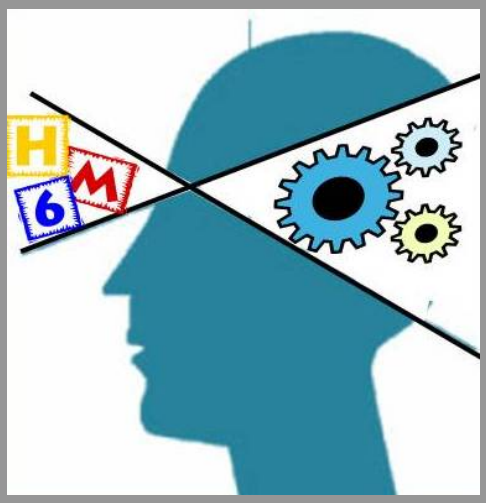
AMERICAN OPTOMETRIC ASSOCIATION®

2016 Employee Benefits Guide



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

Table of Contents

American Optometric Association

Contact Information

Contacts		
Vendors	**Member Services**	**Website / Email**
Medical: *UnitedHealthcare* Policy Number: 743593	866.633.2446	myuhc.com
Dental: *MetLife* Group Number: 5913133	800.275.4638	metlife.com
Vision: *Vision Services Plan* Group Number: 08104211	800.877.7195	vsp.com
401(k): *RPS Benefits*	855.909.4030	rpsbenefits.com
Long-Term Disability: *Mutual of Omaha*	800.877.5176	mutualofomaha.com
Flexible Spending Account (FSA): *TASC*	800.422.4661	www.tasconline.com
Employee Assistance Program (EAP): *H&H Associates*	800.832.8302	hhhealthassociates.com
Benefits Team	**Phone**	**Email**
American Optometric Association: *Wendy Harr - Assoc. Dir. Human Resources* *Jeanie Pancer - HR Administrator* *Geri Krajcir - Payroll & Pension Coordinator*	 314.983.4257 314.983.4140 314.983.4235	 wdharr@aoa.org gfpancer@aoa.org gakrajcir@aoa.org
CBIZ Benefits & Insurance Services: *Donna Clifton - Sr. Account Manager* *Rusty Besancenez - Sr. Account Executive*	314.692.2249 314.692.5812 314.995.5501	dclifton@cbiz.com rbesancenez@cbiz.com

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

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

Employees of American Optometric Association (AOA) who meet eligibility requirements are offered an employee benefit package which includes Medical, Dental, Vision, Basic Life / Accidental Death & Dismemberment (AD&D), Long-Term Disability, Flexible Spending Accounts and Employee Assistance Program.

AOA's medical plan is administered by UnitedHealthcare. This is a benefits rich health plan offering low deductibles and office visit co-pays.

The dental insurance offers two plan options through MetLife. The High Plan offers more benefits with a higher premium. The Low Plan offers reduced benefits for a lower premium.

As an employee of AOA, your Vision benefits through Vision Service Plan (VSP) are offered to you and your dependents at no cost.

Basic Life / AD&D benefits are offered through New York Life and is a benefit that AOA pays for their employees.

The long-term disability benefit is provided through Mutual of Omaha and is a benefit paid by AOA for all active, full-time employees.

For personal or work/life balance issues for you or your family, AOA offers a free confidential program through Employee Assistance Program (EAP).

This Benefit Guide provides a brief summary of all AOA'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 myuhc.com to find network providers near you.
- Ask your provider if they participate in the UnitedHealthcare Choice Plus 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 UnitedHealthcare 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.
- To estimate and compare costs, you can also go online at myuhc.com and look for "Estimate Health Plan Costs".

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

Eligibility

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- Your legal spouse
- 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?

AOA's medical plan covers newborns for up to the first 4 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 AOA'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 UnitedHealthcare Choice Plus 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 and 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 recent 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 employee 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 employee'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.

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 motived to be healthier.

Medical Insurance

UnitedHealthcare

Features	In-Network	Non-Network
Deductible (individual / family)	$500 / $1,000	$1,000 / $2,000
Coinsurance	90%	70%
Out-of-Pocket Maximum* (individual / family)	$2,500 / $5,000	$5,000 / 10,000
Office Visit PCP and Specialist	$20 / $20 Co-Pays	Deductible / Coinsurance
Preventive Benefits	$0	Deductible / Coinsurance
Inpatient Hospital	Deductible / Coinsurance	Deductible / Coinsurance
Outpatient Surgery	Deductible / Coinsurance	Deductible / Coinsurance
Urgent Care	$50 Co-Pay	Deductible / Coinsurance
Emergency Room	$100 Co-Pay	$100 Co-Pay
Retail Pharmacy	$10/35/60	$20/70/120
Mail Order Pharmacy (90 day supply)	$20/70/120	$20/70/120

Advocate4ME

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

Full Spectrum of Health Care Support

Medical Costs

Coverage	Monthly Premium	AOA Portion	Employee Portion	Employee Per Paycheck Deduction
Employee Only	$697.60	$558.08	$139.52	$64.39
Employee + Spouse	$1,869.54	$1,343.28	$526.26	$242.89
Employee + Child(ren)	$1,869.54	$1,343.28	$526.26	$242.89
Employee + Family	$1,869.54	$1,343.28	$526.26	$242.89

Care Options and When to Use Them

PRIMARY CARE

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

CONVENIENCE CARE

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

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

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 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.

URGENT CARE

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

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

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

We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

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

LAB SERVICES

If you require lab work please check to be sure the provider you are going to is in-network. Example, Lab Corp is a network provider and Quest is not. Utilizing

Quest will cause your benefits to be paid at the non-network level.

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

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.

PRESCRIPTION DRUG BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by UnitedHealthcare 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 AOA 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.

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 Designs

Features	High Plan		Low Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible:	$50	$50	$50	$50
Family Deductible:	$150	$150	$150	$150
Type I - Diagnostic/ Preventive: Exams, Cleanings (2 in 12 months)	100%	100%	100%	100%
Type II - Basic Procedures	80%	80%	80%	80%
Type III - Major Services	70%	70%	50%	50%
Surgical Extractions	80%	80%	80%	80%
Endodontics	80%	80%	80%	80%
Periodontics	80%	80%	80%	80%
Other Oral Surgery	70%	70%	50%	50%
Type IV—Orthodontia	50% to $2,000 Lifetime Max.	50% to $2,000 Lifetime Max.	Not Covered	Not Covered
Maximum Benefit/Year	$2,000	$2,000	$1,500	$1,500

Dental High Plan Costs

Coverage	Monthly Premium	AOA Portion	Employee Portion	Employee Per Paycheck Deduction
Employee Only	$46.92	$37.54	$9.38	$4.33
Employee + Spouse	$88.60	$65.46	$23.14	$10.68
Employee + Child(ren)	$104.01	$75.79	$28.22	$13.03
Employee + Family	$145.97	$103.90	$42.07	$19.42

Dental Low Plan Costs

Coverage	Monthly Premium	AOA Portion	Employee Portion	Employee Per Paycheck Deduction
Employee Only	$38.46	$30.77	$7.69	$3.55
Employee + Spouse	$72.62	$53.66	$18.96	$8.75
Employee + Child(ren)	$85.25	$62.12	$23.13	$10.68
Employee + Family	$119.66	$85.17	$34.49	$15.92

Vision Insurance

Vision Service Plan (VSP) Plan Design

Benefits/Service	In-Network
Examination	$0
Lenses: Single Bifocal Trifocal Progressive	$0
Frames	$130 allowance 20% off over allowance
Contact Lenses: Necessary Cosmetic	$145 allowance
Frequency of Service: Exam Lenses Frames Contacts (in lieu of glasses)	 Every 12 Months Every 12 Months Every 12 Months Every 12 Months

Vision benefits are offered to AOA employees and their dependents at no cost.

PLAN HIGHLIGHTS

- Offers Second Pair plan; allows you to get a second pair of glasses or contacts, in addition to those received under the core plan. Co-payment of $20.00 applies to second pair benefits.
- VDT Glasses - Corrective eyewear designed to meet specific health and vision needs of computer users.
- No ID card or claim forms to complete.

Basic Life and AD&D

AOA provides you with one times your annual salary of basic term life and AD&D insurance. Coverage is rounded to the nearest $1,000 up to a maximum of $100,000. This coverage is at no cost to you and is offered through New York Life. There is no medical underwriting for the staff life plan.

Long-Term Disability

The long-term disability benefit is provided through Mutual of Omaha.

In the event you are unable to work because you have suffered an illness or injury, AOA provides, at no cost to all active, full-time employees, a long-term disability plan. This benefit provides you with a percentage of your base monthly pay while you are deemed disabled and unable to earn a living.

If you received medical treatment (including prescription drugs), consultation or medical care during the three months prior to you 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.

The plan design includes a 180 days elimination period under which no benefits are payable until this is exhausted. After being deemed totally disabled by the treating physician for 180 days, you are eligible to receive up to 60% of your monthly salary to a monthly maximum of $10,000. An additional benefit of 10% is available if you participate in an approved rehabilitation program. 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 a two year benefit period.

The LTD benefit has always been provided to employees without a contribution towards the premium. As an employer paid benefit, if you receive a disability benefit, it is considered taxable income. To alleviate the taxable benefit, AOA will change the contribution structure to an Employee paid benefit. This change allows disability benefits to be income tax free. To compensate for the cost of your LTD benefit, the imputed amount will be added to your taxable income.

An additional benefit to the LTD 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.

Flexible Spending Accounts (FSAs)

A Flexible Spending Account allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings.

TYPES OF ACCOUNTS

MEDICAL REIMBURSEMENT ACCOUNT: This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription drug expenses that are not covered under your insurance program or that of your spouse. You may also cover dependent health care expenses through the account even if you choose single coverage. The total amount of your annual pledge is available to you up front thus reducing the risk of a large out-of-pocket expense at any one time during the plan year.

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

What does this mean for you?

- Up to $500 of your current plan funds can be carried over
- Greater flexibility and less guessing future expenses
- Does not change the maximum you can elect in a plan year
- A $500 election in a health FSA can be made without risk of losing funds at the end of the year
- No more rushing to spend down your unused funds at the end of the year

You have 90 days past the plan year to turn expenses in for reimbursement. Any excess amount remaining for a particular benefit at plan year-end will be retained by the plan with the exception of $500.

DEPENDENT CARE REIMBURSEMENT ACCOUNT: This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, “Credit for Child and Dependent Care Expenses.” Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and individuals, as long as the caregiver is not a child of yours under age 19 or anyone you can claim as a dependent for tax purposes. Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. Either may be better, depending on your personal situation. You may not use both. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

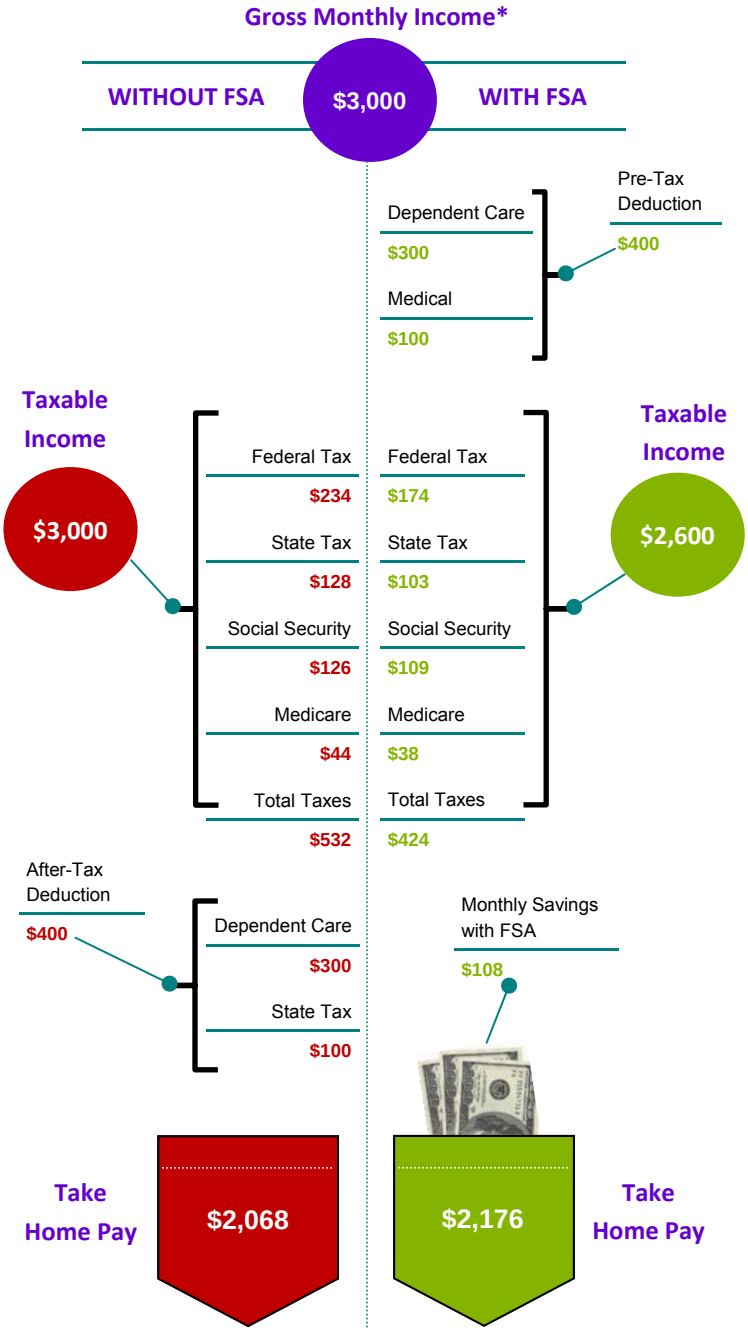
TRANSPORTATION REIMBURSEMENT ACCOUNT

This account allows you to put aside a maximum of $130 per month on a pre-tax basis to pay for work related vanpooling/transit expenses.

Maximum Contributions	
Medical Reimbursement Account	$2,550
Dependent Care Reimbursement Account	$5,000
Transportation Reimbursement Account	$1,560

American Optometric Association

How will a flexible spending arrangement save you money?



* This is an example and for illustration purposes only. Taxes are not exact and will vary.

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

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

HOW THE ACCOUNT WORKS

If you decide to participate in the FSA you should carefully consider the amount you elect to deduct from your paycheck.

You will be able to enroll on-line for the Flexible Spending Account (FSA) plan. Instructions will be sent to all employees via email. If you will not participate in the 2016 FSA, you must notify Jeanie Pancer, HR Administrator in writing or via email.

Online Access: tasconline.com
Phone: 800.422.4661

Employee Assistance Program

Through our Employee Assistance Program (EAP) contract with our service provider, H&H Associates, you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

Our EAP benefit offers confidential, short-term counseling for personal and family issues at no cost to you. The EAP provides short-term, confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns. The EAP also provides the following services to help you balance work and home life:

- Managing stress and change
- Family and relationship concerns
- Parenting issues
- Care management for aging parents
- Identifying school/college resources
- Depression and grief
- Work performance issues
- Health and wellness issues
- Lifestyle weight management
- Budgeting and debt management
- Substance abuse
- Locating child and elder care resources
- Emotional and personal conflicts
- Legal concerns
- Retirement issues
- Financial planning

H&H is an independent firm that specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. H&H professionals answer calls 24 hours a day, seven days a week. H&H's telephone number is 314-845-8302 or 1-800-832-8302. When you call the EAP, an H&H representative will answer any questions you have and set up an appointment for you. Please visit the H&H website for additional information at hhhealthassociates.com.

401(k)

The 401(k) plan is managed by RPS Benefits and includes several different funds in which to invest. The contributions to the 401(k) plan are deducted pre-tax (after tax for Roth contributions) from your paycheck. Employees are eligible to participate in the 401(k) plan upon date of hire.

Contact the Payroll & Pension Coordinator for enrollment information.

Gym Membership Reimbursement Policy

AOA encourages employees to achieve and maintain a healthy lifestyle through physical fitness. Gym membership reimbursement is available to full-time or part-time employees who have been employed for a minimum of 12 months. You will be reimbursed up to $500 per calendar year for eligible fees. These fees include enrollment, annual or monthly fees for an individual membership at a fitness center. Reimbursement is on an annual basis, regardless of membership type (monthly or annual). Please note that receipt of the gym membership reimbursement will be through your payroll check and will be less all withholding required by law. Employees should consult with a physician before beginning a physical regimen.

Tuition Assistance

AOA also offers tuition reimbursement as a part of your employee benefit package. To be eligible, you must be a full-time employee and have worked at AOA for a minimum of 1 year.

This program offers an employee up to 75% of his/her undergraduate college or graduate school tuition, up to a maximum of $2,500 per year. Employees must turn in a final grade of "C" or better in the course. Tuition assistance applies only to tuition and does not include lab fees, books, other supplies or charges. Courses taken must be offered by an accredited institution, and must be job-related and improve the knowledge/skill needed to perform employee's present job or prepare employee for future advancement.

Employee must provide AOA with proof of successful completion of course, final grade, and proof of tuition. Contact Human Resource for additional information.

Important Notices

Special Enrollment Notice

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

AOA 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 your 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 AOA.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your

monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1st through January 31st.

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

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

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

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

More Information

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

Medicaid CHIP Notice

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

If you or your children are eligible for Medicaid or CHIP and you're 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
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 plans 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 AOA 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).

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 service are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services as required under the Affordable Care Act.

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

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

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

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

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

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

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