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SECTION 1: HEALTH INSURANCE EXCHANGE NOTICE

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premiums right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if you employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage you employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employers, then you may lose the employer contributions (if any) to the employer-offered coverage—these contributions are often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online police for the health insurance coverage and contact information for a Health Insurance market plan in your area.

* An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
SECTION 2: NOTICE TO EMPLOYEES

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or you dependents (including your spouse because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or you dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment with 30 days after your or your dependents’ other coverage ends (or after the employer stop contributing toward that other coverage).

In addition, 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. However, you must request enrollment within 30 days after marriage, birth, adoption or placement for adoption.
SECTION 3: EMPLOYER’S CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit 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
Website: http://myalhipp.com/
Phone: 1-855-692-5447 3739

ALASKA – 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

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507
ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
State Relay 711

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

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

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-weserve/seniors/health-care/health-care-programs/programsand-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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

INDIANA – Medicaid
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

IOWA – Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-toz/hipp
Phone: 1-888-346-9562

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/
healthinsurancepremumpaymenthippprogram/index.htm
Phone: 1-800-692-7462
Nebraska – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 1-800-992-0900

South Dakota – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

Texas – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

Utah – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

Vermont – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

Virginia – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

Rhode Island – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

South Carolina – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

Washington – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-healthcare/
program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

West Virginia – Medicaid
Website: http://mywhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin – Medicaid and CHIP
Website:
Phone: 1-800-362-3002

Wyoming – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 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
SECTION 4: GENERAL NOTICE OF COBRA RIGHTS

INTRODUCTION

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 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 must 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.
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.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Burnham & Flower Agency, Inc., and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**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 hour of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; 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.

**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.
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 www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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.
SECTION 5:
CREDITABLE COVERAGE, JANET’S & MICHELLE’S LAW

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE REGARDING WOMEN’S HEALTH AND CANCER RIGHTS ACT (JANET’S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women’s Health and Cancer Rights Act. Under the Women’s Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- 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 lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and co-payments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company’s health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.
The Women’s Health and Cancer Rights Act (Women’s Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women’s Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE’S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle’s Law. This law requires employer health plans to continue coverage for employees’ dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans. The dependent child’s change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING CONTINUED ELIGIBILITY FOR DEPENDENT CHILDREN UNTIL AGE 26

As set forth by the PPACA of 2010, effective as of the first day of the first plan year beginning on or after September 23, 2010 dependent coverage is extended for dependent children to the age of 26 (regardless of Grandfathered Status except as noted below). Under the Health Care Reform Act, if the Plan permits an Eligible Employee to enroll his/her Child for coverage under the Plan, the Child must be permitted to continue such coverage until attainment of 26 years of age. The Plan shall not condition a Child’s eligibility for dependent coverage on the basis of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, eligibility for other coverage and shall not vary the terms of the Plan based on the age of a Child. You are eligible to enroll your dependents in the Health Plan if:

(i) your dependent was denied coverage, or coverage ended, or was not eligible for coverage due to the dependent provisions previously in place;

(ii) and your dependent is under the age of 26. You may request enrollment for your eligible dependents within 30 days from this notice. For more information contact your Plan Administrator.

With respect to a Plan with Grandfathered Status for all Plan Years prior to January 1, 2014, these Plans may elect to exclude a Child who is eligible to enroll in an employer-sponsored health plan (other than a group health plan of a parent).
NOTICE REGARDING LIFETIME LIMITS

Effective for Plan Years beginning on or after September 23, 2010, the lifetime limits on the dollar amount of benefits for any covered individual under the Plan (regardless of its Grandfathered Status) no longer apply. If your coverage (or your Eligible Dependent’s coverage) ended by reason of reaching a lifetime limit under the Plan, you are eligible to re-enroll in the Plan. You will have 30 days from the date of this notice to request enrollment in the Plan and your coverage generally will become effective as of the first day of the Plan Year beginning on or after September 23, 2010 (even if your timely request for enrollment within the 30-day period is made after the first day of the Plan Year).

NOTICE REGARDING PATIENT PROTECTION RIGHTS

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010. You will have the right to designate any primary care provider who participates in the Plan’s network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan’s network. 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 or notifying primary care provider or Plan of treatment decisions. If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

MEDICARE NOTICE

You must notify your employer when you or your dependents become Medicare eligible. Your employer is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice.
If you are covered by Medicare this information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage.

**IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE**

Please note that the following notice only applies to individuals who are eligible for Medicare. Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

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 Plan has determined that the prescription drug coverage offered by The Plan Benefits is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage.
If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

**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 www.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-MEDI CARE (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, visit Social Security at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).
Effective October 15, 2012 mandates treatment of autism spectrum disorders until age 19 (treatment may continue past age 19 where shown medically necessary) for fully insured plans. Treatment applies to Autistic Disorder, Asperger’s Disorder and Pervasive Development Disorder not otherwise specified and has an annual benefit limit of $50,000. Please see your insurance certificate or Summary of Benefits and Coverage for more details.

SECTION 7: STATE SPECIFIC INFORMATION

SECTION 8: INSURANCE DEFINITIONS

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers. EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it be payment, denial, or pending) to a medical claim processed on your behalf.

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

IN NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAIL ORDER PRESCRIPTIONS: Used as an alternative to retail pharmacies, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member’s home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Depending on the policy, it may or may not include charges applied to the deductible and copays.
**MAXIMUM OUT OF POCKET:** The total amount a covered person must pay before his or her benefits are paid at 100%. Depending on the policy, it may or may not include charges applied to the deductible and copays.

**OPEN ENROLLMENT:** Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

**OUT OF NETWORK:** The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

**PARTICIPATING PROVIDER:** Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

**PCP (PRIMARY CARE PHYSICIAN):** A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician. **PPO:** Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

**PREVENTATIVE CARE:** Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

**REFERRAL:** A written recommendation by a physician that a member may receive care from a specialty physician or facility.

**SPECIALIST:** A participating physician who provides non-routine care, such as a dermatologist or orthopedist.