	$ -	$ 25.00	$ 50.00	$ 75.00
Employee/Spouse	$ 230.00	$ 255.00	$ 230.00	$ 255.00
Employee/Child(ren)	$ 175.00	$ 200.00	$ 175.00	$ 200.00
Family	$ 425.00	$ 450.00	$ 425.00	$ 450.00
PPO/HSA 1500				
Employee	$ -	$ 25.00	$ 25.00	$ 50.00
Employee/Spouse	$ 320.00	$ 345.00	$ 320.00	$ 345.00
Employee/Child(ren)	$ 265.00	$ 290.00	$ 265.00	$ 290.00
Family	$ 565.00	$ 590.00	$ 565.00	$ 590.00
PPO 5000 Gap Plan Option				
Employee	$ -	$ 25.00	$ -	$ 25.00
Employee/Spouse	$ 175.00	$ 200.00	$ 175.00	$ 200.00
Employee/Child(ren)	$ 130.00	$ 155.00	$ 130.00	$ 155.00
Family	$ 350.00	$ 375.00	$ 350.00	$ 375.00

Tobacco Free Discounts on Medical Premiums

AbsoluteCARE remains committed to providing a safe and healthy workplace that includes initiatives aimed at reducing tobacco use among our Associates and their families. Employees enrolled in a UMR medical plan will receive a lower rate on medical premiums if they are tobacco free.

This is a voluntary program. If you choose not to certify your tobacco-use status, you are still eligible to participate in the health plan.

Please follow these instructions carefully to qualify for the Tobacco Free Discount:

1. ***Update Tobacco use status accordingly in My Self tab->Personal Information section of Ascentis Self-Service.***
2. ***If you are not a tobacco user, be sure to choose Agree on the Tobacco Attestation screen during your benefits enrollment. If you waive this, you will be defaulted to the non-discounted rate.***

- ***Tobacco users who would like to participate in this program, please see HR for smoking cessation program information.***

We are committed to helping you achieve your best health. If you think you might be unable to complete the qualified smoking cessation program, you might qualify for an opportunity to avoid the surcharge by different means. Contact Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program that is right for you in light of your health status.

Find A UHC Choice Plus Provider

To Find a UHC Choice Plus PPO Provider

Your new preferred provider network will be United HealthCare's (UHC) Choice Plus .

To find a participating provider, please follow the steps below:

WWW.UMR.com

1. Click on "find a provider"
2. Click on "medical"
3. Click on "United Healthcare Choice Plus PPO network"
4. Click "access the UHC Provider Search Application"

This will lead you to the United Healthcare website in which you can choose to search by physician, hospital or other facilities. Or you can call UMR's customer service at ***1-800-826-9781***

Type of care	Wait time	Cost**
NurseLine 1-877-950-5083 Talk to a nurse, 24/7, about common illnesses and types of care.	36 seconds for call to be answered	None
Teladoc 1-800-835-2362 Consults by phone or online video for routine ailments.	17 minutes for doctor to respond	$45 per consultation
Retail clinic/convenient care clinic Clinics located in retail stores, supermarkets and pharmacies.	15 minutes or less	$89 per service
Urgent care/ walk-in clinic Evening and weekend treatment for illnesses or injuries.	20 to 30 minutes	$156 visit cost
Clinical care (your doctor's office) See your primary care provider for preventive and ongoing care.	1 week or longer for an appointment	$166 visit cost
Emergency room (ER) Visit the ER only for serious illnesses or injuries. Your health plan may not cover non-emergency ER visits.	3 to 12 hours for non-critical cases	$570 visit cost

Health Savings Account (HSA)

When you enroll in the UnitedHealthcare Qualified High Deductible HSA medical plan, you are eligible to utilize a Health Savings Account (HSA). AbsoluteCARE has partnered with HSA Bank as the HSA administrator.

What is an HSA? An HSA is a type of savings account that allows you to save for qualified health care expenses on a tax-free basis, and contributions can be taken directly from your paycheck and deposited into your HSA. The savings in your HSA are immediately available to you to pay for qualified medical, dental, and vision expenses (e.g. deductible expenses, coinsurance, and/or non-covered qualified expenses.) You may also choose to contribute to an HSA and save the funds for medical expenses in the future. **Any money you put into this account always belongs to you.**

How much can I deposit into my HSA? For 2018, the annual limitation on deductions for an individual with self-only coverage is $3,450 and $6,900 for family coverage. The IRS has approved an additional catch-up contribution of $1,000 for people aged 55 to 65. Contributions can be made through payroll deductions or electronic transfers (ACH) and may be changed throughout the year by contacting Human Resources.

What are "Qualified Expenses"?

A general list of eligible expenses is below. Please go to www.irs.gov for a complete list. The IRS recommends that you save all receipts in the case of an audit so you can explain why you believed an expense was qualified.

- Medical deductible and co-pays, in-patient and outpatient hospital
- Physical Therapy and Alternative medicine, ex. Chiropractic and acupuncture
- Dental care - excluding cosmetic procedures
- Eye and Hearing care, including contact lenses, lens solution, eye glasses, and hearing aids
- Prescription drugs only if purchased in US; Over-the-counter (OTC) drugs, only if purchased with a prescription
- Insulin and blood sugar testing kits, Crutches, diagnostic devices such as blood pressure monitoring devices, and supplies like bandages
- A percentage of long-term care insurance costs

How Do I Use My Account? There are two ways to pay for healthcare. **Remember to save your itemized receipts in case they are requested during tax time.**

1. **Use Your HSABank Healthcare Payment Card:** This is the simplest way to purchase healthcare! Pay using your HSA Bank healthcare payment card. Then, log on to your online account regularly to check your balance.
2. **Pay Out of Pocket and Request Reimbursement:** Pay using your own credit card, cash, or check. Then, log on to your HSABank online account to file for reimbursement. **TIP: Set up direct deposit online to receive quicker reimbursements.**

How to Pay At…The Doctor, Dentist, Eye Doctor, or Hospital. When you pay for healthcare at the doctor, dentist, eye doctor, or hospital, be sure to always present your health insurance ID card first to ensure proper processing of your charges.

- **Copays.** If you are asked to pay a copay, you may pay with your HSABank payment card, or you may pay out of pocket and request reimbursement online.
- **Additional Charges.** If you're asked to pay additional charges, (including any amount toward your deductible,) do not pay your provider until the claim is processed by your health plan and you receive your Explanation of Benefits (EOB) in the mail. Compare your EOB with the provider bill to verify the amount being charged by your provider is the same as the patient balance on the EOB. You may then pay using your card, or pay out of pocket and request reimbursement online.
- **The Pharmacy.** When purchasing prescriptions, always present your health insurance ID card to the pharmacy to make sure you receive your health plan discount. You may also purchase eligible over-the-counter items at the pharmacy and pay with your HSABank payment card. Or, you may pay out of pocket and request reimbursement online.

Questions? Contact HSABank at 1-800-357-6246

SISLink Group Hospital Confinement Insurance

Employees enrolled in the Choice Plus $5,000 PPO will have the SISLINK Gap Plan included with no additional cost. This plan is used to help pay for out-of-pocket expenses incurred due to a covered Hospital Confinement or covered Out-Patient medical procedures. Covered Expenses Include:

In-Hospital Confinement (The plan covers up to $2,500):

- In-patient hospital stays
- In-patient surgeries
- Physician's in-hospital charges

Out-Patient (The plan covers up to $2,500):

- Hospital emergency room treatment
- Out-patient surgery in an out-patient surgical facility, emergency facility or physician's office
- Diagnostic testing including, but not limited to, x-rays, diagnostic lab, MRI's and CT scans
- Benefits are limited to four (4) occurrences per family per calendar year

All eligible expenses must result from the medically necessary treatment of an Injury or an Illness.

How to file a claim:

Mail, email or fax a copy of your Explanation of Benefits (EOB) and copy of your itemized bill along with your claim form to:

SPECIAL INSURANCE SERVICES, INC.
PO BOX 250349
PLANO, TX 75025-0349

Questions? Contact Customer Service by calling 1-800-767-6811 or emailing customerservice@specialinc.com.

Flexible Spending Accounts (FSA)

AbsoluteCARE allows you to defer a portion of your pay though payroll deduction into flexible spending accounts. The money that goes into an FSA is deducted on a pre-tax basis, which means it is taken from your pay before federal and social security taxes are calculated. Because you do not pay income taxes on money that goes into your FSA, you decrease your taxable income.

It is important that you estimate carefully. If you do not use all of the money in your accounts by the end of the plan year, federal law requires you to forfeit any unused balances. You have up to 3-1/2 months after the plan year ends *(April 15th)* to submit qualified expenses for reimbursement incurred during the prior year.

The AbsoluteCARE FSA program features the *WageWorks Card* enabling you to pay eligible medical and dependent care expenses directly from your FSA, eliminating the need for you to pay out of your own personal funds.

Medical FSA: You may deposit up to **$2,650** per plan year into your medical FSA to cover you and your dependents during the plan year. Eligible expenses include, but are not limited to, deductibles, co-payments and co-insurance payments, routine physicals, uninsured dental expenses, vision care expenses and hearing expenses. You can carry over up to $500 from one plan year to the next - there's virtually no risk of losing your hard-earned money.

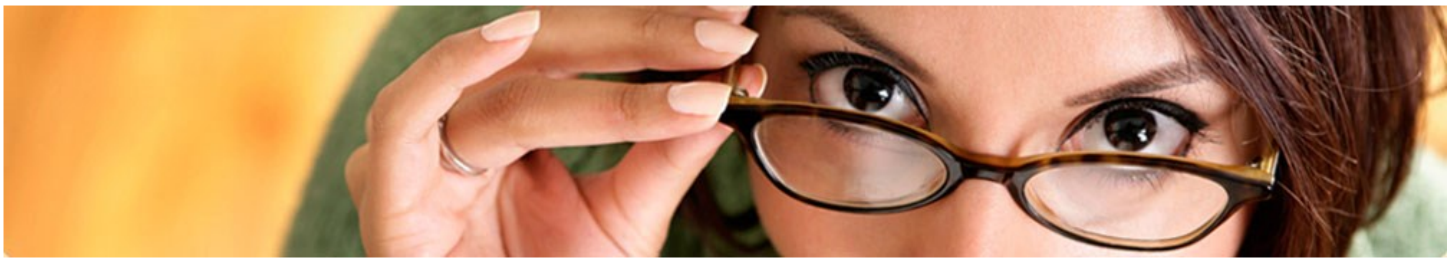
HSA-Compatible FSA (Limited FSA): If you're enrolled in a qualified high-deductible health plan (HDHP) and have an HSA, you can maximize your savings with an HSA-Compatible FSA. With this pre-tax benefit account, you can take advantage of the long-term savings power of an HSA and use a Limited FSA specifically for this year's eligible out-of-pocket dental and vision expenses. You can carry over up to $500 from one plan year to the next - there's virtually no risk of losing your hard-earned money.

Dependent Care FSA: You may deposit up to **$5,000** per plan year into dependent care FSA. Eligible expenses include payments to day care centers, preschool costs, before and after school care and elder care.

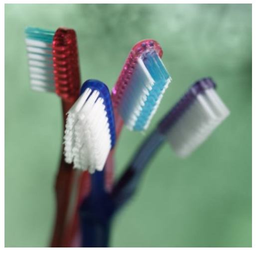
Vision Benefits

Eligible employees may sign up for vision coverage at no cost. Benefits include an examination, frames, spectacle lenses and/or contact lenses every 12 months. Participants have the option of receiving care from an in-network or out-of-network provider; however, the best way to save money through your vision plan is by seeing an Avesis Lab Provider. Please contact HR for a full listing of the Lab Providers available. To print your Avesis ID card, logon to www.Avesis.com.

Payroll Deductions (Semi-Monthly):	
Employee Only	$0.00
Employee & Spouse	$0.00
Employee & Children	$0.00



Dental Benefits



The Good dental health is important to your overall well being. AbsoluteCARE has partnered with Guardian to offer its employees access to a Dental PPO plan. The plan provides affordable coverage based on the type of services obtained - **preventive, basic or major** - and offers flexibility by including coverage for both in– and out-of-network providers. At the time of service you will share in a set percentage of cost after your deductible. If you utilize a network dentist, you will see greater cost-savings than if you were to go out-of-network. Please see the chart at right for a more detailed description of benefits.

Plan Design	Guardian	
	In-Network	Out-of-Network
Individual Deductible (waived for prev):	$50	
Family Deductible (waived for prev):	$150	
Dental Annual Maximum:	**$2,000**	
Out-of-Network Reimbursement:	Fee Schedule	
Coinsurance:		
- Preventive	100%	100%
- Basic	80%	80%
- Major	50%	50%
- Endo/Perio	80%	80%
Orthodontia:	50%	
- Lifetime Maximum	$1,000	

Coverage Level	Rate
• **Employee Only**	$0.00/pay
• **Employee + 1 Dependent**	$13.66/pay
• **Family**	$32.06/pay

Life and Accidental Death & Dismemberment

AbsoluteCARE provides all full-time employees Life Insurance benefits through Lincoln Financial Group, at no cost to you. The benefit is equal to 1 x annual salary to a maximum of $150,000. Your amount of Life Insurance reduces to 65% at age 65 and 60% at age 70. If death is a result of an accident, your Beneficiary will receive an additional benefit amount equal to your Life Insurance.

REMEMBER: It is important to keep your Beneficiary Designation information up to date. See Human Resources at any time to make a change or update information.

Disability Benefits

Your disability benefits provide you with a source of income in the event that you are not able to work due to an accident, illness or injury. AbsoluteCARE provides Short and Long Term Disability coverage to all eligible employees through Lincoln Financial Group, at no cost to you.

Short Term Disability:

Benefit is equal to 66.67% of weekly salary up to $1,000 per week. Benefits begin on the 8th day and are paid for up to 13 weeks.

Long Term Disability:

Benefit is equal to 60% of monthly salary up to $10,000 per month. Benefits begin on the 91st day of disability and continue for as long as you are disabled, to the later of Age 65 or Social Security Normal Retirement Age.

See Human Resources for additional information.

Work Life Balance Employee Assistance Program

With the work-life balance employee assistance program, help is available by phone, website, eMail and up to three face-to-face sessions per incident. Your manager, employees and their families can access:

- Master's -level consultants available 24 hours a day
- Services available even if a disability claim is never filed
- Dedicated Hispanic service center
- Interactive website
- Workplace communication tools available in both English and Spanish
- An extra level of service for employees who are on disability claim

Work-life Balance Employee Assistance Program

Toll-free, 24-hour access
- 1-800-854-1446: English
- 1-877-858-2147: Spanish
- 1-800-999-3004: TTY/TDD

Online access
www.lifebalance.net; *user ID and password:* lifebalance

This is not a medical insurance card.

Keep this card with you at all times. It gives you immediate access to a full range of confidential Work-life Balance services for you and your family. If you need additional cards, contact your workplace plan administrator.

unum.com

Worldwide Emergency Travel

- Whether your travel is for business or personal reasons, our worldwide emergency travel assistance program goes with you when you travel to a foreign country or just 100 miles or more from home
- If you, your spouse or your dependent children need immediate assistance anywhere in the world*

Services are available for simple to extreme travel emergencies:
- Hospital admissions guarantee
- Emergency medical evacuation
- Care if minor children
- Prescription assistance
- Transportation for a friend or family member to join the hospitalized patient.

* *Employees are covered for business or personal travel; spouses and dependent children are covered for personal travel only.*

Voluntary Supplemental Insurance

AbsoluteCARE has partnered with Unum to provide access to a variety of supplemental benefits, on a voluntary basis, for all eligible employees. With Unum Supplemental Insurance, you can select products that meet your individual needs and provide protection for what happens next.

Available insurance plans include:

- Voluntary Life/AD&D
- Accident
- Critical Illness
- Whole Life Insurance
- Short Term Disability
- Hospital Indemnity

Coverage is available for you, your spouse and children with most products. Benefits are paid directly to you, unless you specify otherwise. With most plans, you can continue coverage when you change jobs, with no increase in premiums. Also, with most plans you receive benefits regardless of any other insurance you may have with other insurance companies.

See Human Resources for additional information.

Identity Theft Restoration Service

If your identity is stolen, you may not know where to turn and what you should do to best protect yourself. The recovery process can be time-consuming and can prevent you from being able to focus on your daily responsibilities. Fortunately, Unum can provide support when you need it most.

- **Full-service fraud resolution:** Let professionals handle the stressful work for you.
- **Credit monitoring service:** Receive triple-bureau monitoring after an identity theft incident.
- **Credit restoration:** Get help regaining good standing with creditors.
- **Tax fraud support:** Rely on Enrolled Agents to work with the IRS on your behalf.
- **Financial counseling:** Receive expert guidance to help get back on your feet.
- **Free legal consultations and discounts on legal services:** Get legal advice in serious cases.

HealthAdvocate

The Many Ways Health Advocate Helps

Don't Know Where to Turn? We point the way.

- Find the right doctors, dentists, specialists and other providers
- Schedule appointments: arrange for special treatments and tests
- Locate the right treatment facilities or clinical trials
- Answer questions about test results, treatments and medications
- Research and locate newest treatments; arrange for second opinions
- Facilitate the transfer of medical records, X-rays and lab results

Confused by Health Insurance? We cut through the red tape.

- Explain coverage policies
- Get appropriate approvals for covered services
- Identify alternatives for non-covered services

Overwhelmed by Medical Bills? We go to bat for you.

- Uncover errors
- Get estimates; help negotiate fees for non-covered services
- Supply providers with required information to pay a claim
- Get to the bottom of coverage denials
- Advise about appeal rights

Need Eldercare Services? We ease your burden.

- Find in-home care, adult day care, assisted living or long-term care
- Clarify Medicare, Medicare Supplement plans and Medicaid
- Coordinate care among multiple providers
- Research transportation to appointments

We'll help you starting NOW

Just call (toll-free) 866.695.8622

Health Care Terminology

Annual Out of Pocket Limit (OOP) - once this amount is satisfied, the plan will pay 100% of covered services. Both medical and prescription drug costs covered by the plan accumulate toward the OOP

Balance Billing - when you obtain services from an out-of-network provider they are able to bill you for any remaining amount due (in addition applicable deductible and coinsurance) that is not paid by the insurance company. These charges typically do not apply toward the OOP

Copay - the amount you pay at the time of service for each office visit or trip to the pharmacy

Coinsurance - After you satisfy any applicable deductible, you share the cost of coverage (coinsurance) with the insurance company, until you reach your OOP

Deductible - the amount of out-of-pocket expenses that you must pay for health services before becoming payable by the insurance carrier

Health Savings Account (HSA) - An individually owned, tax-favored savings vehicle that you can use to reimburse your medical, dental, vision and OTC drug expenses as defined under section 213(d) of the Internal Revenue Code. Make deposits pre-tax, and withdraw funds tax-free to pay for eligible expenses

Flexible Spending Account (FSA) - A benefit offered to employees by an employer which allows a fixed amount of pre-tax wages to be set aside for qualified expenses. Qualified expenses my include child care or uncovered medical expenses.

In-Network - typically refers to health care providers who contract with an insurance plan to provide services to members. Coverage for services are typically greater when received from in-network providers

Out-of-Network - typically refers to health care providers who do not contract with the insurance plan to provide services to its members. Coverage for services are typically less than it would be for in-network providers, or not covered at all.

Benefits Contact Information:

Benefit	Group #	Phone	Website
Medical and Prescription Drug Plans			
UMR	76-413263	1-800-826-9781	www.UMR.com
Nurseline		1-877-950-5083	
Teladoc	76-413263	1-800-835-2362	
To find a UHC Choice Plus provider, call or go online and search under "Find a Provider" then click on "medical", click on "United Healthcare Choice Plus PPO network" and click "access the UHC Provider Search Application"		1-800-826-9781	www.UMR.com
Dental Plan			
Guardian	00521218	1-800-541-7846	www.GuardianAnytime.com
To locate a provider, call or go online and search under the plan and dental network you are enrolled under, which can be found on the first page of your dental benefit summary.		1-800-541-7846	www.GuardianAnytime.com
Vision Plan			
Avesis	AbsoluteCare: 20792-1003	1-800-828-9341	www.Avesis.com
To locate a provider, call Customer Service or search the Avesis website			
Gap Coverage			
SISLINK	24936	1-800-767-6811	www.specialinc.com
Submit claims online, via email, mail or by FAX		1-214-291-1301 - Fax	customerservice@specialinc.com
Health Savings Account (HSA)			
HSABank	AbsoluteCare	1-800-357-6246	www.hsabank.com
Flexible Spending Account (FSA)			
WageWorks	AbsoluteCare	1-877-924-3967	www.wageworks.com/myfsa
Life and AD&D Plans			
Unum	909614	1-800-275-8686	www.unum.com
Disability Benefits			
Unum	909614	1-800-275-8686	www.unum.com
Voluntary Benefits			
Unum	909614	1-800-275-8686	www.unum.com
Employee Assistance Program			
Unum / Life Balance	909614	1-800-854-1446	www.lifebalance.net (user ID and password: lifebalance)
Travel Assistance Program	01-AA-UN-762490	1-800-872-1414	E-mail: medservices@assistamerica.com
Health Advocacy Service			
Health Advocate	AbsoluteCare	1-866-695-8622	www.healthadvocate.com/members

DISCLOSURE GUIDE

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

NON-MEDICAL

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or CHIP.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent (s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be

IMPORTANT NOTICE FROM ABSOLUTECARE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current AbsoluteCARE coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current AbsoluteCARE coverage, be aware that you and your dependents may be able to get this coverage back.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact your plan administrator.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Cavalier changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	KANSAS – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
ALASKA – Medicaid	**KENTUCKY – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARKANSAS – Medicaid	**LOUISIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
FLORIDA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
GEORGIA – Medicaid	**MINNESOTA – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
INDIANA – Medicaid	**MISSOURI – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid	**MONTANA – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

NEBRASKA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid	**SOUTH DAKOTA - Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE – Medicaid	**TEXAS – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW YORK – Medicaid	**VERMONT– Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: http://www.coverva.org/ programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/ programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
NORTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
OKLAHOMA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
OREGON – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
PENNSYLVANIA – Medicaid	**WYOMING – Medicaid**
Website:http://www.dhs.pa.gov/provider/medicalassistance/ healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
RHODE ISLAND – Medicaid	
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent.

Your Rights Under COBRA

Under Federal law known as COBRA (continuation of coverage), as a covered employee, you have the right to obtain a temporary extension of your group health insurance.

INDIVIDUAL ELECTION RIGHTS

Each individual covered under your plan on the day before coverage was terminated is a “qualified beneficiary” and has independent election rights to continue coverage. This means that each dependent can elect independently to continue coverage, even if the covered employee chooses not to elect coverage.

ELECTING COVERAGE

During your COBRA election period, benefits are not available to you. Therefore, any access to care or claims submitted would be denied. Following receipt of your election form and any applicable premium due, your benefits will be reinstated retroactive to the termination date, and claims may be submitted for payment in accordance with your benefit plan.

PREMIUM PAYMENT

If you elect to continue your health insurance, you are responsible for the full premium payment for the coverage elected. The COBRA premium includes the employer and employee’s share of the premium. Following your COBRA election, you have a maximum of 45 calendar days from the date of your election to pay all past due premiums.

LENGTH OF CONTINUATION COVERAGE

Coverage will continue for all qualified beneficiaries for a period of 18 months if coverage loss was the result of a covered employee’s termination (except for gross misconduct) or reduction of work hours.

Coverage will extend to qualified beneficiaries for a period of 36 months if the coverage loss was a result of any of the following circumstances:

- Death of a covered employee
- Divorce or legal separation from a covered employee
- Dependent ceasing to qualify as an eligible dependent
- Covered employee losing coverage as a result of Medicare

DISABILITY EXTENSION PROVISION

The initial 18-month extension privilege may be extended for an additional 11-month period for a total of 29 months to all qualified beneficiaries if the Social Security Administration (SSA) determines that a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at the time during the firs 60 days of continuation coverage.

COBRA EMPLOYER REQUIREMENTS

Employers are only obligated to offer COBRA coverage if they offer an employer-sponsored health insurance plan and they have at least 20 employees.

YOUR RESPONSIBILITY

It is your responsibility to obtain the disability determination from SSA and to provide a copy to your employer within 60 days of the date of determination and before the original 18 months of COBRA expires. If you do not comply with these time frames, the additional 11 months of coverage will not be provided. It is also your responsibility to notify the HR Representative within 30 days if a final determination is made tha you are no longer disabled.

SECONDARY EVENTS (IF APPLICABLE)

Extension privileges may be extended beyond the original 18 months if, during the initial 18 months, a second event such as divorce, legal separation, death, Medicare entitlement or a dependent child ceasing to be an eligible dependent takes place. If a second event occurs, the original 18 months will be extended to 36 months from the date of the original qualifying event for the qualified beneficiary spouse and/or dependent child. The extension does not apply to the employee. If a second event occurs, it is your responsibility to notify the HR Representative within 60 days of the second event and before the end of the original 18 month COBRA expiration. In no event will continuation coverage last beyond three years from the date of the original qualifying event.

NEW DEPENDENT & OPEN ENROLLMENT

If you adopt a child or if a childis born to you withinyour COBRA extension period, your coveragemay be changed to include the new dependent. The change to add a new dependent must be done according to the rules of your plan. The new dependent will gain the rights of all other “qualified beneficiaries”.

CANCELLATION OF CONTINUATION

COBRA continuation will end prior to the 18-, 29- or 36-month expiration period for any of the following reasons:

- Your former employer ceases to provide any group health plan to any of its employees
- Any required premium for continuation coverage is not paid within your grace period
- A qualified beneficiary becomes covered under another group health plan (provided the pre-existing condition limitation or exclusion does not apply to the qualified beneficiary)
- A qualified beneficiary becomes entitled to Medicare
- A qualified beneficiary covered under the disability extension provision receives SSA determination that he/she is no longer disabled
- A qualified beneficiary notifies the HR Representative of intention to cancel extended coverage

CONVERSION OPTIONS

When your extension period expires, qualified beneficiaries will be allowed to enroll in an individual conversion plan provided by the current carrier, if such an option is available. GBS will advise you in writing of your conversion option approximately 30 days prior to the expiration date of your continuation coverage. At that time, you must contact the carrier within 30 days to confirm applicable benefits and rates.

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Notes:

AbsoluteCARE
Medical Center & Pharmacy