ep Cares™

Benefits Guide

Health Insurance Solutions for Non-Union Entertainment Employees

Did you know your employer pays at least **HALF** of the lowest cost medical premium?

Login to **myepcares.com** to review or change your benefits

Look for an email from **MyEPCares@ep.com** about when, where and how to enroll.

Didn't see the email? Check your Spam/Junk folder and/or email us at **myepcares@ep.com**.

When does coverage become effective?

1st day of the month following 30 days of employment

You must be enrolled by the 27th of the prior month to get coverage

If you miss this opportunity to enroll, you will not be able to enroll unless you have a **qualifying life event** or during **open enrollment** (typically in November).

You Should Know! While the federal regulation for individuals to have health insurance was lifted in 2018, the following states require their residents to have health insurance or face penalties:

CALIFORNIA | **MASSACHUSETTS** | **NEW JERSEY** | **RHODE ISLAND** | **WASHINGTON, D.C.**

Maryland and **Vermont** have state-based individual mandates, but there are currently no penalties for failure to comply.

TABLE OF CONTENTS

FEATURED

Required Notices

See page 29 for an important notice regarding Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) and page 32 for an important notice regarding your Medicare Part D Coverage.

EP CARES™ QUICK START GUIDE

STEP 1

Log on to myepcares.com.

Your **username** and your temporary **password** will be your first name, the first initial of your last name, and the last four digits of your Social Security Number (SSN). For example:

Name: Ashley Smith
SSN: XXX-XX-6789
Username: ashleys6789
Temporary Password: ashleys6789

Please note that first-time users will be prompted to select a new password upon signing in. All passwords will be reset to the default as of 11/8/2019 for Open Enrollment.

STEP 2

The EP Cares™ Online Enrollment Portal will list your Employer's contribution amount and all plans available to you based on your home zip code. Review each one and pick a plan option that meets your specific needs.

STEP 3

Once you complete the enrollment process on the EP Cares™ Online Enrollment Portal, you will receive an email confirming your elections and the effective date of your coverage. If you are selecting a new plan(s), ID cards will be mailed to the address on record with EP Cares™. Please note there are no ID cards for Dental PPO plans.

NOTE: You must still be working for your current Employer as of the coverage effective date or your benefits will not take effect.

NOTE: Additional information on plan details, coverage options, and applicable disclosures can be found in the Summary of Benefits and Coverage (SBC) and the Summary Plan Descriptions (SPD). A paper copy is also available upon request by contacting the EP Cares™ Contact Center below.

Need Help?

Phone: 855.339.7350 | Email: myepcares@ep.com | Web: myepcares.com

VIDEO LIBRARY

New to health insurance? Looking for more information? Take advantage of our online video library at **ep.com/epc/videos**. A few of the most popular videos are listed below for your convenience.

UNDERSTANDING BENEFITS

- *What Is Open Enrollment?*
- *When Can I Make Changes to My Benefits?*
- *Everything You Need to Know About HSAs*
- *What Is the Form 1095-C?*
- *Everything You Need to Know About COBRA*

UNDERSTANDING HEALTH INSURANCE

- *What Is a Copay?*
- *What Is Coinsurance?*
- *What Is In-and Out-of Network?*
- *Premiums, Deductibles, Copays, and Out-of-Pocket Maximums*
- *What Is Dental Insurance?*

VOLUNTARY BENEFITS

- *Aflac Accident Insurance*
- *Aflac Term Life Insurance*

ELIGIBILITY

EMPLOYEES

All non-union Employees classified as benefit eligible by Employers offering EP Cares™ are eligible to enroll in EP Cares™ benefit plans.

DEPENDENTS

Eligible Employees may also enroll the following dependents:

- **Legally married spouse**
  This includes registered same-sex and opposite-sex domestic partners
- **Children up to age 26**
  This includes natural children, stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, and children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMCSO)
- **Disabled children over age 26** if unmarried, incapable of self-support, dependent on you for primary support, and the disability occurred before the age of 26

If You Cover a Dependent

To control health care costs and meet health plan contract obligations, your Employer may ask to verify family members' eligibility for enrollment in EP Cares™ benefit plans. Your Employer and the insurance carrier(s) reserve the right to request documentation (e.g., marriage and/or birth certificates) to verify eligibility.

Coordination of Benefits

If you currently receive or are eligible for benefits through your spouse or partner, it is your responsibility to check with that plan for specifics surrounding coordination of benefits.

WAITING PERIOD

New Hires

Coverage takes effect on the first day of the month following the 30-day new hire waiting period. **You must be actively employed on that day for the benefits to take effect.**

To get benefits, you must complete the enrollment process by the 27th day of the month prior to your effective date.

Example: Michael is hired on January 16. He has until February 27 to enroll in benefits, and his coverage will take effect on March 1.

Re-Hires and Eligibility

The chart on the following page illustrates break in service scenarios for those Employees who have made benefit elections and are being re-hired **within the same Controlled Group.**

If an Employee leaves one Controlled Group (parent company) and goes to work for another, the Employee would need to re-satisfy the waiting period before becoming eligible for benefits.

RE-HIRES ELIGIBILITY CHART

WITHIN THE SAME CONTROLLED GROUP (PARENT COMPANY)

Break in Service Length of Time	EE can make new benefit elections?	Waiting Period is triggered?	Eligibility Date?	Example
Break in Service < or = 30 Days	No	No	Reverts to initial Eligibility Date (considered "Continuous Employment")	Date of Hire = 3/5/15 Termination Date = 5/20/15 Re-hire = 6/2/15 **Result:** Benefit coverage will be retroactive to the first of the month in which the Re-hire date occurred. In this example, 6/1/15.
Break in Service > 30 Days, but < or = 90 Days	Yes. If benefits are desired, EE must re-enroll in benefits after a break in service of more than 30 days.	No	If the re-hire date is between the 1st and 15th of the month, the coverage will commence retroactive to the first of the month in which the re-hire date occurred. If the re-hire date is between the 16th and 31st of the month, the coverage will commence the first of the following month.	**Example One:** Date of Hire = 3/5/16 Termination Date = 5/20/16 Re-hire = 8/10/16 **Effective Coverage Date= 8/1/16** **Example Two:** Date of Hire = 3/5/16 Termination Date = 5/20/16 Re-hire = 8/22/16 **Effective Coverage Date= 9/1/16** **Result:** EE can make new benefit elections upon Re-Hire date. No waiting period invoked.
Break in Service > or = 91 Days (ACA 13-Week Break in Service)	Yes. If benefits are desired, EE must re-enroll in benefits.	Yes	Eligibility Date is the new Start Date (Considered "New Hire")	Date of Hire = 3/5/15 Termination Date = 5/20/15 Re-hire = 9/15/15 **Result:** EE can make new benefit elections upon New Hire date, but the waiting period applies. Benefit coverage commences on 11/1/15. EE can select COBRA for June, July, August, September, and October coverage.

EE = Employee

For more information on COBRA, see page 38.

TERMINATION OF BENEFITS

Your benefits may be terminated, either voluntarily or involuntarily under specific circumstances. The table below gives some common examples. Please contact EP Cares at **855.339.7350** or **myepcares@ep.com** if you have questions.

Scenario	Coverage End Date	Eligible for COBRA* benefits continuation?
You are reported as terminated, wrapped, etc. by your Employer (for any reason other than gross misconduct)	The last day of the month of your termination date	Yes
Your Employer notifies us of a change in status to a non-eligible class (e.g. move from full time to part time)	The last day of the month of your change in status date	Yes
EP is notified that you are now eligible for union benefits	The last day of the month of your termination date	No
You fail to pay your full share of the cost of benefits within the grace period (see page 11)	The last day of the month for which you fully paid for your insurance (may be retroactive to previous month)	Yes
You notify EP Cares of a Qualifying Life Event and the desire to terminate benefits (see page 12)	The last day of the month following the QLE date	No
Your employer cancels coverage with EP Cares	The last day of the month of the employer's contract with EP Cares	No

For more information on COBRA, see page 38.

MOVING BETWEEN PROJECTS

EP Cares™ is specifically tailored to the needs of non-union employees in the entertainment industry. One of the many advantages of EP Cares™ is that it provides you with consistent access to medical, dental, and vision benefits as you move between different Employers offering EP Cares™. Some geographic restrictions apply and Employer contributions may vary. In most cases, you will have access to the same benefit plan options at the same rates. See the scenarios on the following page for examples.

MOVING BETWEEN PROJECTS: SCENARIOS

SCENARIO 1: Your tenure on a project ends in March and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) within 30 days.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. Upon rehire, your benefits will be reinstated with no lapse in coverage. You will be responsible for your share of premium payments, if any.
SCENARIO 2: Your tenure on a project ends on March 10 and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) in early May.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. You will be offered the opportunity to maintain coverage through COBRA during the period of time you are between jobs. You will receive COBRA information via mail upon termination. Since your next project begins less than 13 weeks after you were terminated from the first project, you will be allowed to re-enroll in your benefits upon your first day of work in May, and your coverage will be effective in accordance with the chart on page 8.
SCENARIO 3: Your tenure on a project ends on March 10 and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) in mid-August.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. You will be offered the opportunity to maintain coverage through COBRA during the period of time you are between jobs. You will receive COBRA information via mail upon termination. Since your next project begins more than 13 weeks after you terminated from the first project, you will be required to satisfy a new hire waiting period. If you elect benefits, your coverage will be effective on the first day of the month (in this example, October 1).

TIP: What is COBRA?

COBRA is a federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the Employer used to pay, plus a small administrative fee. For more information, see page 38.

Need Help?

Phone: 855.339.7350 | Email: myepcares@ep.com | Web: myepcares.com

PLAN ENROLLMENT

NEW HIRE ENROLLMENT

Coverage takes effect on the first day of the month following 30 days from your hire date. To get benefits, you must complete the enrollment process by the 27th day of the month prior to your effective date.

Example: Libby is hired on March 16. She has until April 27 to enroll in benefits, and her coverage will take effect on May 1.

WARNING:
If you miss the new hire enrollment window, you must wait until the next Open Enrollment period or experience a Qualifying Life Event (see page 11) to enroll.

2020 OPEN ENROLLMENT

Each year, during Open Enrollment, you can add, drop, or make changes to your benefits. This year, Open Enrollment runs from **November 11 - December 3, 2019**.

If you choose not to take any action, then your existing selections (if applicable) will apply to the following year.*

New plans and/or rates will apply as of January 1.

Example: Sam selects or changes insurance coverage during Open Enrollment (November 11 - December 3, 2019). His new insurance begins on January 1.

ONLINE BENEFIT ENROLLMENT PORTAL

EP Cares™ provides you with the ability to enroll in your benefit plans online at myepcares.com.

TIP: Before you begin, please make sure you have:
- → **Social Security Number (SSN) for all legal dependents**
- → **Date of Birth (DOB) for all legal dependents**

Log in to myepcares.com:

Your **username** and your temporary **password** will be your first name, the first initial of your last name, and the last four digits of your Social Security Number (SSN). For example:

Name: Elizabeth Munoz
SSN: XXX-XX-4617
Username: elizabethm4617
Temporary Password: elizabethm4617

Please note that first-time users will be prompted to select a new password upon signing in. All passwords will be reset to the default as of 11/8/2019 for Open Enrollment.

NOTE:

Please be sure to review your confirmation statement carefully.

Check the plans, prices, and effective dates. You can log back in and make changes at any time within your enrollment window.

PAYING YOUR SHARE OF INSURANCE

Payment for your share of premiums (if any) is your responsibility. EP Cares offers payroll deductions or a billing service (depending on your employer) as a courtesy, but ultimately **it is your responsibility to ensure that your monthly premium is paid in full.**

Employees with paycheck from EP	Employees of projects with payroll outside of EP, COBRA participants
Employees who get payroll checks from EP will be set up with automatic payroll deduction for medical, dental, and vision insurance. Payroll deductions are not available for Aflac policies.*	Invoice for medical/dental/vision will be mailed to your home.* Watch for mail from our vendor Plansource. You will be responsible for sending in payment for your share of the cost of benefits.

* If enrolled in an Aflac policy, you will pay Aflac directly. Payment details provided by Aflac upon enrollment.

Grace Period for Late Payment of Premiums

If you have paid a significant portion, but not the full amount, of the premium within the Grace Period (the period between the premium due date on the first of the month and the end of the month) and the unpaid portion is not greater than the lesser of $50 or 10% of your share of the premium, your coverage will not terminate retroactively unless the amount remains unpaid for 30 days from the date you receive notice of the underpayment.

If the share of premium you have paid for the month is sufficient to pay for some, but not all of the insurance coverage in which you have enrolled yourself, spouse, and dependents, the premium payments for that month will be applied first to medical insurance, second to dental insurance, third to vision insurance, and then to any additional lines of coverage (if applicable).

If you have questions about your premium, don't see deductions on your paycheck, and/or don't receive invoices from Plansource, please contact us. *You are responsible for making sure payments for your insurance are paid on time.*

WARNING:
Failure to pay your share of premiums will result in the termination of insurance coverage through EP Cares retroactively to the last day of the month for which your share of premiums was fully paid. Full details are provided in the authorization forms you sign during the enrollment process.

MAKING CHANGES TO YOUR BENEFITS

ANNUAL OPEN ENROLLMENT

During annual Open Enrollment, you can re-evaluate and make changes to the plans you and your eligible dependents enroll in for the upcoming year. Open Enrollment for EP Cares™ typically begins in November each year.

Learn more about Open Enrollment by watching a short video.

QUALIFYING LIFE EVENTS (QLEs)

The federal government has set guidelines, referred to as Qualifying Life Events, for when you are allowed to make changes outside of Open Enrollment. Examples of QLEs are:

- **Involuntary loss of other group coverage (including loss due to reaching age 26)**
- **Marriage, legal separation, or divorce**
- **Birth or adoption of a child**
- **Change in eligibility of a child**
- **Death of a dependent family member**
- **Change in your or your spouse's/registered domestic partner's employment status**
- **Your spouse/registered domestic partner reaches age 65 and is covered by Medicare**
- **If you are moving to a different county or state, please advise. You may qualify and/or be required to make changes.**
- **FMLA special requirements**
- **HIPAA special enrollment rights**
- **Increase or reduction of hours that changes employment status**
- **Reduction in hours such that you are expected to work fewer than 30 hours per week**
- **You become eligible to enroll in an exchange or marketplace established under §1311 of the Patient Protection and Affordable Care Act**

If you experience a Qualifying Life Event, as specified by the federal government, you may make changes to your benefit elections within 31 days of the date of the QLE. Please note that any changes to the benefit plans must be consistent with the qualifying event.

MEDICAL BENEFITS AND RATES

EP Cares™ offers quality medical plans with Cigna to provide you with a variety of plan options and resources to support your health. To help you navigate the different medical plans offered, below is a broad overview of the plan options and some items to consider.

Plan Name	California	Outside California
Cigna Local+ IN $4,500	X	
Cigna Local+ IN $5,900 HDHP	X	
Cigna Open Access+ $4,500 HDHP	X	X
Cigna Open Access+ $2,500	X	X
Cigna Open Access+ IN $1,000	X	X
Cigna Open Access+ $750	X	X
Cigna Open Access+ IN $3,500 HDHP		X
Cigna Open Access+ IN $5,900 HDHP		X

What is an HDHP?

Cigna Local+ (EPO) Plans

Depending on where you reside, you may be able to enroll in a Cigna Local+ plan. These EPO plans are similar to an HMO in that services must be provided by a contracted network provider (in this case a Local+ contracted provider), in order for you to receive a benefit. No benefits are provided if you seek non-emergency care or services from a non-contracted provider. Where the plans are different from a traditional HMO is that you do not need to select a Primary Care Physician, which means you may self-refer to any other provider or specialist in the Local+ network.

For more detailed information on the Local+ network and plans, please refer to the specific plan document available on the EP Cares™ Online Enrollment Portal.

Cigna Open Access+ (OAP) Plans

Regardless of where you live, you are able to enroll in a Cigna Open Access+ (OAP) plan. An OAP plan is similar to a PPO in that services can be provided by a contracted network provider, or a non-contracted provider and you will still receive a benefit. Of course, seeing a contracted provider typically results in a lower out-of-pocket expense to you. Under the OAP, you do not need to select a Primary Care Physician, and you can self-refer to any provider.

Cigna Open Access+ IN (EPO) Plans

Regardless of where you live, you have the option of enrolling in a Cigna Open Access+ IN (OAPIN) plan. The intent of the OAPIN is to provide those production workers with a lower cost, EPO type benefit. With the OAPIN, services must be provided by a Cigna OAP contracted network provider in order for you to receive a benefit. No services are covered if you seek non-emergency care from a non-contracted provider. Under the OAPIN, you do not need to select a Primary Care Physician, and you can self-refer to any other provider in the OAP network.

Medical Benefit Summaries

Medical Benefit Summaries are available for review at **ep.com/epc**.

PLAN RATES

Your Employer pays for a portion of the total premium for the benefit plans you enroll in through a monthly defined contribution amount. **Please log on to the EP Cares™ Online Enrollment Portal for details on your Employer's defined contribution amount.**

The table below summarizes the total monthly cost BEFORE the Employer's subsidy amount is applied. Please note that you are responsible for the **difference** between your Employer's subsidy amount and the total cost of the plans you choose.

California Medical Rates [NOTE: "OA+" = "Open Access+"]

Plan	1 Local+ IN $5,900 HDHP	2 Local+ IN $4,500	3 OA+ $4500 HDHP	4 OA+ $2500	5 OA+ IN $1000	6 OA+ $750
Coverage Type	EPO HDHP	EPO	PPO HDHP	PPO	EPO	PPO
Total Premium*						
Employee	**$293**	**$371**	**$385**	**$527**	**$533**	**$557**
Employee + Spouse	**$817**	**$980**	**$1,014**	**$1,385**	**$1,408**	**$1,470**
Employee + Child(ren)	**$708**	**$851**	**$879**	**$1,207**	**$1,223**	**$1,276**
Employee + Family	**$1,151**	**$1,380**	**$1,427**	**$1,954**	**$1,981**	**$2,074**

* Figures represent full monthly premiums without employer subsidy applied.

Outside-California Medical Rates [NOTE: "OA+" = "Open Access+"]

Plan	1 Local+ IN $5,900 HDHP	2 OA+ IN $3500 HDHP	3 OA+ $4500 HDHP	4 OA+ IN $1000	5 OA+ $2500	6 OA+ $750
Coverage Type	EPO HDHP	EPO HDHP	PPO HDHP	EPO	PPO	PPO
Total Premium*						
Employee	**$359**	**$452**	**$506**	**$533**	**$610**	**$651**
Employee + Spouse	**$1,000**	**$1,263**	**$1,336**	**$1,408**	**$1,605**	**$1,720**
Employee + Child(ren)	**$866**	**$1,095**	**$1,158**	**$1,223**	**$1,397**	**$1,490**
Employee + Family	**$1,409**	**$1,780**	**$1,881**	**$1,981**	**$2,263**	**$2,423**

* Figures represent full monthly premiums without employer subsidy applied.

AFLAC ACCIDENT ADVANTAGE

Because you are eligible for EP Cares insurance, you can also purchase Aflac Accident Advantage at low group rates.

Aflac Accident Advantage pays you cash if you or a covered family member has a covered accident. It can help you pay your share of costs that aren't covered by your medical insurance. While the Aflac Accident Advantage plans can be paired with any medical plan (or with no medical plan at all), they are especially useful for people with High Deductible Health Plans.

PLEASE NOTE:

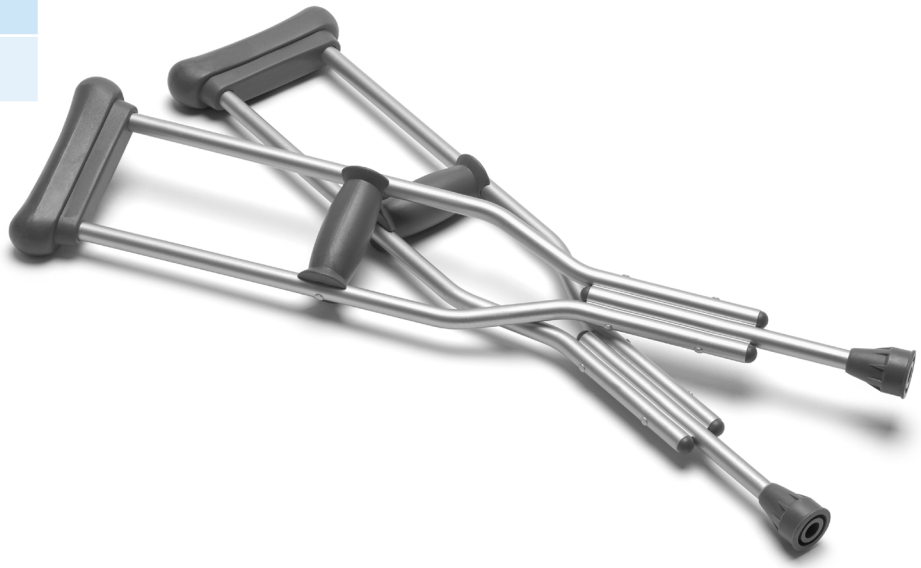
Aflac policies are individual policies. You can enroll by calling Aflac directly at **818-396-6824**, **clicking here** to schedule an appointment, or emailing **russell_nakamura@us.aflac.com**.

Payroll deductions are not available for the Aflac policies.

You may not use your Employer's contribution toward EP Cares health insurance for Aflac policies.

Unlike medical, dental, and vision insurance, Aflac plans do not automatically terminate when you leave your Employer. You may keep these plans at the same rates as long as you continue to pay your monthly premiums to Aflac.

Monthly Rates	
Employee	$22.75
Employee + Spouse	$30.68
Employee + Child(ren)	$35.49
Employee + Family	$44.72



AFLAC ACCIDENT ADVANTAGE

OFF-THE-JOB ACCIDENTAL MEANS-ONLY INSURANCE WITH A WELLNESS BENEFIT

Policy Series A36000

AA

Be Prepared for Life's Unexpected Mishaps

Accidents can happen at any time. You could suffer an accidental injury while you are working around the house or walking into work. Or your child may get injured at basketball practice. When an accident happens, it can be costly. Even with major medical insurance, there may be out-of-pocket expenses that you'll have to pay.

In the event of an unexpected injury, Aflac can help protect your personal finances. We provide individuals and families affordable insurance that helps with expenses that may not be covered by major medical insurance. Aflac pays cash benefits directly to you (unless you specify otherwise), so you can use the cash for anything you want. Which means uncovered medical expenses won't break the bank if you are injured.

And since we can process your claim quickly, Aflac helps give you the peace of mind knowing you can spend more time recovering and less time worrying about bills.

The facts say you need the protection of the Aflac Accident Advantage insurance policy:

FACT NO. 1

ABOUT **1** OUT OF **8**

PEOPLE SEEK MEDICAL ATTENTION FOR AN INJURY.[1]

FACT NO. 2

$5,600

THE AVERAGE MEDICAL EXPENSES FOR AN ACCIDENTAL INJURY.[1]

[1]*Injury Facts*, 2015 Edition, National Safety Council.

Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits for covered accidental injuries directly to you, unless assigned. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

The financial impact of an accident is often surprising. Most people have expenses after an accident they never thought of before. From out-of-pocket medical costs to a temporary loss of income, your finances may be strained. If you or a family member suffered an accidental injury, can your finances handle it?

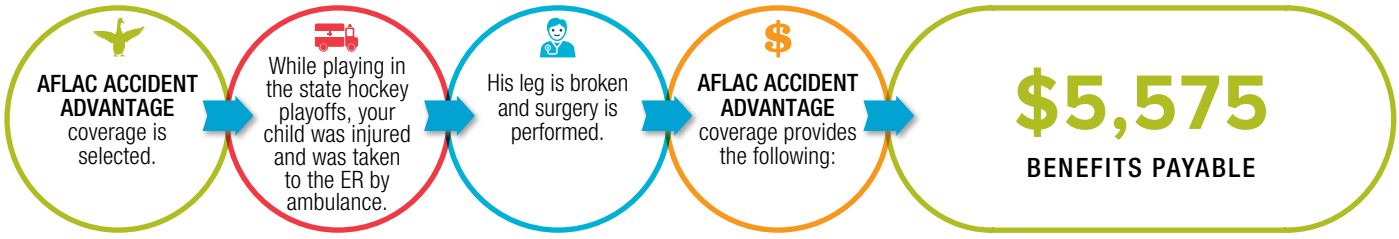
What does the Aflac Accident Advantage policy include?

- A wellness benefit payable for routine medical exams to encourage early detection and prevention.
- Benefits payable for fractures, dislocations, lacerations, concussions, burns, emergency dental work, eye injuries, and surgical procedures.
- Benefits payable for initial treatment, X-rays, major diagnostic exams, and follow-up treatments.
- Benefits payable for physical, speech, and occupational therapy.
- Daily hospitalization benefits payable for hospital stays, and additional daily benefits paid for stays in a hospital intensive care unit.

Why Aflac Accident Advantage may be the right choice for you:

- No underwriting questions to answer
- No coordination of benefits—we pay regardless of any other insurance you may have
- No network restrictions—you choose your own health care provider
- Portable—take the plan with you if you change jobs or retire

How it works



The above example is based on a scenario for the Aflac Accident Advantage that includes the following benefit conditions: Ambulance Benefit of $200 (ground ambulance transportation); Accident Treatment Benefit of $205 (hospital emergency room treatment with X-rays); Accident Specific-Sum Injuries Benefit of $1,750 (fractured leg {femur}–open reduction under anesthesia); Initial Accident Hospitalization Benefit of $1,000; Accident Hospital Confinement Benefit of $250 (hospitalized for 1 day); Major Diagnostic and Imaging Exams Benefit of $200 (CT scan); Appliances Benefit of $300 (wheelchair); Therapy Benefit of $315 (9 physical therapy treatments); Accident Follow-Up Treatment Benefit of $210 (6 follow-up treatments); Family Support Benefit of $20 (hospitalized for 1 day); Family Lodging Benefit of $125 (hospital and motel/hotel more than 50 miles from residence); and Organized Sporting Activity Benefit of $1,000.

The policy has limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the outline of coverage and policy for complete benefit details, definitions, limitations, and exclusions.

AFLAC ACCIDENT ADVANTAGE BENEFIT OVERVIEW

BENEFIT NAME	BENEFIT AMOUNT
INITIAL ACCIDENT HOSPITALIZATION BENEFIT	$1,000 when admitted for a hospital confinement of at least 18 hours or $2,000 when admitted directly to an intensive care unit of a hospital for a covered accident, per calendar year, per covered person
ACCIDENT HOSPITAL CONFINEMENT BENEFIT	$250 per day, up to 365 days per covered accident, per covered person
INTENSIVE CARE UNIT CONFINEMENT BENEFIT	Additional $400 per day for up to 15 days, per covered accident, per covered person
ACCIDENT TREATMENT BENEFIT	Payable once per 24-hour period and only once per covered accident, per covered person Hospital emergency room with X-ray: $205 Hospital emergency room without X-ray: $175 Office or facility (other than a hospital emergency room) with X-ray: $155 Office or facility (other than a hospital emergency room) without X-ray: $125
AMBULANCE BENEFIT	$200 ground ambulance transportation or $1,500 air ambulance transportation
BLOOD/PLASMA/PLATELETS BENEFIT	$200 once per covered accident, per covered person
MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT	$200 per calendar year, per covered person
ACCIDENT FOLLOW-UP TREATMENT BENEFIT	$35 for one treatment per day (up to a max of 6 treatments), per covered accident, per covered person
THERAPY BENEFIT	$35 for one treatment per day (up to a max of 10 treatments), per covered accident, per covered person
APPLIANCES BENEFIT	Benefits are payable for the medical appliances listed below: Back brace: $300 — Wheelchair: $300 — Walker: $100 Body jacket: $300 — Leg brace: $125 — Walking boot: $100 Knee scooter: $300 — Crutches: $100 — Cane: $25 Payable once per covered accident, per covered person
PROSTHESIS BENEFIT	$800 once per covered accident, per covered person
PROSTHESIS REPAIR OR REPLACEMENT BENEFIT	$800 once per covered person, per lifetime
REHABILITATION FACILITY BENEFIT	$150 per day
HOME MODIFICATION BENEFIT	$3,000 once per covered accident, per covered person
ACCIDENT SPECIFIC-SUM INJURIES BENEFITS	Pays benefits for the treatments listed below: DISLOCATIONS ..... $100–$3,750 BURNS ..... $125–$12,500 SKIN GRAFTS ..... 50% of the burns benefit amount paid for the burn involved EYE INJURIES Surgical repair ..... $300 Removal of foreign body by a physician .. $65 LACERATIONS Not requiring sutures ..... $35 Less than 5 centimeters ..... $65 At least 5 cm but not more than 15 cm . $250 Over 15 centimeters ..... $500 FRACTURES ..... $125–$3,500 CONCUSSION (brain) ..... $150 EMERGENCY DENTAL WORK Broken tooth repaired with crown ..... $400 Broken tooth resulting in extraction ..... $130 COMA ..... $12,500 PARALYSIS Quadriplegia ..... $12,500 Paraplegia ..... $6,250 Hemiplegia ..... $4,750 SURGICAL PROCEDURES ..... $200–$1,250 MISCELLANEOUS SURGICAL PROCEDURES ..... $120–$300 PAIN MANAGEMENT (NON-SURGICAL) Epidural $100

ACCIDENTAL-DEATH BENEFIT	Common-Carrier Accident	Other Accident	Hazardous Activity Accident
INSURED	$150,000	$40,000	$10,000
SPOUSE	$150,000	$40,000	$10,000
CHILD	$25,000	$10,000	$5,000

ACCIDENTAL-DISMEMBERMENT BENEFIT	$300–$40,000
WELLNESS BENEFIT	$60 once per calendar year
FAMILY SUPPORT BENEFIT	$20 per day (up to 30 days), per covered accident
ORGANIZED SPORTING ACTIVITY BENEFIT	Additional 25% of the benefits payable, limited to $1,000 per policy, per calendar year
CONTINUATION OF COVERAGE BENEFIT	Waives all monthly premiums for up to two months, if conditions are met
TRANSPORTATION BENEFIT	$600 per round trip, up to 3 round trips per calendar year, per covered person
FAMILY LODGING BENEFIT	$125 per night, up to 30 days per covered accident

REFER TO THE OUTLINE OF COVERAGE AND POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

AFLAC TERM LIFE INSURANCE

Because you are eligible for EP Cares insurance, you can also purchase Aflac Term Life Insurance at low group rates. Term Life Insurance pays a cash benefit to your designated loved ones if something happens to you.

PLEASE NOTE:

Aflac policies are individual policies. You can enroll by calling Aflac directly at **818-396-6824**, **clicking here** to schedule an appointment, or emailing **russell_nakamura@us.aflac.com**.

Payroll deductions are not available for the Aflac policies.

You may not use your Employer's contribution toward EP Cares health insurance for Aflac policies.

Unlike medical, dental, and vision insurance, Aflac plans do not automatically terminate when you leave your Employer. You may keep these plans at the same rates as long as you continue to pay your monthly premiums to Aflac.

AFLAC LIFE SOLUTIONS

INDIVIDUAL TERM LIFE INSURANCE

Policy Series A68000

LS[T]

Is your family protected if something happens to you?

If something happens to you, will your family have the funds to pay the bills without your income? Make sure you've done all you can to help protect their way of life by having an Aflac individual term life insurance policy that will help your loved ones through the tough times. Our coverage offers a measure of stability you and your loved ones can count on.

Face Amounts

If you're **age 50 or under,** you may apply for up to **$500,000** in coverage.[1]

If you're **between the ages of 51 and 68**, you may be eligible for up to $200,000 in life insurance protection.[1]

Aflac also offers the option of guaranteed-issue[2] 10-year, 20-year, or 30-year term life coverage with a face amount of **$20,000**. That means you do not have to complete a medical questionnaire.

Issue Ages

COVERAGE TYPE	ISSUE AGES	COVERAGE TYPE	ISSUE AGES
10-year term life plan	18-68	Spouse 10-year term life rider	18-68
20-year term life plan	18-60	Spouse 20-year term life rider	18-60
30-year term life plan	18-50	Spouse 30-year term life rider	18-50

The facts say you need the protection of the Aflac Individual Term Life insurance plan:

FACT NO. 1

105 Million

AMERICANS AGE 18+ DO NOT HAVE LIFE INSURANCE.[3]

FACT NO. 2

30%

OF ADULTS IN THE U.S. (ABOUT 70 MILLION) ACKNOWLEDGE THEIR NEED FOR MORE LIFE INSURANCE.[3]

[1]Certain face amounts may not be available. Underwriting requirements apply.
[2]Subject to certain conditions.
[3]2015 Insurance Barometer Study, LIMRA, February 2015.

Understand the difference Aflac can make in your financial security.

For almost 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. Our term life insurance policies are just another way to help make sure you're well protected.

How we can help

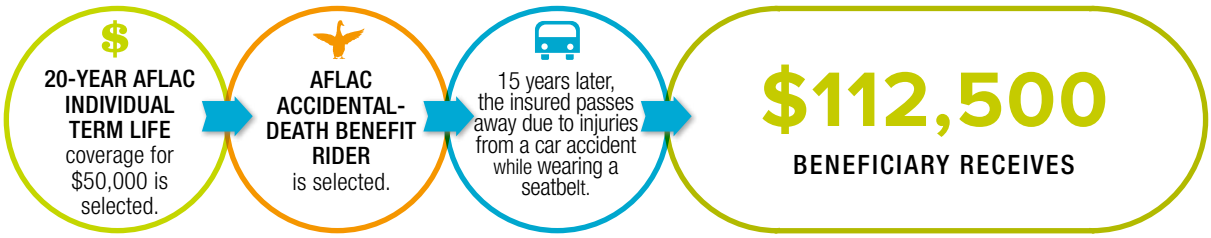
No one likes to think he or she needs life insurance. But when people depend on you, assuring their financial futures with life insurance benefits is simply the right thing to do.

- **Premiums are guaranteed for the selected term option** – You will know how much your coverage will cost from month to month and year to year.
- **Portable** – You can take the plan with you if you change jobs or retire.
- **Payroll deduction** – Your premiums can be deducted from your paycheck.

Why choose Term Life insurance?

- **Higher face amount** – Term life insurance offers the most face amount coverage for the lowest cost.
- **Lower premiums** – Depending on your age and smoking status, term life premiums may be lower than those for whole life insurance policies.
- **Flexible coverage** – Provides protection for a specified time period or term– 10, 20, or 30 years–and is designed for temporary circumstances. Term coverage often is purchased by those who need coverage for a specific time period, such as while they have young children, children in college, or are carrying a large debt load.
- **Policy renewal** – If, at the end of your 20-year or 30-year term, your policy has not lapsed and is still in force, you will have the option to renew your policy on an annual basis.

How it works



The above example is based on a scenario for 20-year term life insurance that includes the following benefit conditions: $50,000 death benefit, $50,000 accidental death benefit, and $12,500 seatbelt benefit.

The policy and riders have limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the policy and riders for complete definitions, benefit details, limitations, and exclusions. The policy prevails if interpretation of this material varies.

HOW MUCH LIFE INSURANCE DO I NEED?

Aflac is here to help you determine the life insurance coverage amount that's right for you.

Our assessment can help you determine how much life insurance you may need to help cover your family's immediate needs, such as funeral expenses, to their long-term need to sustain their current lifestyle.

Life insurance needs worksheet:

IMMEDIATE NEEDS

FINAL EXPENSES
Costs associated with your burial/funeral, uninsured medical costs, estate taxes/probate, etc. $ _____

OUTSTANDING DEBT
Mortgage/rent, car loans, credit cards, and other personal debt + $ _____

LONG-TERM NEEDS

You may want to replace your income for the period of time until your children are independent, or the number of years until your spouse retires. If so, take into account the number of years your family may continue to rely on your income.

REPLACEMENT INCOME
Your annual income to be replaced: No. of years to replace income:

$ _____ X _____ = $ _____

EDUCATION FUND
If you have children (or plan to), life insurance can help with their future education costs + $ _____

AVAILABLE ASSETS

SAVINGS AND INVESTMENTS
Bank accounts (checking/savings), money market, CDs, stocks, bonds, mutual funds, annuities, and social security survivor/child benefit - $ _____

RETIREMENT SAVINGS
IRAs, 401(k)s, SEP plans, SIMPLE IRA plans, Keoghs, pensions, and profit sharing plans - $ _____

PRESENT AMOUNT OF LIFE INSURANCE
Other group life policies through employer and/or individual life policies - $ _____

ESTIMATED AMOUNT OF LIFE INSURANCE NEEDED = $ _____

AMOUNT OF AFLAC LIFE INSURANCE ACTUALLY APPLIED FOR: $ _____

The amount indicated on the brochure may not match the coverage amount ultimately issued by Aflac.

AFLAC LIFE SOLUTIONS

INDIVIDUAL TERM LIFE INSURANCE

DID YOU KNOW?

Laying a loved one to rest costs the average family

$8,000-$10,000.[4]

WHAT IS COVERED?

ACCELERATED DEATH PAYMENT – PRIMARY INSURED ONLY	Aflac will pay 50 percent of the face amount selected if the named insured is diagnosed with a terminal condition. The payment can help you and your loved ones with the expenses of a terminal condition (such as home nursing care, special equipment, and hospitalization). This benefit will be paid only once. The Accelerated Death Payment will be payable immediately upon receipt of due proof of a terminal condition. Any Accelerated Death Payment will automatically establish a lien against the policy. Aflac shall hold the lien as a debt against the death benefit and policy benefits. Any Accelerated Death payment amount requested will be reduced by the amount of any due and unpaid premiums, and the administrative charge.
CONVERSION	You may convert the policy while it is in force to an individual permanent life policy without evidence of insurability, subject to policy requirements. The conversion privilege in the term policies must be exercised the earlier of the end of the term period, or on or before the policy anniversary date following your 65th birthday. Refer to the exact policy for complete details.

OPTIONAL RIDERS

SPOUSE 10-YEAR, 20-YEAR, OR 30-YEAR TERM LIFE INSURANCE RIDER[5]	Aflac will pay 50 percent of the policy's face amount up to a maximum of $50,000 for life insurance coverage on the named insured's spouse.
CHILD TERM LIFE INSURANCE RIDER[5]	Aflac will pay 25 percent of the policy's face amount up to a maximum of $15,000 for life insurance coverage for each insured child up to age 25. To become insured, the child must be at least 14 days old and younger than 18 years old at the time of application. Insurance on each newborn child will become effective on the later of: (1) the date the child attains the age of 14 days, or (2) the date the child is first released from the hospital after birth.
WAIVER OF PREMIUM BENEFIT RIDER[6] (ISSUE AGES 18–59) – PRIMARY INSURED ONLY	Policy premiums will be waived if you become totally disabled under the terms of the policy. Please refer to the Limitations and Exclusions for more information.
ACCIDENTAL-DEATH BENEFIT RIDER (PRIMARY INSURED ONLY)	Aflac will pay an additional amount equal to the face amount selected if your death is the result of a covered accident and occurs within 180 days of the covered accident. Also, we will pay an additional 25 percent of the face amount selected if your death is the result of an automobile accident while you were wearing an unaltered, properly fastened seatbelt installed by the manufacturer, and you were not at fault for the accident, according to the police report. Please refer to the Limitations and Exclusions for more information.

[4]National Funeral Directors Assoc., *Trends and Statistics*, 2014, http://nfda.org/about-funeral-service-/trends-and-statistics.html
[5]Optional riders are not guaranteed-issue. Underwriting requirements apply.
[6]Rider not available if applying for a guaranteed-issue policy.

DENTAL BENEFITS AND RATES

Through EP Cares™, your Employer is offering a choice of two dental plans: a Cigna Dental DHMO and a Cigna Dental PPO.

Learn more about Dental Insurance by watching a short video.

Dental Benefit Summaries are available for review at ep.com/epc.

	Dental HMO	Dental PPO
Must select in-network dentist	Yes	No
Out-of-network benefits available (at a higher cost)	No out-of-network coverage	Yes
Deductible applies	No	Yes
Orthodontics	Some coverage	No
Annual Maximum Benefit	Unlimited	$1,000 – $1,500
Available in all areas	No	Yes
ID Cards issued	Yes	No. Your provider will use your SSN to confirm enrollment.
Dental Plan Rates*		
Employee	**$14.36**	**$47.58**
Employee + Spouse	**$28.72**	**$97.08**
Employee + Child(ren)	**$28.72**	**$102.34**
Family	**$46.68**	**$155.55**

* Figures represent full monthly premiums without Employer subsidy applied.

VISION BENEFITS AND RATES

Through EP Cares™, your Employer is offering Cigna's National Vision Plan. The plan allows you to seek care or services from either a vision contracted network provider or a non-contracted provider and still receive a benefit. Seeing a contracted provider typically results in a lower out-of-pocket expense to you.

Generally, you can get a routine eye exam and an eyeglass lens allowance every 12 months. You can opt for contact lens allowance in lieu of eyeglass lenses and frames. The vision plan covers an eyeglass frame retail allowance every 24 months. See plan summary for more information.

Vision Benefit Summaries are available for review at ep.com/epc.

Vision Plan Rates*	
Employee	**$11.73**
Employee + Spouse	**$23.43**
Employee + Children	**$23.67**
Family	**$37.79**

* Figures represent full monthly premiums without Employer subsidy applied.

LEGALZOOM

LegalZoom is the nation's leading provider of personalized, online legal solutions and legal documents for small business and families.

Through our affiliate program with LegalZoom, you can **get 15% off most LegalZoom services**.

LegalZoom is not legal insurance. If you need legal assistance, LegalZoom may be useful to you through their self-guided services or their network of independent attorneys.

Payments for LegalZoom services are made directly by the user to LegalZoom. You may not use your Employer's contribution toward EP Cares health insurance toward LegalZoom services.

legalzoom®

Business Formation

Limited Liability Company (LLC)
Corporation
Doing Business As (DBA)
View all

Wills and Trusts

Last Will & Testament
Living Trust
Estate Plan
View all

Intellectual Property

Trademarks
Patents
Copyrights
View all

Speak with an Attorney

Legal Plans
Attorney Directory
Schedule a call with an Attorney
View all

MDLIVE

Your employer has selected MDLIVE to provide you with 24/7/365 access to board-certified primary-care doctors and pediatricians by secure video, phone or e-mail. Simply pay the applicable in-network copay, deductible, or coinsurance.

Whether you are at home, at work, traveling, or simply want the most convenient way to see a doctor, MDLIVE is easy to use and available on your schedule anytime, anywhere. Our service is secure, confidential, and compliant with all medical privacy regulations.

To get started and make an appointment, call toll-free 1-888-726-3171 or visit **mdlive.com/epcares**

When should I use MDLIVE?

If you're considering the ER or urgent care for a non-emergency medical issue

Your primary care physician is not available

At home, traveling or at work

24/7/365, even holidays!

What can be treated?

- Allergies
- Cold and Flu
- Respiratory Infection
- Asthma
- Ear Infections
- Sinus Problems
- Bronchitis
- Joint Aches and Pain
- And More!

Who are our doctors?

Our doctors practice primary care, pediatrics, family and emergency medicine, and have incorporated MDLIVE into their practice to provide convenient access to quality care.

Get Started Today

Register onllne or by phone	Complete medical history	Request a consultation
Register online anytime by visiting mdllve.com/epcares You will need to enter your first name, last name, gender, date of birth and your Cigna Customer ID#.	Just complete your medical history during registration.	Simply pay the applicable in-network copay, deductible or coinsurance. MDLIVE staff is available 24/7/365 by online video or phone!

Get Started NOW

mdlive.com/epcares or **888.726.3171**

EMPLOYEE ASSISTANCE PROGRAM (EAP)

HOW CAN WE HELP YOU TODAY?

The Cigna Employee Assistance Program (EAP) has you covered.

As an employee of EP Cares, you have access to the valuable Cigna Employee Assistance Program (EAP) at no cost to you.

EAP personal advocates will work with you and your household family members to help you resolve issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more.

Take advantage of a wide range of services offered at no cost to you

- **3** face-to-face counseling sessions with a counselor in your area, as well as video-based sessions.
- **Legal assistance:** 30-minute consultation with an attorney, face-to-face or by phone.*
- **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.
- **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.
- **Identity theft:** 60-minute consultation with a fraud resolution specialist.

We're here to listen. Contact us any day, anytime.

Call 877-622-4327
Or log in to myCigna.com.
Employer ID: epcares
(Needed for initial registration only)
If already registered on myCigna.com, simply log in and go to the EAP link under the Review My Coverage tab.

Together, all the way.®

Cigna®

*Employment-related legal issues are not covered.

Some work/life services offered under the Cigna Employee Assistance Program may be provided by a Cigna contracted third-party vendor.

HEALTH SAVINGS ACCOUNT (HSA)

Certain high deductible health plans are designed to be compatible with a Health Savings Account (HSA) to give you more control over how your health care dollars are spent. Federal legislation allows you to reduce your taxable income by contributing funds into an HSA. You may then use the funds to pay for qualified health care expenses. Please refer to the table below for IRS imposed annual maximums. If you do not use all of the money in your HSA in a given calendar year, the remaining money "rolls over" for use in future years.

2020 IRS Maximum Contribution Amounts		
	Individual	**$3,550**
	Family	**$7,100**

Individuals age 55 and over may contribute an additional $1,000 per year in catch-up contributions.

Several of the medical plans offered through EP Cares™ are marked as HDHP. To take advantage of the tax savings available via an HSA, enroll in one of these HDHP plan options.

You may then open an HSA at the bank of your choice. Most HSA providers offer a debit card so you can pay for provider services and prescriptions directly from your HSA. Since an HSA operates as a personal bank account, you are responsible for contributing and managing funds in your HSA.

Want to learn more? Watch a quick video:
Everything You Need to Know about HSAs

TIP: HSA Accounts

An HSA functions much like a regular bank account, except that the funds in the account can only be used for qualified medical expenses. The money in the HSA is yours to keep. There is no "use it or lose it" timeframe for HSA funds. You may use the funds at any time for qualified medical expenses. Just like a regular bank account, you can contribute funds to the HSA throughout the year, so long as you are enrolled in a qualified High Deductible Health Plan (HDHP).

IMPORTANT! SAVE YOUR RECEIPTS

Be sure to save all of your receipts for expenses related to your HSA account in case you are later asked by the IRS to justify your expenses.

CONTACT INFORMATION

EP CARES CONTACT CENTER

M-F, 5:00 AM - 8:00 PM (Pacific Time)
855.339.7350
myepcares@ep.com

- General information
- Password resets
- Inquiries about how much your employer pays toward the cost of benefits
- Address changes

CIGNA PRE-ENROLLMENT LINE

800.564.7642
Be sure to reference “EP Cares” when calling

- Specific information on medical, dental, or vision plan details
- Questions about doctors, networks
- Questions about what is covered under the plans

AFLAC

877.452.6994
Be sure to reference “EP Cares” when calling

LEGAL ZOOM

www.legalzoom.com/aff/epcares

Benefits highlighted in this guide are governed by EP Cares™ plan contracts and policies, applicable state and federal law, and company policy. In the event of a conflict, the policies, contracts, and applicable laws govern. EP Cares™ reserves the right to alter, amend, or terminate any of the benefits described in this guide at any time.

Required Notices

See page 08 for an important notice regarding your Medicare Part D Coverage.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid
myalhipp.com
T: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
myakhipp.com
T: 1-866-251-4861
E: CustomerService@MyAKHIPP.com
Medicaid Eligibility
dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
www.myarhipp.com
T: 1-855-MyARHIPP (855-692-7447)

COLORADO – Medicaid
Health First Colorado
healthfirstcolorado.com
T: 1-800-221-3943 / State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711

FLORIDA – Medicaid
flmedicaidtplrecovery.com/hipp/
T: 1-877-357-3268

GEORGIA – Medicaid
dch.georgia.gov/medicaid - Click on Health Insurance
Premium Payment (HIPP)
T: 1-404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
in.gov/fssa/hip/
T: 1-877-438-4479
All other Medicaid
indianamedicaid.com
T: 1-800-403-0864

IOWA – Medicaid
dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
T: 1-888-346-9562

KANSAS – Medicaid
kdheks.gov/hcf
T: 1-785-296-3512

KENTUCKY – Medicaid
chfs.ky.gov/dms
T: 1-800-635-2570

LOUISIANA – Medicaid
dhh.louisiana.gov/index.cfm/subhome/1/n/331
T: 1-888-695-2447

MAINE – Medicaid
maine.gov/dhhs/ofi/public-assistance/index.html
T: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
mass.gov/eohhs/gov/departments/masshealth/
T: 1-800-862-4840

Required Notices

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

MINNESOTA – Medicaid
mn.gov/dhs/people-we-serve/seniors/healthcare/health-care-programs/programs-and-services/medical-assistance.jsp
T: 1-800-657-3739

MISSOURI – Medicaid
dss.mo.gov/mhd/participants/pages/hipp.htm
T: 1-573-751-2005

MONTANA – Medicaid
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
T: 1-800-694-3084

NEBRASKA – Medicaid
ACCESSNebraska.ne.gov
T: 1-855-632-7633

NEVADA – Medicaid
dhcfp.nv.gov
T: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
dhhs.nh.gov/ombp/nhhpp/
T: 1-603-271-5218; Medicaid Service Center: 1-888-901-4999

NEW JERSEY – Medicaid and CHIP
(Medicaid) state.nj.us/humanservices/dmahs/clients/medicaid/
T: (Medicaid) 1-609-631-2392
(CHIP) www.njfamilycare.org
T: (CHIP) 1-800-701-0710

NEW YORK – Medicaid
health.ny.gov/health_care/medicaid/
T: 1-800-541-2831

NORTH CAROLINA – Medicaid
dma.ncdhhs.gov
T: 1-919-855-4100

NORTH DAKOTA – Medicaid
nd.gov/dhs/services/medicalserv/medicaid
T: 1-844-845-4825

OKLAHOMA – Medicaid and CHIP
insureoklahoma.org
T: 1-888-365-3742

OREGON – Medicaid
healthcare.oregon.gov/Pages/index.aspx
(Spanish) oregonhealthcare.gov/index-es.html
T: 1-800-699-9075

PENNSYLVANIA – Medicaid
dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
T: 1-800-692-7462

RHODE ISLAND – Medicaid
eohhs.ri.gov
T: 1-855-697-4347

SOUTH CAROLINA – Medicaid
scdhhs.gov
T: 1-888-549-0820

SOUTH DAKOTA - Medicaid
dss.sd.gov
T: 1-888-828-0059

TEXAS – Medicaid
gethipptexas.com
T: 1-800-440-0493

UTAH – Medicaid and CHIP
(Medicaid) medicaid.utah.gov
(CHIP) health.utah.gov/chip
T: 1-877-543-7669

VERMONT– Medicaid
greenmountaincare.org
T: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
(Medicaid) www.coverva.org/programs_premium_assistance.cfm
T: (Medicaid) 1-800-432-5924
(CHIP) www.coverva.org/programs_premium_assistance.cfm
T: (CHIP) 1-855-242-8282

WASHINGTON – Medicaid
hca.wa.gov/free-or-low-cost-health-care/programadministration/premium-payment-program
T: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
mywvhipp.com
T: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
dhs.wisconsin.gov/publications/p1/p10095.pdf
T: 1-800-362-3002

WYOMING – Medicaid
wyequalitycare.acs-inc.com
T: 1-307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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

Required Notices

Important Notice from the Company About Your Prescription Drug Coverage and Medicare under the Creditable Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drugvcoverage with the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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

2. The Company has determined that the prescription drug coverage offered by the Creditable Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

   Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period, you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs

Required Notices

Important Notice From the Company About Your Prescription Drug Coverage and Medicare Under the Creditable Plan(s)
CONTINUED

of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed at the beginning of this document.

Coordinating Other Coverage with Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Company Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Company Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or Web address listed below.

If you do decide to join a Medicare drug plan and drop your prescription drug coverage with the Company, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage...

Contact the Plan Administrator for further information. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Company changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

Required Notices

HIPAA Notice of Privacy Policy and Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official), and will be posted on any website maintained by the Company that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

→ TREATMENT

Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

→ PAYMENT

Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

→ HEALTH CARE OPERATIONS

The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Required Notices

HIPAA Notice of Privacy Policy and Procedures CONTINUED

Other Uses and Disclosures of Your PHI Not Requiring Authorization

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

→ TO THE PLAN SPONSOR

The Plan may disclose PHI to the employers (such as the Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.

→ TO THE PLAN'S SERVICE PROVIDERS

The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.

→ REQUIRED BY LAW

The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

→ FOR PUBLIC HEALTH ACTIVITIES

The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

→ FOR HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

→ RELATING TO DECEDENTS

The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

→ FOR RESEARCH PURPOSES

In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

→ TO AVERT THREAT TO HEALTH OR SAFETY

In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

→ FOR SPECIFIC GOVERNMENT FUNCTIONS

The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to Have an Opportunity to Object

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Required Notices

HIPAA Notice of Privacy Policy and Procedures CONTINUED

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

→ TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES

You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

→ TO CHOOSE HOW THE PLAN CONTACTS YOU

You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

→ TO INSPECT AND COPY YOUR PHI

Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

→ TO REQUEST AMENDMENT OF YOUR PHI

If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

→ TO FIND OUT WHAT DISCLOSURES HAVE BEEN MADE

You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed on the first page of these notices. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Required Notices

HIPAA Notice of Privacy Policy and Procedures CONTINUED

Contact Person for Information, or to Submit a Complaint

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see first page). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

Women's Health and Cancer Rights Notice

The Company is required by law to provide you with the following notice:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Company's plan(s) provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

Required Notices

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP). Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment by the HIPAA Special Enrollment Deadline after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

The Company's plan(s) provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

Michelle's Law Notice

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began;

or

- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Required Notices

Continuation Coverage Rights Under COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within the COBRA Qualifying Event Period from the qualifying event. Provide this notice to the COBRA Plan Administrator.

Required Notices

Continuation Coverage Rights Under COBRA CONTINUED

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under the **Employee Retirement Income Security Act** (ERISA), including COBRA, the **Patient Protection and Affordable Care Act**, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **healthcare.gov**.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.