2017 Minister Benefits Guide

Helping You Become a Better You.

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the documents shall govern.

Table of Contents

Contact Information

Contacts		
Vendors	**Member Services**	**Website / Email**
Medical: Policy No. 179802 **Plan No. MPP03C36** *Blue Cross Blue Shield of Illinois*	800-538-8833	www.bcbsil.com
Dental: Policy No. 57764156 *MetLife*	1-800-438-6388	www.metlife.com/dental
Vision: Policy No. 30068695 *VSP*	800-877-7195	www.vsp.com
Life / AD&D and Voluntary Life / AD&D: *Mutual of Omaha*	800-646-8882	www.mutualofomaha.com
Voluntary Benefit: *AFLAC*	800-433-3036	www.aflac.com
Benefits TEAm:	**Phone**	**Email**
Penny Etter—Minister of Well being *Jennifer Numainville—Minister of Humanities* *Erika Deschodt—Minister of Culture*	866.418.1350 415.475.5165 415.475.5175	penny@republicoftea.com jen@republicoftea.com erika@republicoftea.com
CBIZ Benefits & Insurance Services: *Eric File – Account Executive* *Donna Clifton - Account Manager*	314.692.5848 314.692.5812	efile@cbiz.com dclifton@cbiz.com

Reasons to Call	Who to Call
Claims Questions	Vendor/ CBIZ
Identification Cards / Numbers	Vendor / CBIZ
Pre-Certification	Vendor
Provider Directories	Vendor Websites
If Drug Prescription is Denied	Provider / Doctor
Payroll Issues / Status Changes / Miscellaneous Issues	The Republic of Tea

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

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

Understanding Your Plan Options

Ministers of The Republic of Tea who meet eligibility requirements are offered a benefit package which includes Medical, Dental, Vision, Basic Life / Accidental Death & Dismemberment (AD&D), Voluntary Life / AD&D, Short-Term Disability, Long-Term Disability, Identity Theft Protection, and Prepaid Legal.

The Republic of Tea offers a medical plan administered by Blue Cross Blue Shield of Illinois.

The dental insurance offered through MetLife includes orthodontia benefits for children up to age 19. This benefit is provided to The Republic of Tea ministers at no cost. There is a cost for dependent coverage.

As a minister of The Republic of Tea, your vision benefits through VSP are offered at no cost. There is a cost for dependent coverage.

Basic Life / AD&D, short-term and long-term disability benefits are offered by Mutual of Omaha and are benefits that The Republic of Tea provides for their ministers. Ministers may purchase additional life through Mutual of Omaha for themselves and their eligible dependents.

Identity Theft Protection from Legal Shield is a voluntary benefit offered to ministers. Using identity theft protection is a way to protect your personal information from being misused.

IDShield from Legal Shield will also monitor your identity from every angle (including Social Security Number, Credit Cards, Bank Accounts, etc.) and notify you if there is any change of status. Their specialists provide counsel when you need it but also restore your identity to pre-theft status

Through Aflac, The Republic of Tea offers critical illness coverage and voluntary short term disability coverage.

This Benefit Guide provides a brief summary of all The Republic of Tea's benefit plans along with the rates based upon the coverage you select. You will also find notices and other important information in this guide.

WHAT CAN I DO TO KEEP MY MEDICAL COSTS DOWN?

Use Network doctors and facilities

- Check www.bcbsil.com to find network providers near you.
- Ask your provider if they participate in the Blue Cross Blue Shield of Illinois network.
- Before you have any procedure, be sure to talk to your doctor or the facility to which you are referred to be sure they are in-network.
- If you are balance-billed by an out-of-network provider, contact them and ask if they will lower the charge if you set up a payment plan.

Understand your benefits

- Always review your health plan documents to fully understand your benefits. If you are not sure, contact Blue Cross Blue Shield of Illinois customer service at the phone number on the back of your ID card.

Ask the provider about their fees before you receive services

- You can ask about fees before you receive services or pharmacy benefits. Contracted fees are not the same for all providers. You have the right to ask before you receive services so you are aware of what your expenses will be. This may not always be possible, however, when it is...ask.

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

Eligibility

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

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

Ineligible:

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

Frequently Asked Questions

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits during the re-enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 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
- Death of an insured member
- Gain or loss of Medicaid entitlement
- You become eligible for Medicare

HOW ARE NEWBORNS COVERED?

The Republic of Tea's medical plan covers newborns for up to the first 31 days. Coverage is based upon the Federal law, The Mother's and Newborns' Health Protection Act. This law requires coverage for a 48-hour inpatient hospital stay for natural birth or 96-hour inpatient stay for cesarean section. If coverage beyond the 48 or 96 hours is wanted, the newborn must be enrolled within the first 30 days. If the medical coverage for a newborn is elected under a spouse's plan, coordination of benefits will take place which will determine if The Republic of Tea's or a spouse's plan will be the primary payer.

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

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

Health Care Coverage Options: COBRA & Its Alternatives

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

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

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

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

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

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

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

WHY IS CBIZ SELECTQUOTE BEING OFFERED?

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

KEEPING YOUR HEALTH CARE AFFORDABLE

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

GETTING STARTED

Review your options at cbiz.selectquotebenefits.com or call at 1.855.801.5742.

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.

Getting sick is never convenient, and finding time to get to get to the doctor can be hard. Blue Cross Blue Shield of Illinois provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLIVE. Whether you're at home or traveling, access to a board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual Visits can also be a better alternative than going to the emergency room or urgent care center.

ACCESS TO VIRTUAL VISITS

Log in to **www.bcbsil.com** and choose a doctor for the virtual visit. After registering and requesting a visit, you will pay the primary care visit copay. Payment is made prior to the virtual visit.

CONDITIONS COMMONLY TREATED THROUGH A VIRTUAL VISIT:

■ Bladder infection/ Urinary Tract Infection	■ Migraine/ Headaches
■ Bronchitis	■ Pink Eye
■ Cold/Flu	■ Rash
■ Diarrhea	■ Sinus Problems
■ Fever	■ Sore Throat

Blue Cross Blue Shield of Illinois - Plan Design

Features

	In-Network	Out-of-Network
Deductible (Individual / Family)	$1,500 / $4,500	$3,000 / $9,000
Coinsurance	80%	60%
Out-of-Pocket Maximum (Individual / Family)	$3,500 / $10,200	$7,000 / $20,400
Office Visit Co-Pay (Primary Care Physician / Specialist)	$30 / $50	60% After Deductible
Preventive Care	100%	60% After Deductible
Inpatient Hospital	80% After Deductible	Deductible; $300 Co-Pay & 40%
Outpatient Surgery	80% After Deductible	60% After Deductible
Lab, X-Ray (Outpatient)	80% After Deductible	60% After Deductible
Major Diagnostics (CT, PET, MRI, MRA, & Nuclear Medicine)	80% After Deductible	60% After Deductible
Emergency Room	$150 Co-Pay	$150 Co-Pay
Urgent Care	80% After Deductible	60% After Deductible
Prescription Drug *Retail* *Mail Order (90-Day Supply)* *Separate Out of Pocket Maximum*	**Preferred Pharmacy** $10/$40/$60 2 x Retail $1,000 Individual $3,000 Family	**Non-Preferred Pharmacy** $15/$50/$70 **Out of Network** $15/$50/$70/ +25%

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 as an alternative.

Convenience Care Centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Wal-mart and Target, and offers services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out-of-pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/ coinsurance.

Convenience Care Center

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

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

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

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

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

If you require lab work, please check to be sure the provider you are going to is in network.

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.

Some examples of emergency conditions may include the following:

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

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.

*If you receive treatment for an emergency in a non-network facility, you may be transferred to an in network facility once the condition has been stabilized.

PRESCRIPTION DRUG BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Blue Cross Blue Shield of Illinois 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, reduced claims expense for The Republic of Tea, and potentially lower future renewal increases.

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

PREVENTIVE CARE

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

Dental Insurance

MetLife Plan Design

Coverage Type	In-Network	Out-of-Network
Individual Deductible:	$50	$50
Family Deductible:	$150	$150
Type A - Preventive Exams X-Rays Cleanings (2 in 12 months) Fluoride (To Age 19)	100% No deductible	100% No deductible
Type B - Basic Procedures Sealants (To Age 19) Fillings Root Canal Periodontal Oral Surgery (Extractions)	80%	80%
Type C - Major Services Crowns/Inlays/Onlays Repairs Bridges Dentures Implants	50%	50%
Type D - Orthodontia (Child Only to Age 19)	50% to $2,000	50% to $2,000
Maximum Benefit/Year	$1,250	$1,250

Find a Provider:

1. Go to www.mutualofomaha.com
2. Select “My Dental Benefits” and look for the link to “Find a Dentist”
3. Search for a specific dentist by last name or enter your city, state, or ZIP code to find dentist in your

Vision Insurance

VSP Plan Design

Coverage Type	In-Network	Out-of-Network
Examination Co-Pay	$10 Co-Pay	$45 Reimbursement
Lenses:		
Single	$25 Co-Pay	$30 Reimbursement
Bifocal	$25 Co-Pay	$50 Reimbursement
Trifocal	$25 Co-Pay	$65 Reimbursement
Frames	$150 Allowance & 20% Discount On Balance	$70 Reimbursement
Contacts:	$150 Allowance	$105 Reimbursement

Frequency of Service:	
Exam	12 Months
Lenses	12 Months
Frames	24 Months

Find a Provider:

1. Go to www.vsp.com/choice
2. Search for a specific doctor by location or service provided .

Basic Life and AD&D

The Republic of Tea provides Basic Life and Accidental Death & Dismemberment coverage at no cost to you through Mutual of Omaha. Your benefit is one times your annual salary to a maximum of $175,000.

Short-Term Disability

In the event you are unable to work because you have suffered an illness or injury, The Republic of Tea provides, at no cost to all active, full-time ministers a short-term disability plan. This plan, through Mutual of Omaha, covers 66 2/3% of your weekly income up to a maximum benefit of $1,500 per week for up to 90 days.

Coverage will begin on the 8th day due to a sickness, or as a direct result of an accidental injury. You must be receiving appropriate care and treatment determined by your physician as necessary to treat the sickness or injury and comply with the requirements of such treatment.

Long-Term Disability

The Republic of Tea provides, at no cost to all active, full-time ministers, excluding Winery ministers, a long-term disability plan. This benefit through Mutual of Omaha provides you with a percentage of your earnings while you are deemed disabled and unable to earn a living.

After being deemed totally disabled by the treating physician for 90 days, you are eligible to receive up to 66 2/3% of your monthly salary to a monthly maximum of $10,000. Benefits are payable for up to two years if you are disabled from your own occupation. If you are disabled and unable to perform any occupation, you are eligible to receive benefits up to age 65, or Social Security Normal Retirement Age (SSNRA). If you are disabled due to a nervous and mental condition, benefits are limited to two years.

If you received medical treatment (including prescription drugs), consultation or medical care during the three months prior to becoming eligible for the long-term disability benefits and then become disabled, you are subject to the pre-existing condition limitation of the contract. You may not be eligible for benefits under this plan until you satisfy the conditions of the contract. Please refer to the Mutual of Omaha benefit information for more details.

This plan allows a one-time lump sum payment of three months of benefit in the event you pass away while receiving benefits under the plan. This survivor benefit is payable to the beneficiary on file.

Voluntary Life / AD&D

During your initial enrollment period you have the opportunity to purchase additional life insurance for yourself, your spouse, and/or dependent child(ren) through Mutual of Omaha. You cannot cover your spouse or dependent child(ren) unless you elect coverage for yourself. You may elect coverage up to the guaranteed issue amount without providing evidence of insurability, which is a statement of health. Guaranteed issue does not apply if you are over the age of 70 for initial coverage. Evidence of insurability is required for any amount of coverage, if you are over the age of 70. Coverage above the guaranteed issue must be approved by Mutual of Omaha before it goes into effect.

MINISTER COVERAGE

Ministers may elect coverage in increments of $10,000 subject to a maximum of the lesser of 5 times your salary or $500,000. Coverage maximum if you are age 70 or older is $500,000.
Guaranteed Issue: $150,000 if you are under age 70.

SPOUSE COVERAGE

Spousal coverage is available in $5,000 increments not to exceed 100% of the minister amount up to a maximum of $150,000. Spouse rates are based upon the minister's age. Guaranteed Issue: $50,000 if you are under age 70; Spouse coverage terminates when you reach age 70.

CHILDREN

Coverage is available for your child(ren) up to age 19 or 26 if they are a full-time student. Coverage is available in $2,000 increments up to $10,000 not to exceed spouse benefit amount. The amount you select is for each child you cover. The cost is based upon the family unit and not each child. Guarantee issue does not apply to child coverage.

MONTHLY MINISTER COST	
Age Band	**Minister & Spouse Rate per $1,000**
Under 30	$0.070
30-34	$0.083
35-39	$0.094
40-44	$0.135
45-49	$0.213
50-54	$0.339
55-59	$0.534
60-64	$0.808
65-69	$1.33
70+	$2.451
Child	$0.029
	AD&D Cost
Minister/ Spouse	$.025
Child	$0.051

HOW TO CALCULATE VOLUNTARY PREMIUM

$\frac{\$50{,}000 \text{ Elected Coverage}}{\div 1{,}000} = \frac{50 \text{ Units}}{} \times \frac{\$0.213 \text{ Rate}}{\text{* See Note}} = \frac{\$10.65}{\text{Per Month Cost}}$

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

Identity Theft Protection

It can be very challenging when your identity has been stolen, leaving you helpless as you deal with the aftermath of the theft. The Republic of Tea offers identity theft protection through LegalShield. This is a voluntarily-elected benefit and will be deducted through payroll.

The LegalShield Identity Theft Shield Plan includes: credit report, continuous monitoring, consultation and restoration services.

In addition to identity theft protection, you may also enroll in Prepaid Legal through LegalShield which will provide you services such as:

- Will preparation
- Unlimited telephonic consultations with an attorney 24/7/365
- Handling of traffic tickets

Additional Benefits

- Employee Assistance Program (EAP)
- Minister discount program for tea purchases
- Educational Assistance (eligible after 6 months of employment—up to $2,000 per year)
- Day Care Reimbursement ($2,000 per family per year paid quarterly)
- 401(k) Profit Sharing based on company performance (eligible after 6 months).

LegalShield
Total access. Total freedom.

For The REPUBLIC of TEA
LEADING PURVEYOR OF PREMIUM TEAS

VOLUNTARY BENEFIT AUTHORIZATION FORM

Employee Name:_____ Birthdate____/____/_____

Last four digits of Social Security number ____

Spouse/Significant Other Name_____Birthdate___/____/____

Dependent_____ Birthdate ____/____ _/_____

Dependent_____ Birthdate ____/____ _/_____

Dependent_____ Birthdate ____/____ _/_____

Dependent_____ Birthdate ____/____ _/_____

As an employee of REPUBLIC OF TEA, I acknowledge that the LegalShield 24/7 Life Events Legal Plan and ID Shield employee benefits were made available and explained to me completely. I have seen the brochure/factsheet listing specific benefit and benefit limitations of these plans. I authorize my employer to deduct premiums from my earnings and remit to LegalShield

Options: (must check at least one box)

- ❑ Both Family plans $33.90/MOTHLY
- ❑ Both Individual plans $25.90/MONTHLY
- ❑ Family Legal plan $18.96/ MONTHLY
- ❑ Individual Legal plan $16.96/ MONTHLY
- ❑ Family IDShield $18.96/MONTHLY
- ❑ Individual IDShield $8.96 /MONTHLY
- ❑ Waive participation at this time

Employee Signature: _____Date____/____/_____

Email address _____@_____

Phone number_____

Address – Street_____ City_____ St ____ Zip_____

Now More Than Ever

Aflac.

1-in-2
The lifetime risk of U.S. men for developing cancer. For women the risk is a little more than one-in-three.[3]

Accident

Helps provide financial stability for everyday expenses and medical treatment if a covered accident occurs.

- 24 hour coverage
- No limit on the number of claims
- Guarantee issue
- Payroll Deduction
- Portable coverage

Critical Illness (Specified Health Event) Cancer

Helps with the costs of treatment if you experience a covered health event, such as a heart attack, stroke or paralysis.

Important Notices

Special Enrollment Notice

During the open enrollment period, eligible ministers 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 copays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

Notice of Privacy Practices

The Republic of Tea 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

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 Republic of Tea.

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 December 15th.

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 minister 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 ministers will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit healthcare.gov for more Marketplace information.

Medicaid CHIP Notice

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

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

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

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

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

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

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

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

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

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

Blue Cross Blue Shield of Illinois has determined that the prescription drug coverage offered by The Republic of Tea 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 this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

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

Glossary of Terms

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

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

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

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

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

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

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