BENEFITS GUIDE

An overview of the wide array of benefits provided by CHRISTENSEN GROUP INSURANCE, to help you enjoy increased well-being and financial security

PREPARED BY CHRISTENSEN GROUP, INC FOR Christensen Group Insurance

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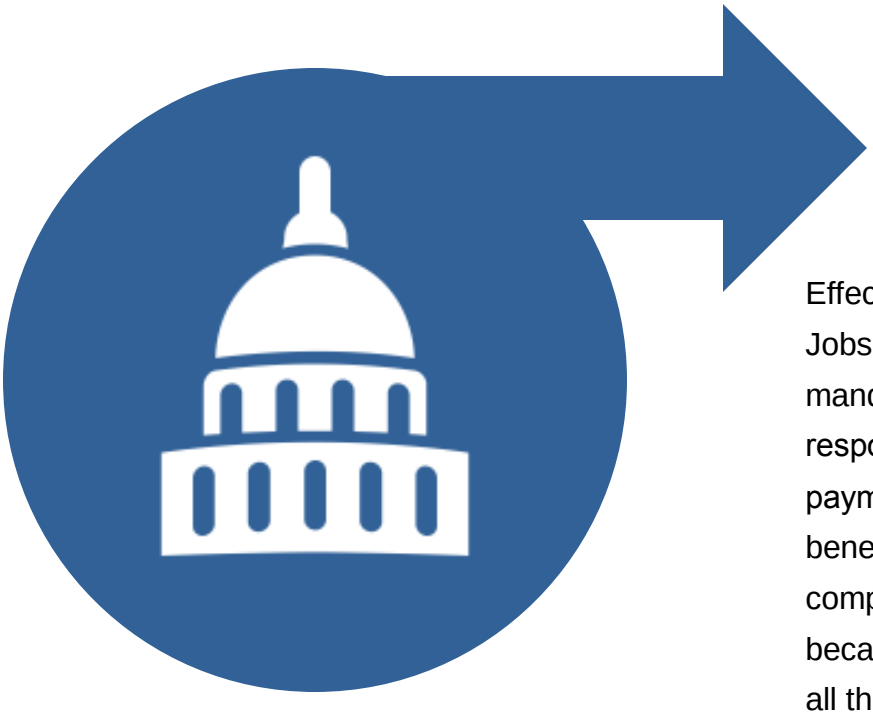
INTRODUCTION

As an employee of Christensen Group Insurance enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization.

For the 2021 plan year, Christensen Group Insurance has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and Christensen Group Insurance is offering an overall benefits package that can be shaped and molded by you to fit your needs.

This benefits booklet is a summary description of your Christensen Group Insurance benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment.

We hope this benefits booklet, along with our additional communication and decision-making tools, will help you make the best health care choices for you and your family.



UPDATE ON HEALTH CARE REFORM

Effective January 1, 2019 the Tax Cuts and Jobs Act (TJCA) repealed the individual mandate to maintain health insurance or be responsible for a “shared responsibility payment”. We hope to keep offering these benefits as a valuable part of your total compensation in the future. However, because we offer you coverage that satisfies all the health reform requirements, you will not qualify for any federal assistance to purchase an individual or family policy on the open market (the “marketplace”).

OVERVIEW OF BENEFITS

CHANGES AND QUALIFYING EVENTS

WHEN COVERAGE BEGINS AND ENDS

Your coverage under the benefits plans will end if you no longer meet the eligibility requirements, your contributions are discontinued or the Group Insurance Policy is terminated.

QUALIFYING EVENTS

- Eligible employees may enroll or make changes to their benefits elections during the annual open enrollment period. As with most benefits, once you elect an option you are bound to that choice for the entire plan year unless you experience a “Qualifying Event”. These may include, but are not limited to:
  - Changes in employment status
  - Changes in legal marital status
  - Changes in number of dependents
  - Taking an unpaid leave of absence
  - Dependent satisfies or ceases to satisfy eligibility requirement
  - Family Medical Leave Act (FMLA) leave.
  - A COBRA-qualifying event
  - Entitlement to Medicare or Medicaid
  - A change in the place of residence of the employee, resulting in the current carrier not being available

MEDICAL PLAN

KEY TERMS TO REMEMBER

ANNUAL DEDUCTIBLE

The amount you have to pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

OUT-OF POCKET MAXIMUM

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible*, copays and coinsurance

*Except for Grandfathered medical plans

COPAYS AND COINSURANCE

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount, and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service, and is generally billed to you after the health insurance company reconciles the bill with the providers.

PLAN TYPES

- EPO/PPO – A network of doctors, hospitals, and other health care providers
- HMO – A network that requires you to select a Primary Care Physician (PCP) who coordinates your health care
- POS – Combines aspects of a PPO and HMO
- HDHP – A plan that has higher annual deductibles in exchange for lower premiums.

MEDICAL PLAN

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations. Through the plans offered by Christensen Group Insurance , all covered individuals and family members are **eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.**

WHICH PREVENTIVE CARE SERVICES ARE COVERED?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

"AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE"

- **Routine Physical Exam**
- **Well Baby and Child Care**
- **Well Woman Visits**
- **Immunizations**
- **Routine Bone Density Test**
- **Routine Breast Exam**
- **Routine Gynecological Exam**
- **Screening for Gestational Diabetes**
- **Obesity Screening and Counseling**
- **Routine Digital Rectal Exam**
- **Routine Colonoscopy**
- **Routine Colorectal Cancer Screening**
- **Routine Prostate Test**
- **Routine Lab Procedures**
- **Routine Mammograms**
- **Routine Pap Smear**
- **Smoking Cessation Programs**
- **Health Education/Counseling Services**
- **Health Counseling for STDs and HIV**
- **Testing for HPV and HIV**
- **Screening and Counseling for Domestic Violence**

MEDICAL PLAN

Pick your plan.

	MN 2800-20% HSA	MN 5250-20% HSA	MN 3000-$30 NON-HSA
Deductible	$2,800 $5,600	$5,250 $10,500	$3,000 $9,000
Out-of-pocket maximum	$5,600 $11,200	$5,950 $11,900	$5,000 $10,000

Note: Under all plans, hospital services are 80% covered after the deductible

COPAYS

$30 Office visits
$12 Generic Rx
$50 Preferred Brand Rx
$90 Non-Preferred Brand Rx

MEDICA®

MEDICAL PLAN

Your monthly cost.

Network: Vantage Plus

TIER	MN 2800-20% HSA	MN 5250-20% HSA	MN 3000-$30 NON-HSA
Employee	$9.82	$0.00	$98.38
Employee + Spouse	$450.50	$356.23	$636.49
Employee + Children	$279.63	$194.34	$447.90
Family	$589.04	$463.34	$837.02

VantagePlus has providers you know and trust from M Health Fairview, North Memorial, and many other popular independent clinics. You can see any doctor in this network at any time without a referral.

MEDICAL PLAN

Your monthly cost.

Network: Ridgeview Community

TIER	MN 2800-20% HSA	MN 5250-20% HSA	MN 3000-$30 NON-HSA
Employee	$9.82	$0.00	$98.38
Employee + Spouse	$419.74	$327.56	$601.59
Employee + Children	$251.80	$168.39	$416.33
Family	$548.02	$425.11	$790.49

Ridgeview Community Network gives you choices from any doctor, clinic or facility from 40 primary care clinics and 6 hospitals within the network, you don't need a referral.

MEDICAL PLAN

Your monthly cost.

Network: Park Nicollet First

TIER	MN 2800-20% HSA	MN 5250-20% HSA	MN 3000-$30 NON-HSA
Employee	$0.00	$0.00	$81.76
Employee + Spouse	$419.74	$327.56	$601.59
Employee + Children	$251.80	$168.39	$416.33
Family	$548.02	$425.11	$790.49

Park Nicollet Network includes Park Nicollet Methodist Hospital and St. Francis Regional Medical Center. Park Nicollet First network providers must specifically direct you to receive care at a hospital.

MEDICAL PLAN

Your monthly cost.

Network: Passport

TIER	MN 2800-20% HSA	MN 5250-20% HSA	MN 3000-$30 NON-HSA
Employee	$83.07	$33.19	$181.48
Employee + Spouse	$604.34	$499.59	$810.99
Employee + Children	$418.81	$324.04	$605.78
Family	$794.16	$654.48	$1,069.69

Medica Choice Passport gives you access to a large, national network and the freedom to see any provider at any time.

MEDICAL PLAN

CG's monthly cost.

TIER	MONTHLY COST
Employee	$649.50
Employee + Spouse	$934.00
Employee + Children	$973.00
Family	$1,257.00

Spousal surcharge: $300 per month charge if your spouse is on the CG plan when they could be on their own employer's plan.

HEALTH SAVINGS ACCOUNT (HSA)

THIS IS HOW AN HSA WORKS:

A health savings account (HSA) is a health care account and savings account in one. The main purpose of this account is to offset the cost of a qualifying high deductible health plan (HDHP) and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement.

This is a "portable" account. You own your HSA! It's included in your employee benefits package, but after you set up your account, it's yours to keep, even if you change jobs or retire.

WHY IS IT A GOOD IDEA TO HAVE AN HSA?

HSAs benefit everyone who is eligible to have this account – single individuals, families, and soon-to-be retirees. You save money on taxes in three ways:

Tax-free deposits
The money you contribute to your HSA isn't taxed (up to the IRS annual limit)

Tax-free earnings
Your interest and any investment earnings grow tax-free

Tax-free withdrawals
Money used toward eligible health care expenses isn't taxed – now or in the future

Setting aside pre-tax dollars into your HSA you pay fewer taxes and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket. For example, if you are in the 30 percent tax bracket, you can save $30 on every $100 spent on eligible health care expenses.

HSA funds roll over from year to year and accumulate in your account. There is no "use-it-or-lose-it" rule with HSAs, and you decide how and when to use your HSA funds, which can be used for eligible expenses you have now, in the future, or during retirement. And when you have a certain balance in your HSA, investment opportunities are available.

2021 HSA LIMITS

Single Coverage: $3,600
Family Coverage: $7,200

ALERUS

FLEXIBLE SPENDING ACCOUNT (FSA)

Medical FSA
Election Maximum: $2,750
Carry Over: If you do not use all your fund during the plan year, you can carry over up to $500 to use during the following plan year
Dependent Care FSA
Election Maximum: $5,000 ($2,500 if married, filling separately)
Using your Plan Dollars
The Flexible Spending plan runs January 1st, 2021 – December 31st, 2021. Funds not claimed by March 1st, 2022 will be lost per IRS rules.

- You set aside money for your FSA from your paycheck before taxes are taken out.
- Then use your pre-tax FSA funds throughout the plan year to pay for eligible medical, dental, & vision expenses or dependent care expenses. (depending on which plan(s) you elect)
- These funds are use it or loss it, so plan carefully.
- If you are enrolled in an HSA medical plan, you are only allowed to spend these dollars on dental & vision expense.

Health FSA Eligible Expenses

- Medical expenses: co-pays, co-insurance, and deductibles
- Dental expenses: exams, cleanings, X-rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services: physical therapy, chiropractor, and acupuncture
- Prescription drugs and insulin
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.

Dependent Care FSA Eligible Expenses

- Care for your child who is under age 13
- Before and after-school care
- Baby sitting and nanny expenses
- Day care, nursery school, and preschool
- Summer day camp
- Care for a relative who is physically or mentally incapable of self-care and lives in your home

ALERUS

Phone: 800-495-4015
www.alerusrb.com

VALUE OF PRE-TAX BENEFITS

Section 125 Plan

Christensen Group Insurance operates a Premium Only Section 125 Plan, which allows you to reduce your total taxable income by your portion of group insurance premiums. In effect, this is just like getting a raise - your withholding taxes are reduced, and your take-home pay increases!

Example: Employee earning $30,000 annually, paying $200/month for benefits		
	Without Pre-Tax Benefits	**With Pre-Tax Benefits**
Gross Pay	$30,000	$30,000
Insurance Deductions/Payments	$0	$2,400
Taxable Income	**$30,000**	**$27,600**
Taxes at 25%	$7,500	$6,900
After-Tax Income	**$22,500**	**$20,700**
After-Tax Payment for Benefits	$2,400	$0
Take-home Pay	**$20,100**	**$20,700**
INCREASE IN TAKE-HOME PAY		**+$600**

MEDICAL PLAN PHARMACY BENEFITS

Pharmacy benefits are an important part of your medical plan. All preventative medication are 100% covered with HSA Plans. You can reduce pharmacy costs by using Mail order prescriptions for planned medication. For unplanned situations, try a generic prescription or use GoodRx to find the medication at a lower-cost pharmacy.

Preventative Pharmacy

Preventative medications are 100% covered on HSA plans.

GoodRx

Members may be able to receive discounts on prescriptions drugs. This app will illustrate what pharmacy sells at the lowest price.

Mail Order

Save money by going to: www.mymedica.com. Receive up to a 90-day supply of medications using the Express Scripts Pharmacy. 1-800-263-2398.

MEDICAL PLAN VALUE ADDS

Fit Choices by Medica

With Fit Choices℠ by Medica, you can earn up to a $20 credit each month toward your health club dues when you meet your monthly visit requirement at a participating health club.* That's up to $240 a year!

Healthy Rewards

Helps you build healthy habits and live your best life.
Whether you want to eat healthier, sleep more, stress less or get fit, My Health Rewards helps you take small steps to reach your health goals. You'll earn points for completing activities and get rewarded on your own personal path to health.

Healthy Savings

Helps you eat healthy and save money on qualified foods at select grocery stores.

Step 1: Shop for weekly promoted items
Step 2: Scan your barcode at checkout
Step 3: Save instantly & live healthier

FIRST STOP HEALTH

First Stop Health

Telemedicine and Virtual Counseling via phone of video.

Cost

FREE to medical plan-enrolled employees and covered dependents (age 2+)

Talk to a doctor 24/7

Get treatment within minutes for minor injuries, illnesses and prescriptions

- Cough & Sore Throat
- Infection (Sinus, Ear, UTI, etc.)
- Skin Rash
- Muscle/Joint Pain
- Medication Refill

Talk to a counselor 24/7

Sometimes, you just need someone to talk to. Talk to a licensed counselor to work though:

- Anxiety
- Depression
- Marital/Relationship
- Substance Misuse
- Workplace Issues

WELLBEATS

WellBeats

WellBeats is part of our wellness offering to support physical and mental health. There are a variety of classes to choose from including at home workouts, desk stretches, mediation or yoga.

Cost

FREE for all employees and spouses. Christensen Group pays 100% of the cost. All employees are automatically enrolled upon hire. To add a spouse, contact HR.

How to use

Log on to Wellbeats.com to get started. Wellbeats is accessible online or through the mobile app.

Use your Christensen Group email to sign in.

DENTAL PLANS

Plan Features	Delta Dental of Minnesota
IN NETWORK	PPO or Premier
Annual Deductible (Individual / Family)	$50 / $150
Preventive Care	100%
Basic Procedures (Extractions, fillings, etc.)	80%
Major Procedures (Crowns, dentures, etc.)	50%
Child Orthodontia	0%
Calendar Year Maximum Benefit	$1,000
OUT OF NETWORK	
Annual Deductible (Individual / Family)	$50 / $150
Preventive Care	100%
Basic Procedures (Extractions, fillings, etc.)	80%
Major Procedures (Crowns, dentures, etc.)	50%
Child Orthodontia	0%
Calendar Year Maximum Benefit	$1,000
MONTHLY PRICING	
Employee	$46.60
Employee + One	$77.77
Family	$122.63

DELTA DENTAL®

651-406-5916
800-448-3515
www.deltadental.org

VOLUNTARY VISION PLAN

Plan Features IN NETWORK	Superior Vision Superior Vision Network
Materials	**$10 copay**
Contact Lens Fitting	**$25 copay**
Vision Exam	N/A
Lenses	
Single	Covered in full
Bifocal	Covered in full
Trifocal	Covered in full
Progressive	Covered up to the providers retail trifocal amount
Frames	**$130** retail allowance
Elective Contact Lenses	Discounts range from 10% - 50%
Frequency (Months)	
Exam	N/A
Lenses	Once every 12 months
Frames	Once every 24 months
Contacts	Once every 12 months
MONTHLY PRICING	
Employee Only Employee + Spouse Employee + Child(ren) Family	**$6.01** **$12.02** **$13.16** **$20.50**

SuperiorVision™

800-507-3800

www.superiorvision.com

**For the highest benefit level, use an Insight network provider*

LIFE

Employer-paid Basic Life and AD&D Insurance Unum	
Plan Features	**Base Life and AD&D**
Employee Benefit Amount	$50,000
Spouse Benefit Amount	$10,000
Children: Live birth – 14 days	$500
Children: 14 days – 6 months	$1,000
Children: 6 months – 26 years	$5,000
The following shows how much benefits are reduced at certain ages:	
Age Band	**Benefit Reduction**
70	65%
75	50%

Note: *We recommend you update and verify your beneficiary information every year. Complete this in Paylocity during Open Enrollment.*

Supplemental / Voluntary Term Life Insurance Reliance Standard Life Insurance	
Plan Features	**Base Life and AD&D**
Employee Benefit Amount	Up to $300,000, under age 70
Spouse Benefit	$100,000, under age 70
Dependent Benefit	$10,000 age 14 days – 26 years
Employee Age Rate/$10,000	**Monthly**
18-29	$0.67
30 – 34	$0.79
35 – 39	$1.10
40 – 44	$1.62
45 – 49	$2.54
50 - 54	$4.03
55 – 59	$6.12
60 – 64	$8.45
65 - 69	$14.15
70 – 74	$31.54
75+	$71.98
AD&D Coverage	Add $0.03/$1,000
Child Rate/$10,000	$0.60 One amount covers all children

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

DISABILITY PLAN

Christensen Group pays 100% of the cost for employees.

Long-Term Disability is offered as a gross-up benefit. You will see under the earnings section of your paycheck the same premium amount that is being deducted for Long-Term Disability. This change provides a non-taxable benefit if you were to become disabled and qualify for Long-Term Disability benefits.

You will pay taxes on the LTD premium. Paying taxes on the LTD premium means you will not be taxed on the benefit should you become LTD eligible. This will increase the amount of dollars you receive to replace your income.

SHORT TERM DISABILITY

Plan Features	Unum
Employee Benefit Amount	**60%**
Maximum Benefit Amount	**$1,000**
Elimination Period (Accident)	**7 days**
Elimination Period (Sickness)	**7 days**
Benefit Duration	**12 weeks**

LONG TERM DISABILITY

Plan Features	Unum
Employee Benefit Amount	**60%**
Maximum Benefit Amount	**From $10,000 - $24,000 based on your job duties**
Elimination Period	**90**
Benefit Duration	**Up to SSNRA**

ANCILLARY PLANS

Christensen Group offers these additional services to you at no additional cost to you.

Employee Assistance Program (EAP)

Help when you need it most for Stress, Legal Questions, Child Care, Grief and Loss, Depression

Online/phone support: unlimited, confidential, 24/7
In-person: 3 visits with a licensed professional counselor at no additional cost

www.unum.com/lifebalance
(800) 854-1446

Assist America

Whenever you are more than 100 miles from your home, Assist America provides emergency services including Hospital Admission Assistance, Prescription Assistance, Emergency Medical Evacuation, Lost Luggage & Document Assistance, Care and Transport of Unattended Minor Children, Passport Replacement Assistance

(800) 872-1414 or
(609) 986-1234 outside the U.S.

LEGAL PLAN AND IDENTITY THEFT

Legal Shield

Available legal services include services like (but are not limited to):

- Bankruptcy
- Domestic Matters
- Civil Actions
- Defense of Criminal Misdemeanors
- Consumer protection
- Smalls Claims & Mediation
- Traffic Tickets
- Landlord & Tenant Matters
- Real Estate
- Wills, Trusts, & Estate Planning
- Tax Issues

ID Shield

A comprehensive identity protection plan with proprietary features that go beyond other plans in monitoring your personal data and restoring it if a data breach occurs. Theft specialists are on stand-by, ready to assist you 24/7.

MONTHLY PRICING	LEGALSHIELD ONLY	ID SHIELD ONLY	LEGALSHIELD & ID SHIELD
Employee Only	$15.95	$8.45	$24.40
Employee + Spouse	$15.95	$15.95	$28.90
Employee + Family	$15.95	$15.95	$28.90

LegalShield®
Worry Less. Live More.

866-760-0302
www.legalshield.com

PET INSURANCE

My Pet Protection

- Get cash back on eligible vet bills
- Choose the reimbursement level that fits your needs
- Same price for pets of all ages
- Use any vet, anywhere
- Optional wellness coverage available (includes spay/neuter, dental cleaning, exams, vaccinations and more)

Get quote today:
www.petinsurance.com/christensengroup

Nationwide®

401(k) PLAN

SUMMARY

Christensen Group offers employees an opportunity to participate in a 401(k) retirement plan. The plan is managed by Empower Retirement. Participation for eligible employees begins as soon as possible starting on the first of the month following your start date.

YOUR CONTRIBUTIONS

New employees who meet the eligibility requirements are auto-enrolled in the plan and may opt out. The initial auto-enroll feature will set each employee up with a 3% salary deferral into the plan. Each January 1, your automatic deferral amount will increase by 1% each year up to a maximum of 10% of pay, however each employee has the ability to opt out or change the participation % each year. Both Rosh (after-tax) and pre-tax deferrals are accepted. Your contributions and any roll-overs are always 100% vested.

OUR CONTRIBUTIONS TO YOU

At our discretion, Christensen Group may match your plan deferral contributions up to a percentage of your pay. We may also make other contributions on your behalf as determined by us. Discretionary contributions, if any, are 100% vested after three years.

EMPOWER RETIREMENT®

For Investment Questions:
Spencer Rose
952-653-1047
srose@christensengroup.com
General Questions:
800-338-4015
www.empowermyretirement.com

To establish 401(k) account access, visit *Empower Retirement* and follow the prompts to log in.

This is only a summary of the 401(k) plan. The Summary Plan Description prevails in case of error and provides complete details.

CONTACTS

Carrier Name	Website	Email	Phone Number
Reliance Standard	http://www.reliancestandard.com	user.services@rsli.com	(800) 351-7500
Superior Vision	www.superiorvision.com	gateway@superiorvision.com	(800) 507-3800
UNUM	www.unum.com	unum@unum.com	(800) 275-8686
Medica	medica.com	info@medica.com	(800) 4585512
Delta Dental of Minnesota	www.deltadentalmn.org		(800) 553-9536
LegalShield	www.legalshield.com		(800) 654-7757
Alerus (HSA)	www.alerusrb.com	healthbenefits@alerus.com	(800) 495-4015
Alerus (FSA)	www.alerusrb.com		(800) 495-4015
Nationwide	www.petsnationwide.com		(877) 738-7874

OVERVIEW

Open Enrollment will be November 2nd – November 12th.

How to sign up for benefits:

1. Log into Paylocity to enroll in all benefits
2. Company code: B5812
3. Click on the gray bar that says Self-Service Portal and select Enterprise Web Benefits
4. Network option changes and open enrollment selections may be changed
5. Final elections must be made by end of the day on November 12th

For questions, please contact:

Sam Olinger
Director of Human Resources
952-653-1118
solinger@christensengroup.com

Alicia Williams
Administrative Assistant
952-653-1055
awilliams@christensengroup.com

Christensen Group Insurance

LEGAL NOTICES

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).

LEGAL NOTICES

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

LEGAL NOTICES

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

LEGAL NOTICES

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

LEGAL NOTICES

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

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998 Notice

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As specified in the Act, if you or a covered family member, elect breast reconstruction in connection with a mastectomy you also will be covered 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; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The coverage will be provided in a manner determined in consultation with the attending physician and the patient. Deductibles and co-insurance established for other benefits under your plan also apply to these reconstructive surgery benefits.

USERRA Rights

If you, or your spouse or dependent, are absent from work for uniformed service, you may have the right to continue participating in the Plan under the Uniform Services Reemployment and Rights Act (USERRA). USERRA is intended to lessen the difficulty that may occur if you need to be absent from your civilian employment to serve in the United States uniformed services. USERRA seeks to make sure that those who serve their country can keep their civilian employment and benefits, and can seek reemployment without discrimination because of their service.

Under USERRA, employees absent for uniformed service (and their covered spouse and covered dependents) are eligible for continuation coverage for the period of service (plus time allowed under USERRA to apply for reemployment) or for up to twenty-four (24) months, whichever is less. If your service is for less than thirty-one (31) days, the plan may charge only your share of the monthly health care premium. If your service is more than thirty-one (31) days, your employer may charge the full premium plus 2% (for a total of 102% of the premium). You may have rights under both COBRA and USERRA and are entitled to the continued coverage that provides the more favorable benefit.

- An individual who serves in the military will be considered on leave of absence and will be entitled to all rights and benefits not determined by seniority that are generally provided to similarly situated employees on leave of absence or other types of leave.

- The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA.

LEGAL NOTICES

Mental Health Parity and Addiction Equity Act of 2008

Under the Mental Health Parity and Addiction Equity Act of 2008, the conditions (for example, copayments and deductibles) and treatment limitations for mental health and substance use disorders generally must not be more restrictive than those applicable to medical and surgical procedures. Review your plan documents for additional information about mental health coverage.

Michelle's Law

Certain covered dependents may be eligible to extend their plan coverage for a limited period of time when that coverage would otherwise end due to loss of student status.

Under Michelle's Law, the Plan cannot terminate coverage for a dependent child whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a medically necessary leave of absence. In this situation, the Plan will continue the dependent's coverage until the earlier of:

- The date that is one year after the first day of the medically necessary leave of absence.
- The date on which the dependent's coverage would otherwise end under the Plan's terms.
- A dependent in this situation will be eligible for continued Plan coverage under Michelle's Law if you provide the Plan a written certification from the dependent's treating physician stating that:
- The dependent is suffering from a serious illness or injury.
- The leave of absence (or other change of enrollment) is medically necessary.

A medically necessary leave of absence means a leave of absence from a postsecondary educational institution, or any other change in enrollment of the dependent at the institution, that:

- Begins while the dependent is suffering from a serious illness or injury.
- Causes the dependent to lose student status for purposes of coverage under the Plan's terms.

Newborns' and Mothers' Health Protection Act

Generally, group health plans, cannot restrict any hospital length of stay in connection with childbirth for the mother or the baby to less than forty-eight (48) hours after a vaginal delivery, or less than ninety-six (96) hours after a cesarean delivery. Group health plans cannot require that an attending doctor get permission from the plan to keep the mother and baby longer than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean delivery. The attending doctor may consult with the mother and decide to release the mother and baby earlier than forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a cesarean delivery.

LEGAL NOTICES

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes numerous requirements on employer health plans regarding how certain individually identifiable health information – known as protected health information or PHI – may be used and disclosed. This Notice describes how the plan, and any third party that assists in the administration of the plan, may use and disclose your protected health information for treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information that is maintained or transmitted by the Plans, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We will use PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request of it. Our insurers' Notices of Privacy Practices will apply, except for the limited medical information the we may receive and maintain from you when you ask us to assist you in a claims processing or benefit determination dispute, information related to your enrollment or disenrollment in the plan, and certain summary health information.

Your personal doctor or health care provider may have different policies or notices regarding their use and disclosure of your medical information.

We are required by law to abide by the terms of this notice to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect.

It is important to note that these rules apply to the Plans, not the company as an employer.

LEGAL NOTICES

HIPAA Notice of Privacy Practices (*continued*)

1. How We May Use and Disclose Medical Information About You. HIPAA generally permits use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. These uses and disclosures are more fully described below. Please note that this Notice does not list every use or disclosure; instead it gives examples of the most common uses and disclosures.

    - Treatment: When and as appropriate, medical information may be used or disclosed to facilitate medical treatment or services by providers.
    - Payment: When and as appropriate, medical information may be used and disclosed to determine your eligibility for the Plans' benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility and coverage under the plan, or to coordinate your coverage.
    - Health Care Operations: When and as appropriate, medical information may be used and disclosed for the plan's operations, as needed. Your genetic information will not be used or disclosed for underwriting purposes.
    - The plan will always try to ensure that the medical information used or disclosed is limited to a "Designated Record Set" and to the "Minimum Necessary" standard, including a "limited data set," as defined in the law for these purposes.

OTHER PERMITTED USES AND DISCLOSURES

- Disclosure to Others Involved in Your Care: Medical information may be disclosed to a relative, a friend, or to any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care.
- Disclosure to Health Plan Sponsor: Information may be disclosed to another health plan for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to personnel solely for purposes of administering benefits under the plan.
- Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- To Comply with Federal and State Requirements: Medical information will be disclosed when required to do so by federal, state, or local law.
- To Avert a Serious Threat to Health or Safety: Medical information may be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is able to help prevent the threat.

LEGAL NOTICES

HIPAA Notice of Privacy Practices (*continued*)

- Military and Veterans: If you are a member of the armed forces, medical information may be released as required by military command authorities.
- Business Associates: Medical information may be disclosed to business associates. We have contracted with entities (defined as "business associates" under HIPAA) to help us administer your benefits. We will enter into contracts with these entities requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.
- Other Uses: If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical examiner. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Uses and disclosures other than those described in this notice will generally require your written authorization. Your written authorization is required for: most uses and disclosures of psychotherapy notes; uses and disclosures of PHI for marketing purposes; and disclosures that are a sale of PHI. You may revoke your authorization at any time, but you cannot revoke your authorization if the Plans have already acted on it.

The privacy laws of a particular state or other federal laws might impose a more stringent privacy standard. If these more stringent laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974 (ERISA), the plan will comply with the more stringent law.

2. Your Rights Regarding Medical Information About You. You have the following rights regarding medical information that we maintain about you:

    - Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your benefits under the Plans. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. If the Plans do not maintain the health information, but know where it is maintained, you will be informed of where to direct your request.

LEGAL NOTICES

HIPAA Notice of Privacy Practices (*continued*)

- Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You also must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:
    - Information that is not part of the medical information kept by or for the plan.
    - Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
    - Information that is not part of the information which you would be permitted to inspect and copy.
    - Information that is accurate and complete.
- Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" (that is, a list of certain disclosures the plan has made of your health information). Generally, you may receive an accounting of disclosures if the disclosure is required by law, made in connection with public health activities, or in situations similar to those listed above as "Other Permitted Uses and Disclosures". You do not have a right to an accounting of disclosures where such disclosure was made:
    - For treatment, payment, or health care operations.
    - To you about your own health information.
    - Incidental to other permitted disclosures.
    - Where authorization was provided.
    - To family or friends involved in your care (where disclosure is permitted without authorization).
    - For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
    - As part of a limited data set where the information disclosed excludes identifying information.

To request this list or accounting of disclosures, you must submit your request, which shall state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. Notwithstanding the foregoing, you may request an accounting of disclosures of any "electronic health record" (that is, an electronic record of health-related information about you that is created, gathered, managed, and consulted by authorized health care clinicians and staff). To do so, however, you must submit your request and state a time period, which may be no longer than three years prior to the date on which the accounting is requested.

LEGAL NOTICES

HIPAA Notice of Privacy Practices (*continued*)

- Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. If the Plans do agree to a request, a restriction may later be terminated by your written request, by agreement between you and the Plans (including orally), or unilaterally by the Plans for health information created or received after the Plans have notified you that they have removed the restrictions and for emergency treatment. To request restrictions, you must make your request in writing and must tell us the following information:
    - What information you want to limit.
    - Whether you want to limit our use, disclosure, or both.
    - To whom you want the limits to apply (for example, disclosures to your spouse).
- Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

3. Breach Notification. Pursuant to changes to HIPAA required by the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH Act") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), this Notice also reflects federal breach notification requirements imposed on the Plans in the event that your "unsecured" protected health information (as defined under the HITECH Act) is acquired by an unauthorized party.
    - The plan will notify you following the discovery of any "breach" of your unsecured protected health information as defined in the HITECH Act (the "Notice of Breach"). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by email if you have previously agreed to receive such notices electronically. If the breach involves:
        - 10 or more individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute individual Notice of Breach by either posting the notice on the benefits website on the company intranet or by providing the notice in major print or broadcast media where the affected individuals likely reside.
        - Less than 10 individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute Notice of Breach by an alternative form.

LEGAL NOTICES

HIPAA Notice of Privacy Practices (*continued*)

Your Notice of Breach shall be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and shall include, to the extent possible:

- A description of the breach.
- A description of the types of information that were involved in the breach.
- The steps you should take to protect yourself from potential harm.
- A brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches.
- Relevant contact information.

Additionally, for any substitute Notice of Breach provided via web posting or major print or broadcast media, the Notice of Breach shall include a toll-free number for you to contact us to determine if your protected health information was involved in the breach.

4. Changes to This Notice. We can change the terms of this notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will send you a copy of the revised notice.

5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the plan or with the Secretary of the Department of Health and Human Services.

All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

6. Other Uses of Medical Information. Other uses and disclosures of medical information that are not covered by this notice or the laws that apply to us will be made only with your written permission. If you grant us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we may be required to retain our records related to your benefit determinations and enrollment.

LEGAL NOTICES

Model General Notice of COBRA Continuation Coverage Rights

Introduction: You're getting this notice because you recently gained coverage under a group plan (the Plan) that may result in your eligibility for COBRA coverage. 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 it would otherwise end because of a life event. This is also called 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 Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.
If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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.

LEGAL NOTICES

Model General Notice of COBRA Continuation Coverage Rights (*continued*)

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

- 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; or
- 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 60 days after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA continuation 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.

LEGAL NOTICES

Model General Notice of COBRA Continuation Coverage Rights (*continued*)

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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 www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

LEGAL NOTICES

Model General Notice of COBRA Continuation Coverage Rights (*continued*)

If you have questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your employer. 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 www.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 www.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.

HIPAA Initial Notice of Special Enrollment Rights

This notice is to inform you of your right, under a federal law called the Health Insurance Portability and Accountability Act (HIPAA), to enroll in Plan at times other than the Plan's annual open enrollment periods, upon the occurrence of specified events (for example, if have a baby). These enrollment periods are known as "special enrollment" opportunities. Generally, you must request enrollment within 30 days or as outlined in the plan documents.

- If you or your dependents lose eligibility for other coverage that you were enrolled in you may be able to enroll in this plan.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan.
- If you, you spouse, or your dependents become eligible for assistance under Medicaid or a state children's health insurance program, or lose coverage under such a program, you may be allowed to enroll yourself and your dependents in the Plan.

Qualified Medical Child Support Orders (QMCSOs)

A description of the procedures governing qualified medical child support orders (QMCSOs) can be obtained, without cost, from the plan administrator.

LEGAL NOTICES

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers covered under the law from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by the law. GINA's employment nondiscrimination requirements prohibit the company from discriminating against any employee or applicant with respect to hiring, discharge, compensation, terms, conditions or privileges of employment on the basis of genetic information with respect to the employee or applicant. As a result, the company will not fail or refuse to hire, or discharge any employee or applicant because of genetic information. The company will not limit, segregate or classify employees or applicants in any way that would deprive or tend to deprive them of employment opportunities or adversely affect their status as employees because of genetic information relating to the employees or applicants. The company will not discriminate or retaliate against individuals who oppose unlawful practices under GINA, or who make a charge, testify, assist or participate in any investigation, proceeding or hearing related to the employment nondiscrimination requirements. However, the company will not violate GINA if they limit or restrict an employee's job duties based on genetic information because they were required to do so by a law or regulation mandating genetic monitoring.

"Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Additionally, the plan will generally not:

- Request or require individuals or their family members to undergo genetic testing.
- Use genetic information to determine eligibility for coverage or to impose preexisting condition exclusions.
- Collect genetic information for underwriting purposes or with respect to any individual before enrollment or coverage.
- Adjust group premium or contribution amounts on the basis of genetic information.

Wellness Plans

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us your employer and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

LEGAL NOTICES

Notice Regarding Designation of Primary Care Providers

The plan may allow or even require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your employer. For children, you may designate a pediatrician as the primary care provider.

Notice Regarding Coverage for Obstetric or Gynecological Care

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Contact the plan for a list of participating health care professionals who specialize in obstetrics or gynecology.

Plan Benefits While on FMLA Leave

If you take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), the way in which you participate in the Plan will depend on whether or not you continue to get a paycheck from your employer while you are on leave. If your employer does not pay you while you are on leave, your participation in the Plan will be treated in the same way as if you had terminated your employment, unless you pay for benefits, on an after-tax basis while you are on leave. When you return to work your prior benefits will start again.

If you take a leave of absence that is a family or medical leave under the FMLA, you should contact the employer in order to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid family or medical leave under the FMLA, you may continue to participate in the Plan, but you may be required to continue your contribution.

Please contact the company as soon as you know you will be taking a Family or Medical Leave.

LEGAL NOTICES

Other notices that require plan-specific customization:

- **Creditable Coverage Notice:** Plan sponsors must provide annual notice to Medicare eligible participants about whether their prescription drug coverage is at least as good as Medicare prescription coverage.
  - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index?redirect=/CreditableCoverage/

- **Notice to Employees of Coverage Options:** Required notice to employees about the Health Insurance Marketplace / State Exchange.
  - https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-options-notice