City of Columbia MISSOURI

2017 Benefits Enrollment 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 CONTENT

CONTACT INFORMATION 1
- Reasons to Call 1
- How to Use This Claims Resolutions 1

WHAT'S INSIDE 2

ENROLLING IN THE PLANS 2
- Who's Eligible 2
- When to Enroll 2
- Open Enrollment 2
- Changing Coverage During the Year 2

MEDICAL INSURANCE OPTIONS 4
- UnitedHealthcare - HSA Choice Plus - $2,600 QHDHP 4
- UnitedHealthcare - Choice Plus PPO - $1,500 Deductible Plan 5
- UnitedHealthcare - Choice Plus PPO - $750 Deductible Plan 6

HEALTH SAVINGS ACCOUNT (HSA) 7

YOUR HEALTH BENEFITS 9
- Stay Healthy with Medical Coverage 9
- Get the Most from Your Benefits 9
- When to Use Primary Care, Convenience Care, Urgent Care, Lab Services or Emergency Care 9

DENTAL INSURANCE 12
- Dearborn National Dental 12
- Network Savings Example 12
- About Your Dental Insurance 12

VISION INSURANCE 13
- Choice Plan VSP 13

LIFE AND ACCIDENTAL DEALTH & DISMEMBERMENT INSURANCE 14
- Basic Employee Life Insurance 14
- Optional Employee Life 15
- Basic Dependent Life 15
- Supplemental Spouse Life 15

LONG-TERM DISABILITY 15

FLEXIBLE SPENDING ACCOUNTS (FSA) 16
- Health Care FSA 16
- Dependent Care FSA 17
- Limited Purpose FSA 17

VOLUNTARY WORKSITE BENEFITS 18
- Critical Illness 18
- Supplemental Health 18
- Accident Insurance 19

EMPLOYEE ASSISTANCE PROGRAM (EAP) 20
- Boone Hospital Center's Employee Assistance Program 20

RETIREMENT BENFITS 21
- Missouri Local Government Employees Retirement System (LAGERS) 21
- Columbia Police and Firemen's Retirement Fund 21
- 457 Deferred Compensation Plan 21
- 401(a) Plan 21

EMPLOYEE WELLNESS 22
- Services/Programs 22

TIME OFF 22

IMPORTANT NOTICES 23
- Special Enrollment Notice 23
- Women's Health and Cancer Rights Act Of 1998 23
- Notice of Privacy Practices 23
- Marketplace Options 23
- Important Information Regarding 1095 Forms 24
- Medicaid CHIP Notice 24
- Medicare Part D Credible Coverage 24

CONTACT INFORMATION

Contact Information		
		
UnitedHealthcare Choice Plus *(Medical)* Group Number: 7049419	Toll-Free 866.734.7670	myuhc.com
Dearborn National *(Dental)* Group Number: F018532-0001	Toll-Free 800.721.7987	dearbornnational.com
Central Bank of Boone County *(Health Savings Account - HSA)*	Toll-Free 800.749.5344	centralbank.net
VSP Choice Plan *(Vision)* Group Number: 30 021754	Toll-Free 800.877.7195	vsp.com
Dearborn National *(Life Insurance/LTD)* Group Number: F018532-0002	Toll-Free 800.721.7987	dearbornnational.com
ASIFlex *(Health Care FSA, Dependent Care FSA, Limited Purpose FSA)*	Toll-Free 800.659.3035 573.442.3035	asiflex.com
Humana *(Voluntary Accident, Critical Illness, Supplemental Health)* Group Number: 7213062000	Toll-Free 800.327.9728	humanavoluntarybenefits.com
Boone Hospital Center *(Employee Assistance Program)*	Toll-Free 877.327.0327 573.815.6034	**EAP office is located at:** 1701 E Broadway, Broadway Medical Plaza 3, Suite 303, Columbia, MO 65202
Benefits Team	**Phone**	**Email**
Human Resources Manager	573.441.6614	jackie.lowrey@como.gov
Human Resources Techs	573.874.7678 573.874.7560 573.874.7236	HRTECH@gocolumbiamo.com

Reasons to Call:

Claim Questions—Contact Carrier
I.D. Cards / Numbers—Contact Carrier
Provider Search—Carrier Websites
Payroll Issues / Status Changes/ Miscellaneous Issues - City of Columbia Human Resources

How to Use This Claims Resolutions:

1. First contact Member Services
2. If issue still unresolved, contact City of Columbia Human Resources.

WHAT'S INSIDE

This brochure provides a summary of your benefit options and is designed to help you make your choices and enroll for your coverage. Please contact Human Resources to enroll. If you have any questions after enrolling, please call the benefit plan providers directly or log on to their websites for more details. Provider contact information is listed.

ENROLLING IN THE PLANS

Who's Eligible

As a permanent full-time employee working 20 or more hours per week, you are eligible for the benefits described in this brochure. If you elect coverage, your medical, dental and vision benefits will begin on the first day of the next month following your date of hire.

You can also enroll your eligible dependents for coverage. Eligible dependents include your legal spouse and your children up to age 26, domestic partners, and children of domestic partners. You will be required to provide proof of dependent eligibility such as marriage license, birth certificate, legal guardianship or adoption paperwork.

When to Enroll

You can enroll for coverage within 31 days of your date of hire or during the annual open enrollment period. Outside the open enrollment period, the only time you can change your coverage is within 31 days after you experience a qualified change in status. *(See "Changing Coverage During the Year" for details.)*

Open Enrollment

The City of Columbia's Open Enrollment period is in October each year, with coverage effective January 1 of the following calendar year. During Open Enrollment you can make the following changes:

- Enroll in a medical, dental and vision plan, if you are eligible and you currently do not have medical, dental or vision benefits
- Change your medical, dental or vision plan
- Add or drop eligible dependent's medical, dental or vision coverage
- Enroll in the voluntary insurance benefits - Critical Illness and Cancer, Accident, and Supplemental Health

Changing Coverage During the Year

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- Domestic Partner (according to Domestic Partner affidavit rules);

- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in you or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of you or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

If you wish to change your election, you must contact Human Resources within 30 days of the change in family status. Otherwise, you will need to wait until the next annual open enrollment.

MEDICAL INSURANCE OPTIONS

UnitedHealthcare - HSA Choice Plus - $2,600 QHDHP

Benefit Plan	In-Network	Out-of-Network
Deductible (calendar year)		
Single	$2,600	$5,000
Family	$5,200	$10,000
Coinsurance (plan pays/you pay)		
	80% / 20%	60% / 40%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$5,000	$10,000
Family	$10,000	$20,000
Copayments		
Primary Physician Visit	Deductible, then you pay 20%	Deductible, then you pay 40%
Specialist Physician Visit	Deductible, then you pay 20%	Deductible, then you pay 40%
Preventive Care	Plan pays 100%	Not Covered
Emergency Room Visit	Deductible, then you pay 20%	Deductible, then you pay 20%
Urgent Care Center Visit	Deductible, then you pay 20%	Deductible, then you pay 40%
Prescription Drug Coverage		
Retail Pharmacy	Deductible, then you pay 20%	Deductible, then you pay 20%
Mail Order Pharmacy	Deductible, then you pay 20%	Not Covered

$2,600 QHDHP Actives	Monthly EE Cost
Employee Only	$0.00
Employee & Spouse	$311.45
Employee & Child(ren)	$186.66
Employee & Family	$531.32
2 City EEs Married/Dom Part w/full family coverage	$41.23

$2,600 QHDHP Pre 65 Retirees	Monthly Cost
Single Only	$719.45
Single & Spouse	$1,467.69
Single & Child(ren)	$1,194.30
Full Family	$2,086.42

When you select the UnitedHealthcare HSA Choice Plus $2,600 Deductible Plan also known as a Qualified High Deductible Plan (QHDHP), you are eligible to open a Health Savings Account (HSA). An HSA is an account set up where employee pre-tax payroll contributions along with the City of Columbia contributions can be used by you to pay for current or future medical expenses. **The City of Columbia contributes $1,500 per year for single coverage and $3,000 per year family coverage.** The employee contribution limits for 2017 are $1,850 for single and $3,750 for family. In an HSA, funds roll over and accumulate from year to year if not spent. (The HSA is explained in more detail on Page 7.)

UnitedHealthcare - Choice Plus PPO - $1,500 Deductible Plan

Benefit Plan	In-Network	Out-of-Network
Deductible (calendar year)		
Single	$1,500	$4,500
Family	$4,500	$13,500
Coinsurance (plan pays/you pay)		
	80% / 20%	60% / 40%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$4,000	$12,000
Family	$12,000	$36,000
Copayments		
Primary Physician Visit	$25 Co-Pay	Deductible, then you pay 40%
Specialist Physician Visit	$50 Co-Pay	Deductible, then you pay 40%
Preventive Care	Plan pays 100%	Not Covered
Emergency Room Visit	$200 Co-Pay, then deductible & coinsurance	$200 Co-Pay, then deductible & coinsurance
Urgent Care Center Visit	$55 Co-Pay	Deductible, then you pay 40%
Prescription Drug Coverage		
Retail Pharmacy	$10/$35/$75/$150	$10/$35/$75/$150
Mail Order Pharmacy	$25/$87.50/$187.50/$375	Not Covered

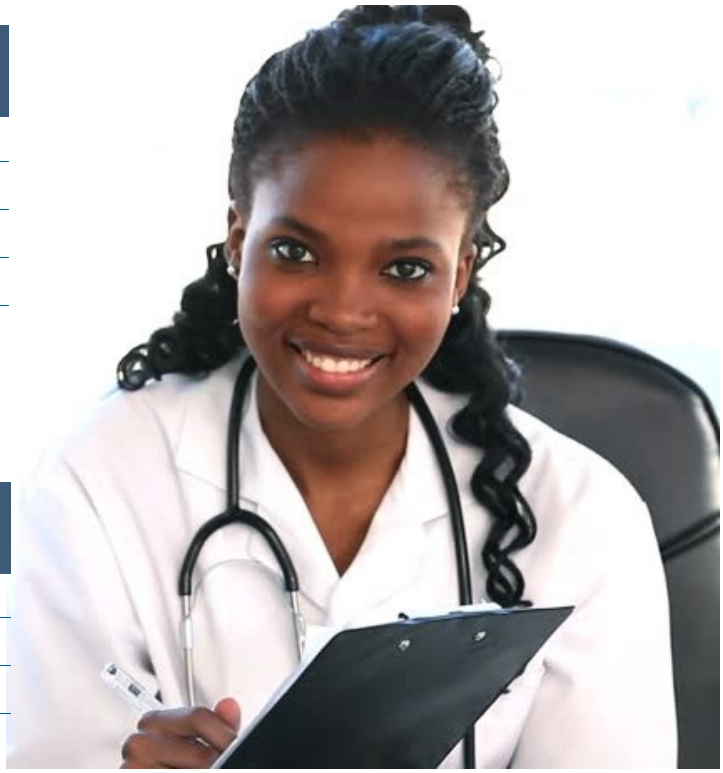
$1,500 Deductible PPO Plan Actives	Monthly EE Cost
Employee Only	$15.49
Employee & Spouse	$341.01
Employee & Child(ren)	$210.71
Employee & Family	$573.37
2 City EEs Married/Dom Part w/full family coverage	$62.25

$1,500 Deductible PPO Plan Pre 65 Retirees	Monthly Cost
Single Only	$742.53
Single & Spouse	$1,514.78
Single & Child(ren)	$1,232.63
Full Family	$2,153.37

UnitedHealthcare - Choice Plus PPO - $750 Deductible Plan
PLAN CLOSED TO NEW PARTICIPANTS

Benefit Plan	In-Network	Out-of-Network
Deductible (calendar year)		
Single	$750	$2,250
Family	$2,250	$6,750
Coinsurance (plan pays/you pay)		
	80% / 20%	60% / 40%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$3,000	$9,000
Family	$9,000	$27,000
Copayments		
Primary Physician Visit	$25 Co-Pay	Deductible, then you pay 40%
Specialist Physician Visit	$50 Co-Pay	Deductible, then you pay 40%
Preventive Care	Plan pays 100%	Not Covered
Emergency Room Visit	$200 Co-Pay, then deductible & coinsurance	$200 Co-Pay, then deductible & coinsurance
Urgent Care Center Visit	$55 Co-Pay	Deductible, then you pay 40%
Prescription Drug Coverage		
Retail Pharmacy	$10/$35/$75/$150	$10/$35/$75/$150
Mail Order Pharmacy	$25/$87.50/$187.50/$375	Not Covered

$750 Deductible PPO Plan Actives	Monthly EE Cost
Employee Only	$47.56
Employee & Spouse	$473.59
Employee & Child(ren)	$317.43
Employee & Family	$770.56
2 City EEs Married/Dom Part w/full family coverage	$160.84



$750 Deductible PPO Plan Pre 65 Retirees	Monthly Cost
Single Only	$769.47
Single & Spouse	$1,569.72
Single & Child(ren)	$1,277.32
Full Family	$2,231.46

HEALTH SAVINGS ACCOUNT (HSA)

With the Election of the UnitedHealthcare HSA Choice Plus Plan (QHDHP) for your insurance coverage, you may also open an HSA.

What is an HSA?

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

Why would I want an HSA?

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

What Rules Must I Follow?

- You must be covered under a Q*ualified High Deductible Health Plan (QHDHP)* in order to establish an HSA.
- You cannot establish an HSA if you also have a medical *flexible* spending account (FSA).
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouses employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent under someone else's tax return.

What is the Difference Between a Qualified High Deductible Health Plan and a Traditional PPO Plan?

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

What Else Do I Need to Know?

- HSA contributions are deposited over 24 paychecks and are based on a calendar year. For 2017, the **City of Columbia contributes $1,500 for Single and $3,000 for Family coverage**. The employee contribution levels for 2017 are $1,850 for single coverage and $3,750 for family coverage. The employee cannot put more than this amount in the account; but can put less.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services. (medical, dental, vision and over-the-counter medically necessary items)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled and/or qualify for Medicare, you can use the account for other purposes without paying the 20% penalty but you will pay income taxes.
- The savings account MUST be established with Central Bank of Boone County, so contributions can be deposited on your behalf and you can take advantage of payroll deductions on a pre-tax basis.

Another advantage is that your account can grow over time.

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

The HSA is also an investment opportunity.

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

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

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

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

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

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

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

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

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

YOUR HEALTH BENEFITS

Stay Healthy with Medical Coverage

As a foundation for your good health, the City of Columbia provides you with a medical plan that offers quality, flexibility, and value. The City contributes toward employee and dependent coverage, you will pay any difference in cost for the plan you select. Review the comparison chart below for a summary of medical plan features.

myNurseLine

Chat with a nurse live on myuhc.com or call the Customer Care number on the back of your health plan ID card

myNurseLine can help you:

- Understand treatment options
- Ask medication questions
- Choose appropriate medical care
- Locate available local resources
- Find a doctor, hospital, or specialist and check if a doctor is in your network and is accepting new patients. We may even be able to make the appointment for you

This is all available to you 24 hours a

Get the Most From Your Benefits

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

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

- Purchase your maintenance medications through the mail order program
- Ask your doctor for the generic equivalent of the brand-name drug prescribed
- Visit in-network providers for your care

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

PRIMARY CARE

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

CONVENIENCE CARE

Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center that can be an alternative to seeing your doctor.

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

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.

office visit co-pays and/or deductible/coinsurance.

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

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

URGENT CARE

Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room. We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

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

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Small cuts
- Sore throats
- Rashes
- Preventive Screenings
- Back Pain or Strains

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

Services that are available for Urgent Care may vary per center. If you choose to use an urgent care center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the carrier's website at myuhc.com.

LAB SERVICES

If you require lab work consider having these services performed at Boyce & Bynum Pathology Laboratories. When coded as preventive, the cost of your lab services will be covered 100%. LabCorp is an alternative in-network laboratory as well.

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 you or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to you or your loved one's bodily functions
- Serious dysfunction of any of you or your loved one's bodily organ(s) or bodily part(s)

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.

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.

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

PRESCRIPTION BENEFITS

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

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

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for the City of Columbia and potentially lower future renewal increases. Some prescription drugs are covered only if the physician obtains prior authorization from UnitedHealthcare. In addition, coverage for some drugs is provided in limited quantities and duration.

Rx Benefits

Some prescriptions through OptumRx (i.e., specialty prescriptions) may be required to be filled at specific pharmacies.

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

DENTAL INSURANCE

Dearborn National Dental

Benefit/Service	In-Network	Out-of-Network Benefit
	% of Maximum Allowance	% of Reasonable and Customary
Diagnostic, Preventive and Miscellaneous Services	**100%**	**100%**
Basic	**80%**	**80%**
Major	**50%**	**50%**
Ortho	**Not Available**	
Deductibles & Maximums		
Deductible Individual *	$25	
Calendar Year Maximum**	$1,500	

* Does not apply to diagnostic, preventive and miscellaneous services.

** Per covered person.

Dental Plan (Actives)	Monthly EE Cost
Employee Only	$0
Employee & Spouse	$31.46
Employee & Child(ren)	$31.46
Employee & Family	$62.86
Married/Dom Part w/full family coverage	$15.62

Dental Plan (Pre 65 Retirees)	Monthly Cost
Single	$31.63
Single & Spouse	$63.09
Single & Child(ren)	$63.09
Full Family	$94.49

About Your Dental Insurance

An employee may receive benefits for two dental cleanings and exams at any time during the calendar year.

Dependent children are covered until the end of the year upon attaining age 26. Dependents with a disability are eligible as long as they were incapacitated before the age limit was reached. There is no age limit for coverage on dependents with a disability.

Network Savings Example

Your dentist says you need a crown, a Major service. The dentist's usual fee is $950.00. The in-network dental provider fee is $550.00 and the reasonable and customary fee for out-of-network is $850.00. (The example below assumes that your annual deductible has been met.

In-Network	
Dentist's Usual Fee is:	$950.00
The In-Network Dental Provider Fee is:	$550.00
Your Plan Pays:	
50% X $550 (In-Network Dental Provider Fee):	-$275.00
Your Out-of-Pocket Cost:	**$275.00**

Out-of-Network	
Dentist's Usual Fee is	$950.00
Reasonable and Customary Fee:	$850.00
Your Plan Pays:	
50% X $850 Reasonable and Customary:	-$425.00
Your Out-of-Pocket Cost:	**$525.00**

By selecting an In-Network dentist in the above example, you save **$250**!

VISION INSURANCE

Choice Plan VSP

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Doctor			
WellVision Exam	Focuses on your eyes and overall wellness	$10	Every Calendar Year
Prescription Glasses		$20	See Frame and Lenses
Frames	• $150 allowance for a wide selection of frames • 20% off amount over your allowance	Included in Prescription Glasses	Every Other Calendar Year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every Calendar Year
Lens Options	• Scratch-resistant coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options	$0 $55 $95 - $105 $150 - $175	Every Calendar Year
Contacts (instead of glasses)	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation)	$0	Every Calendar Year
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

Your Coverage with Other Providers			
Exam….up to $45	Single Vision Lenses….up to $30	Lined Trifocal Lenses….up to $65	Contacts….up to $105
Frame…up to $70	Lined Bifocal Lenses….up to $50	Progressive Lenses…...up to $50	

	Monthly EE Cost
Employee Only	$8.06
Employee & Spouse	$16.13
Employee & Child(ren)	$17.25
Employee & Family	$27.60

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Dearborn National

Read Carefully Before Completing Group Life Enrollment Form

1) **All life insurance coverage is TERM insurance.** There is NO whole-life coverage available from the City.

2) **You will have to satisfy evidence of insurability in the event ANY of the following occurs:**
   a) You and/or your dependents request coverage under ANY of the life insurance plans more than 31 days after first becoming eligible;
   b) YOU request more than two times your salary or $100,000 (whichever is less) in supplemental life benefits;
   c) Your SPOUSE requests more than $25,000 in supplemental life benefits; or
   d) You wish to upgrade from any Basic Dependent Plan (e.g., 1 to 2 or 3; 2 to 3).

3) **ALL employees now have "free" basic life insurance. You will pay a premium if any of the following applies:**
   a) You are a permanent part-time employee;
   b) You enroll for dependent life coverage; or
   c) You enroll for supplemental life coverage.

4) **All life insurance premiums are deducted out of the second check of each month, and are automatically adjusted in the event either of the following occurs:**
   a) Your death benefit is adjusted (due to salary change, for example); or
   b) The age of you or your spouse changes and you move to a new premium bracket (applies to supplemental life benefits only).

5) Supplemental coverage applies to employees and spouses only. There are no additional benefits available for children beyond what is provided under the Basic Dependent Life plan.

Basic Employee Life Insurance

A double indemnity (includes Accidental Death and Dismemberment benefits) term life insurance policy is available to all permanent employees. Upon enrollment, a benefit equal to 1-1/2 times your annual salary (rounded to the next higher $1000, if not a multiple thereof) and not to exceed $50,000 will be payable in the event of your death. If the death is accidental (whether it is on or off the job) an amount equal to that payable under the Basic life policy will also be paid. Benefits payable due to accidental dismemberment vary according to the nature of the injury.

The cost for coverage under this plan is .10 per $1000 of coverage. If you are a permanent part-time employee you will pay a portion of your coverage. Refer to the table to the right to determine what percentage of the premium you are required to pay:

UNION AFFILIATION	% CONTRIBUTION	
	CITY	EMPLOYEE
Unrepresented	100%	0%
CPOA	100%	0%
Local 1055	100%	0%
Local 773	100%	0%
CPLA	100%	0%
Permanent Part-Time	Based on FTE %	Based on FTE %

Optional Employee Life

In addition to Basic Employee Life coverage you may purchase Supplemental coverage of up to two times your salary (not to exceed $200,000). You must be enrolled in the Basic Employee Life plan in order to apply for Supplemental coverage. Also, if you wish to purchase more than $100,000 under this plan, you will have to satisfy evidence of insurability.

The cost of Supplemental coverage is based upon the amount requested AND your age. Refer to the following table for premiums under this plan.

Basic Dependent Life

Three basic Dependent Life options are available to all employees. Coverage applies to all eligible dependents, including spouse and/or child, whichever is applicable. Upon enrollment (or following approval if applying for coverage late), a flat rate is charged per employee and is deducted out of the last paycheck of each month. A comparison of the three plans is shown here.

AGE	COST/$1000	AGE	COST/$1000
<25	.08	**50-54**	.40
25-29	.09	**55-59**	.63
30-34	.10	**60-64**	1.00
35-39	.13	**65-69**	1.90
40-44	.18	**70 +**	3.09
45-49	.26		

BASIC DEPENDENT LIFE OPTIONS			
COVERED DEPENDENT	**Dependent Plan 1** *Cost = $.70/ee/mo.*	**Dependent Plan 2** *Cost = $1.25/ee/ mo.*	**Dependent Plan 3** *Cost = $1.50/ee/ mo.*
Spouse	$5,000	$7,500	$10,000
Child (Birth – 26 yrs.)	$2,000	$2,500	$4,000

Supplemental Spouse Insurance

You may purchase Supplemental SPOUSE coverage for up to one-half of the amount of coverage for which YOU qualify (basic + supplemental) -- even if you do not elect BASIC Dependent Life coverage. The maximum amount that can be purchased is $100,000. Also, if you elect to purchase more than $25,000 under the Supplemental Spouse policy, your spouse must satisfy evidence of insurability. Premiums for the coverage are shown below.

AGE	COST/$1000	AGE	COST/$1000
<25	.08	**50-54**	.40
25-29	.09	**55-59**	.63
30-34	.10	**60-64**	1.00
35-39	.13	**65-69**	1.90
40-44	.18	**70 +**	3.09
45-49	.26		

LONG-TERM DISABILITY - *Dearborn National*

Your Dearborn Life long-term disability insurance coverage is a benefit paid for you by the City of Columbia. This insurance coverage allows you to maintain a portion of your income should you become disabled. Your benefit begins after a 180 day elimination period.

FLEXIBLE SPENDING ACCOUNTS (FSA) - *ASIFlex*

Health Care FSA

The Health Care Flexible Spending Account is a tax-free account that allows you to pay for essential health care expenses that are not covered, or are partially covered, by your medical, dental and vision insurance plans. By contributing a portion of your payroll dollars into your Flexible Spending Account on a pre-tax basis, you can save from 25% to 40% on the cost of eligible expenses you are already incurring.

When you enroll in a Flexible Spending Account, you decide how much to contribute to each account for the entire Plan Year. The money is then deducted from your paycheck, pre-tax (before Federal & State income taxes and FICA taxes are deducted) in equal amounts over the course of the plan year. After you incur expenses that qualify for reimbursement, you submit claims (reimbursement requests) to ASIFlex to request tax-free withdrawals from your Flexible Spending Account to reimburse yourself for these expenses.

The key to getting the most out of your Health Care Flexible Spending Account is to maximize your contributions based on the expenses you, or any of your tax dependents, anticipate incurring during the plan year. **To plan your annual election amount**:

1. Review the list of Eligible Expenses, which can be found at asiflex.com
2. Review your medical expenses from last year.
3. Write down any additional eligible expenses you anticipate incurring in the coming plan year.
4. Be sure to include at least some money to cover your deductible expenditures.
5. Estimate your cost for each of these Flexible Spending Account eligible expenses. (Don't forget that your tax dependents' expenses qualify, too, even if they are on a different health insurance program.)

Things to remember about the Health Care Flexible Spending Account:

1. Your election amount is typically fixed for the entire plan year (unless you have a qualifying event)
2. You must submit valid claims before the end of the claims run out period. Any unclaimed remaining funds will be forfeited to your employer, so estimate your expenses carefully and set money aside accordingly.
3. Expenses for any of your tax dependents are eligible for reimbursement, even if they are not on your employer's health insurance program.

The City of Columbia participates in a "Grace Period" which allows services provided through March 15th of the plan year. The "Run-out-period" extends your filings until March 31st each year.

Dependent Care FSA

Dependent Care Flexible Spending Accounts create a tax break for dependent care expenses (typically child care or day care expenses) that enable you to work. Additionally, if you have an older dependent who lives with you at least 8 hours per day and requires someone to come into the house to assist with day-to-day living, you can claim these expenses through your Dependent Care Flexible Spending Account. If you are married, your spouse must be working, looking for work or be a full-time student. **If you have a stay-at-home spouse, you should not enroll in the Dependent Care Flexible Spending Account**. The IRS allows no more than $5,000 per household ($2,500 if you are married and file a separate tax return) be set-aside in the Dependent Care Flexible Spending Account in a calendar year.

Please note that IRS regulations disallow reimbursement for services that have not yet been provided, so even if you pay in advance for your expenses, you can only claim service periods that have already occurred. For example, if you are required to pay for all of January's child care expenses on January 1st, you cannot claim the entire month's expense until the end of January. However, you may submit a claim every week, at the end of that week, for those expenses.

Eligible expenses include day care, baby-sitting, and general purpose day camps.

Ineligible expenses include overnight camps, care provided by a dependent, your spouse or your child under the age of 19 & care provided while you are not at work. Expenses may only be claimed for dependents that are under the age of 13; or for older dependents that live with you at least 8 hours each day and are incapable of self-care.

Remember that **your election is fixed for the entire year unless you have a qualifying event**.

Limited Purpose FSA

A Limited Purpose (or Limited Scope) FSA is a savings option for employees that are enrolled in a Health Savings Account (HSA). The Limited Purpose FSA works the same way a standard FSA does: pre tax, “use it or lose it” elections and expenses must occur within the plan year. The difference is that it limits what expenses are eligible for reimbursement. In a Limited Purpose FSA you can only submit claims for eligible vision and dental expenses.

Remember: Cosmetic procedures such as teeth bleaching are not eligible under any Flexible Spending Account.

VOLUNTARY WORKSITE BENEFITS - *Humana*

Humana offers voluntary products that are used to compliment your medical benefits by helping you cover your expenses until your deductible and coinsurance are satisfied.

Critical Illness

With critical illness and cancer plans, you'll receive a benefit after a serious illness or a condition such as a heart attack, stroke, coronary artery disease, or cancer is diagnosed. During your recovery, you and your loved ones can rest a little easier knowing you won't have to deplete your bank accounts or take on additional debt to cover day-to-day living expenses.

The following is displaying weekly payroll deductions.

Age	Employee Non-Tobacco User			Employee Tobacco User		
Benefit:	**$5,000**	**$15,000**	**$20,000**	**$5,000**	**$15,000**	**$20,000**
18-29	$1.92	$2.95	$3.47	$2.19	$3.79	$4.58
30-39	$2.66	$4.44	$5.33	$3.33	$6.45	$8.00
40-49	$3.79	$7.16	$8.85	$5.46	$12.15	$15.49
50-55	$5.53	$11.39	$14.32	$8.38	$19.94	$25.72
56-59	$5.53	$11.39	$14.32	$8.38	$19.94	$25.72
60-64	$7.58	$17.55	$22.53	$12.17	$31.33	$40.90
65-69	$8.64	$20.73	$26.78	$13.92	$36.55	$47.87

Age	Spouse Non-Tobacco User			Spouse Tobacco User		
Benefit:	**$2,500**	**$7,500**	**$10,000**	**$2,500**	**$7,500**	**$10,000**
18-29	$1.66	$2.18	$2.44	$1.80	$2.59	$2.99
30-39	$2.22	$3.11	$3.55	$2.55	$4.11	$4.89
40-49	$2.95	$4.64	$5.48	$3.78	$7.13	$8.80
50-55	$4.06	$6.99	$8.46	$5.49	$11.27	$14.16
56-59	$4.06	$6.99	$8.46	$5.49	$11.27	$14.16
60-64	$5.09	$10.07	$12.57	$7.38	$16.96	$21.75
65-69	$5.62	$11.67	$14.69	$8.25	$19.57	$25.23

Age	Children	
Benefit:	**$2,500**	**$5,000**
0-24	$0.49	$0.62

Supplemental Health

Supplemental Health pays cash benefits when you're hospitalized. You can use the benefits however you want – to help pay medical bills or everyday living expenses such as housing, car payments, utility bills, childcare, groceries, and credit card bills.

The table to the left is displaying weekly payroll deductions.

	Non-Tobacco User				Tobacco User			
Age	**Employee**	**Employee & Spouse**	**Employee & Children**	**Family**	**Employee**	**Employee & Spouse**	**Employee & Children**	**Family**
18-35	$5.80	$11.08	$10.10	$14.22	$7.12	$12.93	$11.43	$16.06
36-49	$5.45	$10.39	$9.83	$13.61	$6.69	$12.12	$11.06	$15.33
50-59	$7.46	$14.40	$9.93	$16.23	$9.20	$16.83	$11.66	$18.66
60-64	$10.66	$20.82	$12.83	$22.41	$13.20	$24.36	$15.37	$25.97

Accident Insurance

This voluntary plan offered through Humana offers coverage for accidents, injuries, ambulance services, and accidental death in addition to your primary medical insurance. It's also available to your spouse and children.

Benefit:	Level One	Level Two	Level Three	Level Four
Accident medical expense: Pays the actual expenses up to the amount selected for diagnosis or treatment by a physician or in an emergency room. ER subject to a $50 deductible.	$500	$1,000	$1,500	$2,000
Ambulance: Pays actual expenses up to the amount selected if injury requires ground or air ambulance transportation.	$250	$500	$750	$1,000
Hospital indemnity: Pays a benefit equal to the amount selected if an injury requires inpatient hospital confinement, including a room charge, that starts within 30 days after the accident. The benefit is limited to 30 days per accident.	$75	$150	$225	$300
Accidental death, dismemberment and loss of sight (AD&D): Loss of life Any combination of two or more hands, feet, or eyes Loss of single hand, foot or eye Multiple fingers and/or toes Single finger or toe	 $5,000 $5,000 $2,500 $500 $250	 $10,000 $10,000 $5,000 $1,000 $500	 $15,000 $15,000 $7,500 $1,500 $750	 $20,000 $20,000 $10,000 $2,000 $1,000

The following is displaying weekly payroll deductions.

Level One				
Age	**Employee**	**Employee & Spouse**	**Employee & Children**	**Family**
18-50	$2.98	$5.96	$6.93	$9.91
51-67	$3.41	$6.82	$7.36	$10.77
Level Two				
18-50	$3.55	$7.09	$8.28	$11.83
51-67	$3.98	$7.95	$8.71	$12.68
Level Three				
18-50	$4.02	$8.04	$9.77	$13.79
51-67	$4.45	$8.90	$10.20	$14.65
Level Four				
18-50	$4.45	$8.89	$10.93	$15.38
51-67	$4.88	$9.75	$11.36	$16.24

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Boone Hospital Center's Employee Assistance Program

Each day we juggle all parts of our lives . . . work, family fun . . . usually balancing them with success. On occasion, however, a personal problem may become so overwhelming it can interfere with our job, everyday life and sometimes our future. There may be times you need outside help and guidance. Boone Hospital Center's Employee Assistance Program offers help to employees and their families.

What is the Employee Assistance Program? The Employee Assistance Program (EAP) is a confidential assessment, short-term counseling and referral service that provides direction to troubled employees and their families.

Why have an Employee Assistance Program? Because we care about you as a valued employee. We also recognize that personal problems arise that can affect job performance. Seeking help with problems is a healthy way to keep your life and career on a steady course. That's why we're giving you an EAP.

What problems does the program deal with? EAP deals with all kinds of problems . . . marriage, family, emotional, abuse, alcohol, drugs, adjusting to life changes, retirement, death in the family, etc. Sometimes short-term counseling is all you need to manage these life changes and get you back on the right track. Getting help for a problem is not a weakness, it's a sign of strength. Going for help early can prevent a problem from getting too big and interfering with your job and life.

What is the cost? Permanent City employees may take advantage of up to eight visits per fiscal year, paid for by the City of Columbia. There is no cost to you. EAP is a benefit for you and your immediate family members. If the problem requires a referral to an outside agency or professional, you then would be responsible for the cost. The EAP counselor will assist you in determining the kind of help you need.

What about confidentiality? Confidentiality is the foundation of this program. In fact, the program could not exist without it. Records are under a separate system from personnel and other departmental records. Disclosure of information occurs only with a signed release from the employee or when law mandates release.

What now? If you have more questions or feel a need to contact EAP, call 573-815-6034 or toll free 877-327-0327. You don't have to let a problem escalate to the point of jeopardizing your job or personal well-being.

We believe strongly in our commitment to you. That's why we are providing you with an Employee Assistance Program.

The EAP office is located at:

Broadway Medical Plaza 3
1701 E. Broadway, Suite 303 ■ Columbia, MO 65202
573-815-6034 ■ Toll Free: 877-327-0327

RETIREMENT BENEFITS

Prepare for the future with retirement benefits. It is never too early to start planning for retirement. The City helps you prepare for a secure financial future.

Missouri Local Government Employees Retirement System (LAGERS)

This plan is fully funded by the City and provides a retirement benefit for the remainder of your life based on your years of service and final average salary for your highest 36 consecutive months in the ten years prior to retirement.

You become vested, or entitled to, your benefit when you complete five years of full-time employment or immediately if your death is work-related.

You may receive an early retirement benefit at age 55, but the benefits are reduced to account for the longer period you will receive benefits.

The plan also provides a death benefit payable to your eligible spouse or children if you die with a vested benefit before you retire.

Columbia Police & Firefighter Pension

Eligible employees contribute to this plan, which provides a retirement benefit for the remainder of your life based on your years of service and final average salary for your highest 36 months of covered employment.

You become vested, or entitled to, your benefit when you complete one year of service.

Firefighters employed after 10/1/2012 are eligible for retirement benefits upon reaching age 55 or when age and active service equals 80. Police Officers employed after 10/1/2012 are eligible for retirement benefits upon reaching age 65 or 25 years of credited service.

The plan also provides a death benefit if you die with a vested benefit before you retire or while you are disabled.

457 Deferred Compensation Plan

You are eligible to participate in the 457 Deferred Compensation Plan if you are a full-time or part-time employee. Contributions are deducted from your pay before taxes are taken. The IRS limits the dollar amount you can contribute to **any** qualified plan in a calendar year. The limit for 2017 is $18,000. If you are age 50 or over, you may also contribute an additional $6,000 in 2017 under the “catch-up contribution” rule. You are always 100% vested in your account and you can move the money to another qualified 457 plan, withdraw the funds, or leave the money in this plan if you terminate employment. You must begin receiving payments from your 457 plan by the time you reach age 70½.

401(a) Plan

Reduce your current income taxes while you boost your retirement investments. All employees, **except CPOA, CPLA and 1055 union employees,** that participate in the 457 Deferred Compensation Plan are eligible to participate in the

401(a) Plan as well. You may make contributions to this Plan on an after-tax basis. The City will also make contributions to your account (except for CPOA, CPLA and 1055 union employees); matching the contributions you make to the 457 Plan dollar for dollar, up to 2 percent of your eligible compensation. As with the 457 Plan, you can move the money to another qualified plan, withdraw the funds, or leave the money in this plan if you terminate employment.

EMPLOYEE WELLNESS

Wellness is an active process through which our employees become aware of, and make choices toward, a more successful existence. This healthy balance of the mind, body, and spirit results in the overall feeling of well-being. City Wellness programs are designed to help achieve a state of well-being by providing services focused on the promotion or maintenance of good health. The UHC Rally program will once again be offered to all employees who enroll in the City's medical plan.

Services/Programs

- Wellness/Health Resources
- Nutrition/Weight Management
- Disease Management
- Tobacco Cessation
- Stress Reduction
- CPR/AED Instruction
- Physical Activity
  - Group Fitness Classes
  - On-site 24/7 Fitness Facility

Rally

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

TIME OFF

You accrue time off according to the following schedule:

Type of Leave	Amount Available Per Year
Vacation	2 weeks per employment year (3.08 hrs. per pay period) for first five years; increased by 2½ days every 5 years through 20th year
Sick*	18 days per year
Floating Holidays	4 days per fiscal year (prorated in first year)
Holidays	7 days per fiscal year

Type of Leave	When You Become Eligible
Vacation	After 6 months of employment
Sick*	After 30 days of employment
Floating Holidays	After 12 months of employment
Holidays	At hire

***Sick Leave Buy Back**: You may sell accrued unused sick leave days earned in the previous FY once you accumulate a sick leave balance in excess of the number of hours they normally work in a 26-week period (for example 1,040 for a 40 hour per week employee).

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 your Human Resource Department.

Women's Health and Cancer Rights Act of 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular 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 Privacy Practices

The City of Columbia 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 the City of Columbia's Human Resources Department.

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 City of Columbia.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October through February 15.

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.

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2016. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form before January 31, 2017. We are also required to send a copy of your 1095-C form to the IRS.

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

If you were covered by health insurance in 2016, you will need a 1095 form from your provider or employer to complete your annual Federal tax return.

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 healthcare.gov.

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

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

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

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

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

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

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

Medicare Part D Credible Coverage

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

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

> UnitedHealthcare has determined that the prescription drug coverage offered by the City of Columbia is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

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

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

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

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