UTAH youth village

2022

BENEFITS ENROLLMENT GUIDE

Effective | January 1, 2022

BENEFIT PROGRAM INFORMATION

BENEFITS OVERVIEW

Utah Youth Village offers a comprehensive benefits package to promote health and wellness along with financial security for both you and your family. The complete benefit package is briefly summarized in this enrollment guide. Please be sure to review it carefully so that you are able to elect the coverage that is most appropriate for your personal situation. If there is any discrepancy between the insurance carrier's certificate of coverage and this guide, the insurance carrier's certificate of coverage is the prevailing document.

For information about...	Go to..
Your Benefits	Lynette Roberts Utah Youth Village HR 801.308.1054 lroberts@youthvillage.org
Customer Service Support	NFP Client Services 800.553.3903 NFPUTClientServices@nfp.com
Medical Plan	Cigna 866.492.2111 www.cigna.com
Health Savings Account, and Flexible Spending Account	HealthEquity 866.346.5800 www.healthequity.com
Dental and Vision Plans	Cigna 800.244.6224 www.cigna.com
Supplemental Health Benefits: Accident, Hospital, Critical Illness	Eli Swenson Supplemental Health Benefits Specialist 385.352.9379 eli.swenson@nfp.com
Basic Life, Voluntary Life, Short-Term Disability, and Long-Term Disability	New York Life 800.225.5695 www.newyorklife.com
Employee Assistance Program (EAP)	New York Life 800.225.5695 www.newyorklife.com
Teladoc / Advocacy Program	New Benefits 800.800.7616 www.mymemberportal.com
Retirement Plan	401(k) Recordkeeper Empower 855.756.4738 www.empower-retirement.com/participant

BENEFIT PROGRAM INFORMATION

ELIGIBILITY

Coverage begins for enrolled eligible employees on the first of the month following 60 days of employment.

To obtain benefits you must satisfy the following:

- You must be a full-time employee working 30 hours or more per week
- If eligible, you may enroll your spouse and dependent children on the offered benefit plans
- Dependent children are eligible if less than 26 years of age

ELIGIBLE DEPENDENTS

- Legally married spouse
- Children until they turn 26 regardless of student, marital, or employment status. This includes natural children, stepchildren, adopted children (or those placed for adoption), and children for whom you are legal guardian.

OPEN ENROLLMENT

During open enrollment, you may enroll in or make changes to your benefit programs. Open enrollment is the only time that you may add or change benefits during the year unless you have a qualifying life event. Make sure that you understand the offerings and enroll yourself and your eligible dependents in the programs that you would like for the upcoming plan year.

QUALIFYING CHANGES

The following events allow you a **30-day** special enrollment period to complete and submit a change request to update your benefits outside of the open enrollment period:

- You get married, divorced or legally separated
- You add a child through birth, adoption or change in custody
- Your spouse or child dies
- Your spouse or child(ren) lose eligibility for coverage

The following events allow you a **60-day** special enrollment period to complete and submit a change request to update your benefits outside the open enrollment period:

- You, your spouse or child loses coverage under either a Medicaid plan under Title XIX or under a state child health plan (CHIP) under Title XXI of the Social Security Act due to a loss of eligibility for that program's coverage

- You, your spouse, or child becomes eligible for premium assistance with respect to the cost of coverage under our group health plan through either a Medicaid plan under Title XIX (such as Utah's Premium Partnership) or under a state child health plan (CHIP) under Title XXI of the Social Security Act (see enclosed disclosure)

NFP®

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

MEDICAL

CIGNA - OAP 3000 HSA QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

	In-Network	Out-of-Network*
Preventive Care Services *See list of covered preventive services on pages 28-31*	Covered 100%	Not Covered
Deductible	You Pay	You Pay
Employee Only / Family	$3,000 / $4,500 Embedded**	$6,000 / $9,000 Embedded**
Out of Pocket Maximum Employee Only / Family Includes Copays, Coinsurance & Deductibles	$4,500 / $6,750 Embedded**	$10,000 / $15,000 Embedded**
Office Visits	You Pay	You Pay
Primary Care Provider	20% AD	40% AD
Specialist Physician	20% AD	40% AD
Urgent Care	20% AD	40% AD
Prescriptions	Tier 1 / Tier 2 / Tier 3 / Tier 4	
30 Day Supply: Mail Order & Retail	$15 AD / $30 AD / $60 AD / 20% AD	
90 Day Supply: Mail Order & Retail	$38 AD / $75 AD / $150 AD / N/A	
Diagnostic Lab / X-Ray Services	You Pay	You Pay
Minor	20% AD	40% AD
Major	20% AD	40% AD
Hospital Services* **	You Pay	You Pay
Outpatient	20% AD	40% AD
Inpatient	20% AD	40% AD
Maternity	20% AD	40% AD
Durable Medical Equipment* **	20% AD	40% AD
Emergency Room	20% AD	
Mental Health Services* **	You Pay	You Pay
Office Visits	20% AD	40% AD
Inpatient / Outpatient	20% AD	40% AD
Chiropractic: 20 Visits Per Year	20% AD	Not Covered

AD: After Deductible

*Member pays balance of billed charges above In-Network Rate. To receive the maximum benefits from the plan you should always use in-network providers. To find an in-network provider, visit https://hcpdirectory.cigna.com/

**Embedded: If one person in a family hits the individual deductible and out-of-pocket limit in a calendar year, benefits will be paid at 100% for the remainder of the year.

***Preauthorization may be required

MEDICAL COST

Cigna - OAP 3000 HSA Medical Plan	Employer Contribution	Employee Cost Per Month
Employee Only	$492.14	$164.00
Two-Party	$1,003.72	$335.00
Family	$1,107.48	$369.00

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

HEALTH SAVINGS ACCOUNT

What is a Health Savings Account (HSA)?

A qualified high deductible health plan with a Health Savings Account is an alternative to traditional health insurance plans. The HSA is a savings product that offers a different way for consumers to pay for their health care costs. HSAs enable you to pay for current qualified expenses and save for future medical and retiree health expenses on a tax-free basis.

You must be covered by a Qualified High Deductible Health Plan (QHDHP) to be able to contribute to an HSA. You own and control the money in your HSA. As your account balances grow, you may also decide what types of investments to make with your HSA money.

You and/or your employer may contribute to your HSA, up to the legal maximum. **In 2022, the maximum annual contribution for single enrollee set by the IRS is $3,650, and the maximum family contribution is $7,300.** A catch-up contribution, up to an additional $1,000, is allowed for individuals who are 55 years or older. Please see the contribution chart below to determine the amount contributed to your HSA by your employer.

What you can do with your HSA

- Pay qualified health care expenses: Use the HealthEquity online PayChoice payment platform at www.MyHealthEquity.com to pay for qualified health care expenses. You can use your debit card, request a check by phone or online, or transfer funds online
- Save money for future medical expenses: You may not have significant health care expenses every year, but saving the maximum amount every year helps you build a sizeable savings for when you are faced with larger medical expenses
- Save for post-retirement expenses: Once you reach age 65, you can use your HSA funds to pay for anything you wish. Qualified medical expenses are still not taxed; any other expenses are subject to tax but not penalties

Your HSA is *your* money. Whatever you do not spend in a given year rolls over to the next. If you change jobs or retire, your HSA balance goes with you.

HSA ANNUAL LIMITS

	Employee Only Coverage	Two-Party Coverage	Family Coverage
2022 Maximum Contribution to HSA	$3,650	$7,300	$7,300
Catch-up Contribution (age 55 & older)	$1,000	$1,000	$1,000

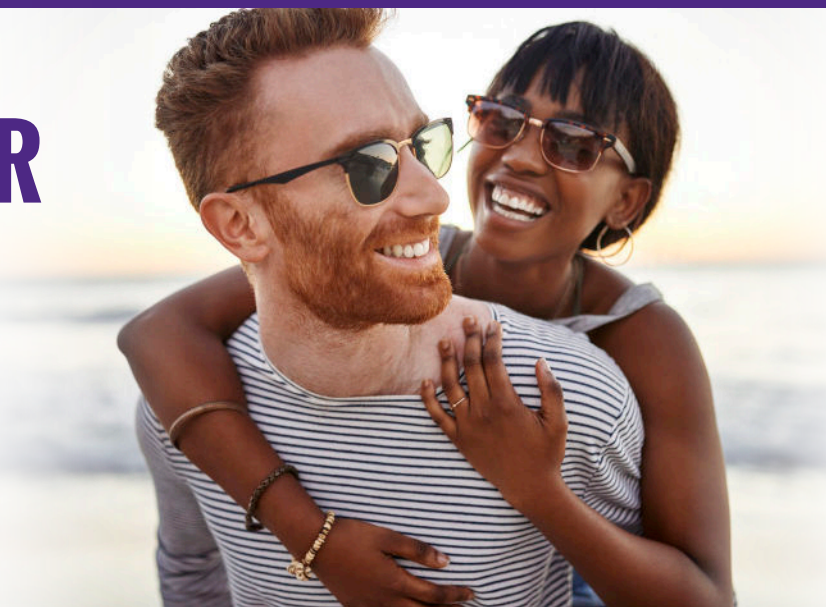
EMPLOYER CONTRIBUTION

Coverage	Per Month	Annual Total
Employee Only	$83.33	$1,000
Two-Party	$166.66	$2,000
Family	$183.33	$2,200

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

ACCELERATE YOUR HEALTH SAVINGS

Combining a HealthEquity HSA with an HSA-qualified health plan delivers incredible benefits



BUILD HEALTH SAVINGS

Choose a low premium health plan.

HSA-qualified health plans offer the lowest premiums, enabling you to unlock immediate savings. Just put the money you would have paid toward traditional premiums into your HSA. Voila! Long-term health savings.

MAXIMIZE TAX SAVINGS

Pre-tax contributions help reduce your annual taxable income.

Your HSA earns tax-free interest and you never pay taxes or penalties when you withdraw HSA dollars for qualified expenses. See a full list of qualified medical expenses at **Learn.HealthEquity.com/QME**

KEEP YOUR MONEY—FOREVER

Spend it. Save it. Invest it.[2] It's yours.

Unlike flexible spending accounts (FSA), money in your HSA rolls over year after year—even if you change employers or health plans.

HSA triple-tax advantage[1]

- Make pre-tax contributions
- Grow tax-free interest earnings
- Enjoy tax-free distributions for qualified medical expenses

SAVE FOR RETIREMENT

Your HealthEquity HSA works like a second 401(k).

Invest your HSA dollars into low-cost mutual funds, then watch your earnings grow tax-free. When you're 65, you can withdraw HSA dollars for any expense—you'll just need to pay regular income taxes. Of course, if you use that money for qualified medical expenses, you never pay taxes at all.[3]

[1]HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

[2]Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. Investing may not be suitable for everyone and before making any investments, review the fund's prospectus.

[3]After age 65, if you withdraw funds for any purpose other than qualified medical expenses, you will be subject to income taxes. Funds withdrawn for qualified medical expenses will remain tax-free.

HealthEquity®

Your HSA

Direct payments to providers

After you have received an invoice from your provider and matched it with an EOB from your health plan, you are ready to make a payment. You can use the HealthEquity member portal to setup a direct payment using our online payment tool. We'll send the payment directly to the provider and include all of the information necessary to apply the payment to your bill.

HSA debit card payments

You can also use your HealthEquity HSA debit card to make payments to your provider(s). This is especially convenient at the pharmacy. Most providers will also accept the card over the phone, online or written-in on the statement for payment. In order for your card to work, you must have the balance available in your HSA; no overdraft is available. The card will not work at ATMs and will typically only work at appropriate medical facilities. The card should always be run as "credit" and no PIN is required. Lastly, be sure to keep all receipts as documentation of your purchases or upload them to the HealthEquity Documentation Library in the member portal.

Qualified medical expenses

Qualified medical expenses are designated by the IRS. They include medical, dental, vision and prescription expenses. See IRS publication 502 for a list of specific examples. Some highlights include:

- Acupuncture
- Alcoholism (rehab, transportation for medically advised attendance at AA)
- Ambulance
- Amounts not covered under another health plan
- Annual physical examination
- Artificial limbs/teeth
- Birth control pills/prescription contraceptives
- Body scans
- Breast reconstruction surgery following mastectomy for cancer
- Chiropractor
- Contact lenses
- Crutches
- Dental treatments
- Eyeglasses/eye surgery
- Hearing aids
- Long-term care expenses
- Medicines (prescribed, not imported from other countries)
- Nursing home medical care
- Nursing services
- Optometrist
- Orthodontia
- Oxygen
- Stop-smoking programs
- Surgery, other than unnecessary cosmetic surgery
- Telephone equipment and repair for hearing-impaired
- Therapy
- Transplants
- Weight-loss program (if prescribed by a physician for a specific disease)
- Wheelchairs
- Wigs (if prescribed)

Non-qualified medical expenses

The federal penalty for using HSA funds for non-qualified expenses is 20% if you are under age 65, plus the loss of tax-free treatment for the distribution. Keep itemized receipts and copies of prescriptions for over-the-counter drugs in case of an IRS audit.

- Concierge services
- Dancing lessons
- Diaper service
- Elective cosmetic surgery
- Electrolysis or hair removal
- Funeral expenses
- Future medical care
- Hair transplants
- Health club dues
- Insurance premiums other than those explicitly included
- Medicines and drugs from other countries
- Nonprescription drugs, medicines (unless prescribed)
- Nutritional supplements, unless recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician
- Teeth whitening

HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-free with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

MEDICAL

CIGNA - OAP 2000 TRADITIONAL HEALTH PLAN		
	In-Network	**Out-of-Network***
Preventive Care Services *See list of covered preventive services on pages 28-31*	Covered 100%	Not Covered
Office Visits	You Pay	You Pay
Primary Care Provider	$30	40% AD
Specialist Physician	$45	40% AD
Urgent Care	$75	40% AD
Prescriptions	Tier 1 / Tier 2 / Tier 3 / Tier 4	
30 Day Supply: Mail Order & Retail	$15 / $30 / $60 / 20%	
90 Day Supply: Mail Order & Retail	$45 / $90 / $180 / N/A	
Deductible	You Pay	You Pay
Individual / Family	$2,000 / $4,000	$4,000 / $8,000
Out of Pocket Maximum Individual / Family Includes Copays, Coinsurance & Deductibles	$5,500 / $11,000	$11,000 / $22,000
Diagnostic Lab / X-Ray Services	You Pay	You Pay
Minor	Covered 100%	40% AD
Major	20% AD	40% AD
Hospital Services**	You Pay	You Pay
Outpatient	20% AD	40% AD
Inpatient	20% AD	40% AD
Maternity	20% AD	40% AD
Durable Medical Equipment**	20% AD	40% AD
Emergency Room	$250 AD	
Mental Health Services**	You Pay	You Pay
Office Visits	$30	40% AD
Inpatient / Outpatient	20% AD	40% AD
Chiropractic: 20 Visits Per Year	$45	40% AD

AD: After Deductible;

*Member pays balance of billed charges above In-Network Rate. To receive the maximum benefits from the plan you should always use in-network providers. To find an in-network provider, visit https://hcpdirectory.cigna.com/

**Preauthorization may be required

MEDICAL COST		
Cigna - OAP 2000 Traditional Medical Plan	**Employer Contribution**	**Employee Cost Per Month**
Employee Only	$575.95	$192.00
Two-Party	$1,174.67	$392.00
Family	$1,295.06	$432.00

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

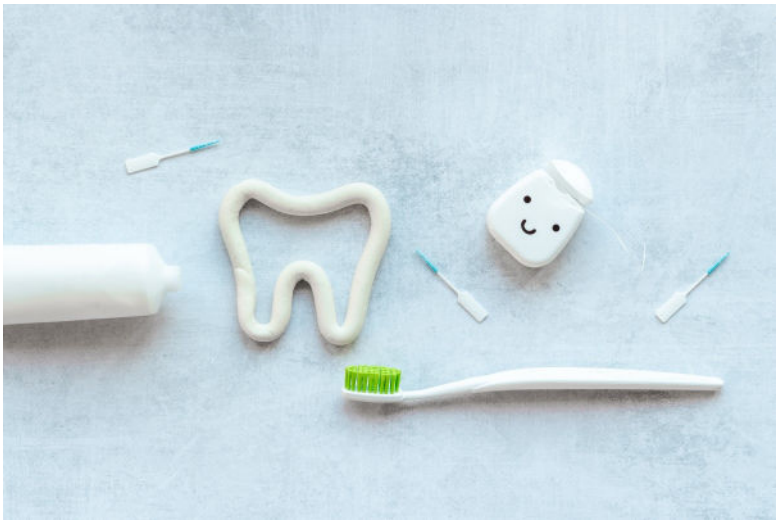
DENTAL

CIGNA - TOTAL PPO DENTAL PLAN

	In-Network	Out-of-Network*
Deductible: Individual / Family	$50/$150	
	Plan Pays	
Preventive Services**		
Routine Exams and Cleanings: 2x per year Topical Fluoride: Under age 19, 1x per year Bitewing X-rays: 2x per calendar year Panorex: 1x every 3 years Sealants: Up to age 14, 1 per tooth per 3 years, posterior teeth only	Covered 100%	
Basic Services**		
Fillings, Periodontics, Endodontics, Oral Surgery	80% AD	
Major Services**		
Crowns, Bridges, Dentures	50% AD	
Calendar Year Maximum	$1,750	
Orthodontia: Children up to Age 19	50%	
Orthodontia Lifetime Maximum	$1,500	

*You pay the difference between billed and allowed charges, if any. The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by an in-network provider. To receive the maximum benefits from the plan you should always use in-network providers. To find an in-network provider, visit https://hcpdirectory.cigna.com/

** Limitations and exemptions may apply based on age, frequency, and more. Please review plan summary for details.



EMPLOYEE COST

Carrier Name - Dental Plan	Employer Contribution Per Month	Employee Cost Per Month
Employee Only	$21.86	$7.00
Employee + Spouse	$43.05	$14.00
Employee + Child(ren)	$51.97	$17.00
Family	$78.61	$26.00

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

VISION

CIGNA - STANDARD PPO VISION PLAN

	In-Network	Out-of-Network Reimbursement*
Examinations	Once Every 12 Months	
Lenses or Contact Lenses	Once Every 12 Months	
Frames	Once Every 12 Months	
Eye Examination	$10 Copay	Up to $45
Contact Lens Exam: Fitting & Evaluation	Up to $60 Copay	
Frames	$150 Retail Allowance	Up to $83
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $40
Lined Bifocal	$25 Copay	Up to $65
Lined Trifocal	$25 Copay	Up to $75
Lenticular Lenses	$25 Copay	Up to $100
Standard Progressive	$25 Copay	Up to $75
Contact Lenses		
Contacts In Lieu of Prescription Eyeglasses	$150 Retail Allowance	Up to $120

*You pay the difference between billed and allowed charges, if any. The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by an in-network provider. To receive the maximum benefits from the plan you should always use in-network providers. To find an in-network provider, visit https://hcpdirectory.cigna.com/

EMPLOYEE COST

Cigna - PPO Vision Plan	Employee Cost Per Month
Employee Only	$7.46
Employee + Spouse	$14.93
Employee + Child(ren)	$15.08
Family	$24.06

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

FLEXIBLE SPENDING ACCOUNT

You have the option to participate in an employee benefit that may increase your spendable income and lower your taxes. A Flexible Spending Account (FSA) allows you to pay for your portion of the group benefit premium, un-reimbursed health care expenses and dependent or child care services with **pre-tax dollars**. With an FSA, contributions are deducted from your paycheck before state and federal taxes. By making these contributions with pre-tax dollars, you will reduce your taxable income **and take home a larger portion of your paycheck.**

Three Components of the Flexible Spending Account:

1. **Group Benefit Premiums:** An FSA allows your portion of group medical, dental, vision and most supplemental plan premiums to be deducted from your paycheck on a pre-tax basis.

2. **Flexible Spending Account (FSA)-Health Care Reimbursement (Including Dental and Vision):** Each year, you may set aside up to $2,850 pre-tax dollars to pay for qualifying out-of-pocket medical, dental, vision, and some over the counter expenses. **A Limited Purpose Flexible Spending plan, associated with HSA participation can only be used for dental and vision expenses.**

3. **Flexible Spending Account (FSA)-Dependent Care Reimbursement**: Each year, you may set aside up to $5,000 pre-tax dollars (or $2,500 if you are married and filing individually) to pay for eligible dependent care expenses. This may include child care, elder care or other eligible dependent care. Funds are available for reimbursement only as they are deducted from your paycheck.

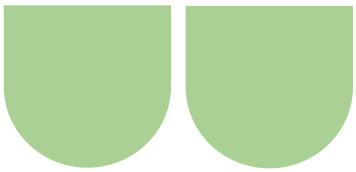
There are two types of Flexible Spending Accounts Available:

Flexible Spending Account –To be used without HSA Account Participation

Limited Purpose Flexible Spending Account –To be used with HSA Account Participation

Facts You Should Know:

- Participation is voluntary
- Participation in the plan simply allows you to pay for qualified expenses with pre-tax dollars
- Flexible Spending Accounts are subject to the “use it or lose it” rule. Participants may forfeit any balance in the account(s) at the end of the plan year.
- Over-the-counter medications and other items are eligible without a prescription.



EXAMPLE OF SAVINGS USING A FLEXIBLE SPENDING ACCOUNT

	Without Flexible Spending	With Flexible Spending
Gross Income	$40,000	$40,000
Pre-Tax Expenses for Health/Dependent Care	$0	$2,500
Taxable Income	$40,000	$37,500
Less Taxes	$10,279	$9,563
After-Tax Expenses for Health	$2,500	$0
Spendable Income	$27,221	$27,938
Your Savings With Flexible Spending		**$716**

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

LIFE & DISABILITY

NEW YORK LIFE - BASIC LIFE, AD&D, AND DEPENDENT LIFE	
Employee Life Benefit	$50,000
Employee AD&D	Matches Basic Life Benefit
Spouse Life Benefit	$5,000
Child(ren) Life Benefit	$5,000
Benefit Age Reduction *(Reduction is based on Employee age)*	Reduces to 65% of the original benefit amount at age 65, and 50% at age 70

AD&D: Accidental Death & Dismemberment

NEW YORK LIFE - SHORT-TERM DISABILITY	
Benefit Percentage	60% of Weekly Covered Earnings
Maximum Weekly Benefit	Up to $1,500
Benefit Duration	Up to 12 Weeks
Benefit Commencement Period	15 Days Accident 15 Days Sickness

NEW YORK LIFE - LONG-TERM DISABILITY	
Elimination Period	90 days
Benefit Percentage	60% of pre-disability earnings
Maximum Monthly Benefit	Up to $10,000
Benefit Duration	Social Security Normal Retirement Age
Definition of Disability	2 years - own occupation
Mental Illness / Substance Abuse	24 months
Pre-Existing Condition Limitations*	3/12

* This limitation applies to new hires only and conditions for which an employee receives medical services within three months of the effective date of coverage. No benefits are payable for a disability resulting from such condition until the employee has been covered for three consecutive months with no medical care for the condition, or until the employee has been covered for 12 consecutive months.

EMPLOYER CONTRIBUTION:

Your employer pays the full cost for basic life, accidental death and dismemberment (AD&D), short-term disability (STD), and long-term disability (LTD) benefits for all employees.

EMPLOYEE COST
$0.00

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

VOLUNTARY LIFE

In addition to the basic life insurance provided by your employer, you have the option to buy supplemental life insurance. To view total rates, or to purchase this plan, please log in to your Bswift enrollment portal.

NEW YORK LIFE - VOLUNTARY LIFE AND AD&D	
Employee	
Benefit Amount	Up to $500,000, in $10,000 increments Not to exceed 5x Annual Earnings
Guarantee Issue Amount	$300,000
Benefit Age Reduction	Reduces to 65% of the original benefit amount at age 65, and 50% at age 70
Late Entrants (other than at hire)	Subject to Evidence of Insurability (EOI)
Spouse	
Benefit Amount	Up to $200,000, in $5,000 increments Not to exceed 100% of employee Voluntary Life amount*
Guarantee Issue Amount	$35,000
Benefit Age Reduction *(Based on age of Employee)*	Reduces to 65% of the original benefit amount age 65, and 50% at age 70
Late Entrants	Subject to Evidence of Insurability (EOI)
Child(ren)	
Birth up to 6 months	$10,000
6 Months up to Age 19	$10,000 or $20,000

*Basic life benefits illustrated on previous page do not count toward the maximum benefit amounts for voluntary life.

VOLUNTARY LIFE AND AD&D RATES

Monthly Rates Per $1,000 of Coverage

Age Band	Employee	Spouse
< 25	$0.075	$0.075
25-29	$0.085	$0.085
30-34	$0.090	$0.090
35-39	$0.100	$0.100
40-44	$0.125	$0.125
45-49	$0.175	$0.175
50-54	$0.235	$0.235
55-59	$0.455	$0.455
60-64	$0.685	$0.685
65-69	$0.925	$0.925
70+	$2.015	$2.015

CHILD(REN) VOLUNTARY LIFE AND AD&D RATES

Monthly Rates by Coverage Amount

$10,000	$2.25
$20,000	$4.50

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

SUPPLEMENTAL HEALTH BENEFITS

ACCIDENT (OFF JOB) PLAN BENEFITS

	Value Plan	Premier Plan
Accident Coverage	Off Job	Off Job
Accidental Death and Dismemberment	Employee: $10,000 Spouse: $5,000 Child: $5,000	Employee: $50,000 Spouse: $25,000 Child: $5,000
Accidental Death: Seatbelts and Airbags Benefit	Seatbelts: $10,000 Seatbelt and airbag: $15,000	Seatbelts: $10,000 Seatbelt and airbag: $15,000
Wellness Benefit	**$150 per year benefit for completing certain routine wellness screenings or procedures** *(refer to plan for example procedures)*	**$150 per year benefit for completing certain routine wellness screenings or procedures** *(refer to plan for example procedures)*
Child Organized Sports	**20% increase to Child Benefits**	**20% increase to Child Benefits**
Catastrophic Loss	Quadriplegia: 100% AD&D Speech & hearing loss (both ears): 100% of AD&D Loss of cognitive function: 100% of AD&D Hemiplegia: 50% of AD&D Paraplegia: 50% of AD&D	Quadriplegia: 100% AD&D Speech and hearing loss (both ears): 100% of AD&D Loss of cognitive function: 100% of AD&D Hemiplegia: 50% of AD&D Paraplegia: 50% of AD&D
Accident Emergency Room Treatment	$150	$200
Accident Follow-Up Visit: Doctor	$25 up to 6 treatments	$75 up to 6 treatments
Air Ambulance	$500	$1,500
Ambulance	$100	$200
Burns: 2nd Degree / 3rd Degree	9 to 18 sq. inches: $0 / $2,000 18 to 35 sq. inches: $1,000 / $4,000 Over 35 sq. inches: $3,000 / Up to $12,000	9 to 18 sq. inches: $0 / $2,000 18 to 35 sq. inches: $1,000 / $4,000 Over 35 sq. inches: $3,000 / Up to $12,000
Coma	$7,500	$12,500
Concussions	$50	$100
Dislocations	Schedule up to $3,600	Schedule up to $4,800
Emergency Dental Work	Crown: $200 | Extraction: $50	Crown: $400 | Extraction: $100
Epidural Pain Management	$100, 2 times per accident	$100, 2 times per accident
Eye Injury	$200	$300
Fracture	Schedule up to $4,500	Schedule up to $6,000
Hospital Admission	$750	$1,250
Hospital Confinement	$175 per day, up to 1 year	$250 per day, up to 1 year
Hospital ICU Admission	$1,500	$2,500
Hospital ICU Confinement	$350 per day, up to 15 days	$500 per day, up to 15 days
Initial Physician's Office or Urgent Care Facility Treatment	$50	$100
Knee Cartilage	$500	$750
Joint Replacement: Hip / Knee / Shoulder	$1,500 / $750 / $750	$3,500 / $1,750 / $1,750
Laceration	Schedule up to $300	Schedule up to $500
Ruptured Disc with Surgical Repair	$500	$750
Surgery: Cranial, Open Abdominal, Thoracic	$1,000 | Hernia: $125	$1,500 | Hernia: $200
Tendon / Ligament / Rotator Cuff	1: $250 2 or more: $500	1: $750 2 or more: $1,500
X-Ray	$20	$40

EMPLOYEE COST PER MONTH

	Value Plan	Premier Plan
Employee Only	$13.73	$20.92
Employee + Spouse	$23.99	$35.72
Employee + Child(ren)	$24.69	$35.76
Employee + Family	$34.95	$50.56

Minimum of 5 employees must enroll for policy to be issued.

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

SUPPLEMENTAL HEALTH BENEFITS

HOSPITAL BENEFITS PLAN		
	Plan 1	**Plan 2**
Daily Hospital Confinement	$100	$100
Daily ICU Confinement	$100	$200
Hospital Admission Benefit (Inpatient) One Benefit per Covered Person Per Plan Year	$1,000	$1,500
Wellness Care One Benefit per Covered Person Per Plan Year	**$100**	**$150**

Hospital admission benefit is payable once per year, per person

Daily hospital & Daily ICU confinement benefits are payable up to 30 combined days per year, per person

Hospital admission & confinement benefits are not payable for a newborn unless the child is admitted to the Neonatal ICU

The state of California requires residents to have an overlying medical plan to enroll in Voluntary Hospital Indemnity

PLAN HIGHLIGHTS

- **Guaranteed issue; no medical questions**
- **No pre-existing conditions exclusions**
- No deductibles
- Portable
- Coverage offered on a voluntary basis

EMPLOYEE COST PER MONTH		
	Plan 1	**Plan 2**
Employee Only	$22.79	$30.77
Employee Plus Spouse	$48.05	$64.94
Employee Plus Children	$34.27	$46.16
Employee Plus Family	$59.43	$80.32
Rate Guarantee	Rates are guaranteed for two years	
Minimum of 5 employees must enroll for policy to be issued.		

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

SUPPLEMENTAL HEALTH BENEFITS

CRITICAL ILLNESS BENEFITS		
Covered Conditions	**First Occurrence***	**Second Occurrence***
Heart Attack, Invasive Cancer, Stroke, Kidney (Renal) Failure, Heart Failure, Organ Failure	100%	50%
Carcinoma in Situ and Arteriosclerosis	30%	0%
Benign Brain Tumor	75%	0%
Enhanced Covered Conditions	Addison's Disease, Huntington's Disease, Multiple Sclerosis: 30% Permanent Paralysis (1 limb), Alzheimer's Disease: 50% Permanent Paralysis (2 limbs), ALS (Lou Gehrig's Disease), Coma, Loss of Speech / Sight / Hearing, Parkinson's Disease: 100%	0%
Childhood Covered Conditions	Cerebral Palsy, Cleft Lip / Palate, Club Foot, Cystic Fibrosis, Down's Syndrome, Muscular Dystrophy, Spina Bifida, Type 1 Diabetes: 100% of Child Benefit	0%
Cancer Vaccine	$50	
Wellness (Health Screening) Benefit	**$150 per year**	

Dependent Age Limit: Childbirth up to 26 years

*Benefit payment issued in lump sum

EMPLOYEE COST PER MONTH		
Age*	**Guarantee Issue: $5,000**	**Guarantee Issue: $20,000**
<30	$2.05	$8.20
30-39	$4.45	$17.80
40-49	$8.35	$33.40
50-59	$16.80	$67.20
60-69	$29.70	$118.80
70+	$43.55	$174.20
Children: Covered for 25% of Employee's elected amount at no additional cost Minimum of 5 employees must enroll for policy to be issued		

*Age-banded premium rates are based on the age at last birthday. They will change on the policy anniversary date coinciding with or next following the Insured's age. Premium/Benefit is payable in US currency.

Age Reduction: For Insureds age 70 and over, the Amount of Insurance is subject to an automatic 50% reduction of the elected coverage amount. This reduction also applies to Insureds who are age 70 or over on their Individual Effective Date. The Dependent spouse Amount of Insurance will reduce in the same manner as the Insured's Amount of Insurance upon the Dependent spouse's attainment of the reducing age. The Child Amount of Insurance will continue at the percentage (reflected on the Plan Description) of the Insured's Amount of Insurance prior to any reductions due to age.

Rate Guarantee: We guarantee the final premium rates for 24 months from the Policy effective date.

SUPPLEMENTAL HEALTH BENEFITS

APPROVED ACCIDENT WELLNESS VISITS

- **Bone Marrow testing**
- **Breast Ultrasound**
- **CA 15-3** | blood test for breast cancer
- **CA 125** | blood test for ovarian cancer
- **CAE** | blood test for colon cancer
- **Serum Protein Electrophoresis** | blood test for Myleloma
- **PSA** | blood test for prostate cancer
- **Colonoscopy / Virtual Colonoscopy**
- **Flexible Sigmoidoscopy**
- **Hemoccult Stool Analysis**
- **Mammography**
- **Pap Smear / Thin Prep Pap Test**
- **Thermography**
- **Blood Test for Triglycerides**
- **Stress Test** | on a bicycle or treadmill
- **Fasting Blood Glucose Test**
- **Chest X- Ray**
- **Serum Cholesterol** | Test to determine level of HDL and LDL
- **Double Contrast Barium Enema**
- **EKG**
- **Immunizations**
- **Routine / Annual Physicals**
- **Skin Cancer Biopsy**
- **Completion of a Smoking Cessation or Weight Reduction program**

APPROVED HOSPITAL PLAN HEALTH SCREENINGS

- **Bone Marrow testing**
- **Breast Ultrasound**
- **CA 15-3** | blood test for breast cancer
- **CA 125** | blood test for ovarian cancer
- **CAE** | blood test for colon cancer
- **Serum Protein Electrophoresis** | blood test for Myleloma
- **PSA** | blood test for prostate cancer
- **Colonoscopy / Virtual Colonoscopy**
- **Flexible Sigmoidoscopy**
- **Hemoccult Stool Analysis**
- **Mammography**
- **Pap Smear / Thin Prep Pap Test**
- **Thermography**
- **Blood test for Triglycerides**
- **Stress Test** | on a bicycle or treadmill
- **Fasting Blood Glucose Test**
- **Chest X-Ray**
- **Serum Cholesterol Test** | to determine level of HDL and LDL
- **Lymphocyte Genome Sensitivity Test (LGS)**
- **Cancer Genetic Mutation Test**
- **Completion of a Smoking Cessation or Weight Reduction program**

SUPPLEMENTAL HEALTH BENEFITS

APPROVED CRITICAL ILLNESS HEALTH SCREENINGS

- **Bone Marrow testing**
- **Breast Ultrasound**
- **CA 15-3** | blood test for breast cancer
- **CA 125** | blood test for ovarian cancer
- **CAE** | blood test for colon cancer
- **PSA** | blood test for prostate cancer
- **Serum Protein Electrophoresis** | blood test for Myeloma
- **Colonoscopy / Virtual Colonoscopy**
- **Flexible Sigmoidoscopy**
- **Hemoccult Stool Analysis**
- **Mammography**
- **Thermography**
- **Blood test for Triglycerides**
- **Stress Test** | on a bicycle or treadmill
- **Fasting Blood Glucose Test**
- **Chest X-Ray**
- **Serum Cholesterol Test** | to determine level of HDL and LDL
- **Pap Smear / Thin Prep Pap Test**
- **Completion of a Smoking Cessation or Weight Reduction program**

Whatever life throws at you – throw it our way.

Life Assistance Program from New York Life Group Benefit Solutions.

Life. Just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, New York Life Group Benefit Solutions (NYL GBS) is there for you with our NYL GBS Life Assistance Program. It can help you and your family find solutions and restore your peace of mind.

Call us anytime, any day

We're just a phone call away whenever you need us. At no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

Visit a specialist

You have three face-to-face sessions with a behavioral counselor available to you – and your household members. Call us to request a referral.

Monthly webinars

Educational seminars on a variety of relevant topics such as managing your life, work, money and health, are available in a quarterly calendar of monthly webcasts distributed to your employer.

Achieve work/life balance

For help handling life's challenges, go online for articles and resources on family, care giving, pet care, aging, grief, balancing priorities, working smarter, and more.

Legal consultation and referrals*
Receive a free 30-minute consultation with a network attorney. And up to a 25% discount on select fees.

Financial consultations
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Life Assistance Program 24/7 support
Phone: **(800) 538-3543**
Website: www.cignalap.com

*Legal consultations and discounts are excluded for employment-related issues.

These programs are NOT insurance and do not provide reimbursement for financial losses. Some restrictions may apply. Employee assistance services are provided by Cigna Behavioral Health, Inc. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Programs are provided through third party vendors who are solely responsible for their products and services. Full terms, conditions and exclusions are contained in the applicable client program description, and are subject to change. Program availability may vary by plan type and location, and are not available where prohibited by law. These programs are not available under policies insured by New York Life Group Insurance Company of NY.

New York Life Group Benefit Solutions products and services are provided by Life Insurance Company of North America and New York Life Group Insurance Company of NY, subsidiaries of New York Life Insurance Company.

New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010

923865 a 0521 SMRU 1903057 Exp. Date 06.08.2023

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

NEW BENEFITS

THE BENEFITS YOU CAN DEPEND ON.

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ADVANTAGE CHOICE: ADVOCACY PACKAGE

- New Benefits Teladoc
- Medical Health Advisor
- Medical Bill Saver TM
- NurselineTM
- Doctors Online
- Health Wealth Connection

EMPLOYER CONTRIBUTION:
Your employer pays the full cost for the Advocacy Package.

EMPLOYEE COST
$0.00

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

new benefits®
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Teladoc

Enjoy On-Demand Healthcare

with 24/7 Access to Doctors by Phone at No Cost

What Teladoc Does for You

- Doctors offer a diagnosis, treatment options, and prescription, if medically necessary
- Treatment for common medical issues such as colds, flu, poison ivy, respiratory infections, bronchitis, pink eye, sinus problems, allergies, urinary tract infections and ear infections
- Visits for all ages — from children to seniors
- Includes spouse and dependents
- If you are caring for an aging parent or loved one, you can provide them access to $45 visits
- U.S. board-certified doctors with an average 20 years practice experience
- Upon request, Teladoc can share visit information with your doctor

Avoid the waiting room — Teladoc doctors respond in 10 minutes on average

Google Play | Available on the App Store

Download the New Benefits Mobile App

844.713.2870 | MemberPortal.NewBenefits.com

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creating advantage.

Roadside Assistance

Stay Safe on the Road
with 24/7 Assistance Just a Call Away

What Roadside Assistance Does for You

- Even when the right precautions are taken, car issues can happen to anyone at any time
- Keep yourself and your family protected on the road with 24/7 assistance available for common car troubles
- Help is available for flat tires, lock-outs, dead batteries, and collisions
- Towing service is available with coverage up to $80 per occurrence
- Roadside Assistance will also bring fuel, oil, fluid, and water

Drivers are expected to experience an average of five flat tires in their lifetime

ANDROID APP ON Google Play

Available on the App Store

Download the New Benefits Mobile App
844.713.2870 | MemberPortal.NewBenefits.com

Limit one service within 72 hours and five free services per year. This is not an insurance product. For a complete explanation of this benefit log on to MemberPortal.NewBenefits.com and read Terms and Conditions.

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Experts Help You Navigate Healthcare
and Negotiate Medical Bills

Health Advocate Solutions gives you access to:

- **Health Advocacy**
  - You'll be connected to a Personal Health Advocate who can help:
    - Untangle medical bills and insurance claims
    - Locate doctors, specialists, hospitals, dentists, and pharmacies
    - Clarify benefits and answer questions about tests, treatments, and medications
    - Coordinate care among multiple providers
    - Assist with eldercare and related healthcare issues
    - Arrange second opinions
    - Transfer medical records
    - Provide information about generic drug options
- **Medical Bill Saver™**
  - Experts who know the ins and outs of billing practices will attempt to negotiate discounts on your behalf, possibly leading to a reduction in your costs
  - Receive an easy-to-read personal Savings Results Statement summarizing the outcome and payment terms for successful negotiations
- **NurseLine™**
  - Highly trained registered nurses are on-call 24/7 to answer your questions for non-urgent concerns
  - Nurses can offer self-care tips, direct you to the appropriate care for immediate attention, or tell you how to ease common problems such as a sore shoulder
  - Respond to most requests by the next business day
  - Have passed rigorous credentialing and completed extensive training

In-network healthcare prices vary by 300% or more.

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The Health Advocacy program is not health insurance. Health Advocacy provides administrative, informational and referral type services, through its employees. Health Advocacy does not provide medical services and does not recommend treatment. Independent healthcare practitioners, who are not Health Advocacy's employees or agents, provide all medical services.

RETIREMENT

DEFINED CONTRIBUTION PLAN 401(k)

Utah Youth Village employees may participate in the company sponsored 401(k) Plan. The plan offers diverse investment choices. The following information is intended as a brief summary only. The 401(k) plan document should be referenced for all questions or details concerning the plan.

ELIGIBILITY

All employees who are at least 18 years of age, and who have completed one year of service and at least 1,000 work hours, are eligible to make contributions into the plan. Participation in the plan is voluntary and your contribution amount can be changed at any time throughout the year. Eligible employees may enroll quarterly, on the first day of January, April, July and October of each year.

CONTRIBUTIONS

You may elect to contribute as little as 1% up to 100% of your compensation into the plan. The maximum dollar amount the IRS will allow you to contribute in 2022 is $20,500. If you are age 50 or older, you may contribute an additional $6,500 as a “catch-up” contribution for a total of $27,000 annually.

You will automatically become a participant in the non-elective employer contributions on the 1st day of the quarter following attainment of one year of service. Employer contributes two types of non-elective contributions. The first, a safe-harbor non-elective contribution of 3% of your compensation. Second, your employer may also make an additional discretionary contribution of 2% (1-10 years of service) or 12% (10+ years of service), respectively.

VESTING SCHEDULE

You are always 100% vested in your employee contributions. Discretionary employer contributions are vested as shown on the vesting schedule below:

VESTING SCHEDULE	
Years of Service	Percentage Vested
0-1	0%
2	20%
3	40%
4	60%
5	80%
6+	100%

FOR MORE INFORMATION

Visit **https://plan.empower-retirement.com**
Or call: **1-855-756-4738**
Plan Number: **331084-01**

Retirement plan participants may want advice as they face complex decisions and choices that will define their retirement income potential in the future. Most feel unprepared to make these difficult decisions alone.

Our **WellCents** program delivers participants the tools they need to get on track to retire successfully. NFP’s retirement plan advisors are licensed and trained to deliver sound advice, rooted in research-proven retirement planning techniques and investment advisory services. To schedule your appointment with an NFP advisor, look for communication and instructions from your Human Resource department.

FINANCIAL WELLNESS

WELCOME TO WELLCENTS

We are excited to announce a new and exciting benefit for Utah Youth Village employees. Employees are able to enjoy the benefits of our new financial wellness program offered through WellCents™. WellCents is a comprehensive, holistic financial wellness solution designed to help you create confidence in your financial life. Our goal is to help you develop a real-life action plan to move you toward being financially well, and in turn, help you secure a financially sound retirement.

WHERE TO START

It all begins with an online *Personal Financial Wellness Assessment*. Once you take the assessment you will receive a customized analysis of your current financial situation and recommended steps to help improve your position. It will also provide links to resources, articles, checklists and calculators designed to improve your financial literacy.

FINANCIAL WELLNESS ASSESSMENT

We hope everyone will participate in the program and take advantage of the new tools and resources available through the WellCents Portal.

ONE ON ONE MEETING

Many of you who are currently participating in the Utah Youth Village 401(k) Plan may have already taken advantage of the one-on-one retirement planning sessions offered in partnership with our advisors at NFP. WellCents builds on that program and is available to all employees regardless of whether you participate in the company's retirement plan. Scheduling your personal advisory session will now happen through your personalized WellCents Dashboard.

FOR MORE INFORMATION

If you have questions, contact us at:
retirementsolutions@nfp.com
Or call: **1-800-553-3903**
Plan Number: **331084-01**

NEXT STEPS

Go to https://mywellcents.com/UYV

Business Code for App: UYV

Safe Harbor Notice

331084-01 Utah Youth Village, Inc. Profit Sharing Plan

empowermyretirement.com

The Utah Youth Village, Inc. Profit Sharing Plan (the "Plan") allows both the participants and Utah Youth Village, Inc. (your "Employer") to make contributions to the Plan. In order to allow you to make an informed decision on the level of your own contributions, if any, and to meet certain Internal Revenue Code nondiscrimination requirements, your Employer must inform you of the type of contribution it will make to your Plan account. These contributions to your account are called “safe harbor” contributions. This notice is intended to meet that requirement for the Plan Year ending December 31, 2022.

Paycheck Contributions

As explained more fully in the Summary Plan Description (SPD), you can contribute a portion of your eligible pay to your Plan on a before-tax or after-tax Roth basis. Your total paycheck contributions may not exceed the annual dollar limit set by the Internal Revenue Service (IRS).

If you are age 50 or older, you may be eligible to make before-tax or after-tax Roth “catch-up” contributions beyond the limits described above, up to the maximum annual “catch up” contribution amount.

Check your SPD for more information on the types and amounts of other paycheck contributions that can be made to your plan (if any), on the limits and the types of compensation included in eligible pay. If your Employer/Plan utilizes an Automatic Contribution Arrangement, you will receive a separate notice regarding these provisions from your Plan.

You may begin making paycheck contributions or change the amount of your paycheck contributions by accessing empowermyretirement.com or calling 1-800-338-4015.

Safe Harbor Employer Contribution

To help you make an informed decision about your paycheck contributions, it is important to know about the safe harbor employer contributions your Employer will make to your account.

Your Employer will make the following safe harbor nonelective contribution: 3% of compensation. This contribution will be made on your behalf regardless if you contribute to the Plan.

Your Employer may amend the plan during the year to reduce or suspend the safe harbor employer contributions. If your Employer chooses to do so, you will receive a notice explaining the reduction or suspension at least 30 days before the change is effective. Your Employer will make any safe harbor contributions you have earned up to that point.

Other Plan Contributions

In addition to the contributions described above, your Plan may allow for other contributions to be made. Check your SPD for other types of contributions allowed in the Plan, if any.

Vesting Provisions

Vesting means the portion of your accounts in the Plan that you are entitled to receive if you no longer are employed by your Employer. Your paycheck contributions to the Plan and the safe harbor contributions made by your Employer (together with any investment gain or loss) are always fully vested.

You will also be fully vested in your plan accounts if you leave employment after reaching the Plan’s normal retirement age, or upon becoming disabled, or as a result of death. If you leave your employment for any other reason, you will be entitled to receive only the vested portion of your Employer contribution accounts under the following schedule or schedules:

VESTING SCHEDULE

Money Type	Years of Service	Vested Percentage
EMPLOYER MATCH	0 - 2	0%
	2 - 3	20%
	3 - 4	40%
	4 - 5	60%
	5 - 6	80%
	6 - 99	100%
EMPLOYER PROFIT SHARING	0 - 2	0%
	2 - 3	20%
	3 - 4	40%

VESTING SCHEDULE		
Money Type	Years of Service	Vested Percentage
	4 - 5	60%
	5 - 6	80%
	6 - 99	100%
SAFE HARBOR NON-ELECTIVE	0 - 99	100%
SAFE HARBOR MATCH	0 - 99	100%
EMPLOYER NON-ELECTIVE - TA - RETIREMENT PLAN	0 - 2	0%
	2 - 3	20%
	3 - 4	40%
	4 - 5	60%
	5 - 6	80%
	6 - 99	100%

Withdrawal Provisions

Even if you are vested in your Plan account, Plan provisions dictate when you may withdraw your funds. These Plan provisions may be important to you in deciding how much, if any, to contribute to the Plan.

In general, amounts accumulated in your Plan account are available after you leave employment with your Employer. Your beneficiary may withdraw any vested amount remaining in your Plan account after you die. You may also withdraw certain vested amounts from specified eligible money sources in your Plan account under the following circumstances (note that additional conditions may need to be satisfied):

- when you reach age 59½.
- when you reach the Plan's normal retirement age.
- Refer to the Plan's SPD for qualifying reasons and other requirements for hardship withdrawals.

There may be certain money sources that are available for withdrawal at any time.

There is generally a 10% early withdrawal penalty on taxable withdrawals taken before age 59½ unless another exception applies. You can also learn more about taxation and the early withdrawal penalty in the Internal Revenue Service (IRS) Publication 575, "Pension and Annuity Income" or by seeking guidance from a financial expert.

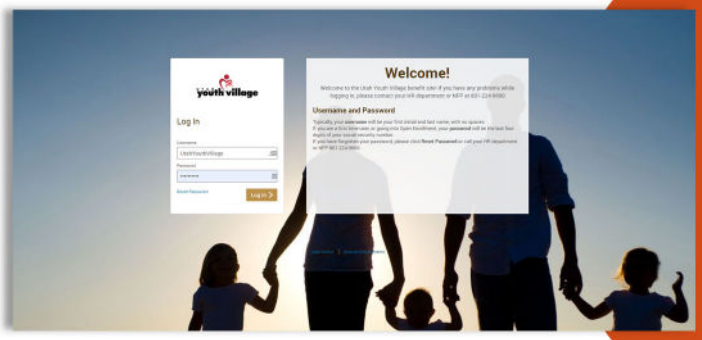
Check your SPD for more information on your Plan's withdrawal provisions.

Additional Information

If you have additional questions after reading this notice and the Summary Plan Description (or to obtain a copy of the SPD), please contact Empower Retirement at 1-800-338-4015.

If there is a conflict between contents of this Safe Harbor notice and the Plan Document, the terms of the Plan Document will govern.

BSWIFT

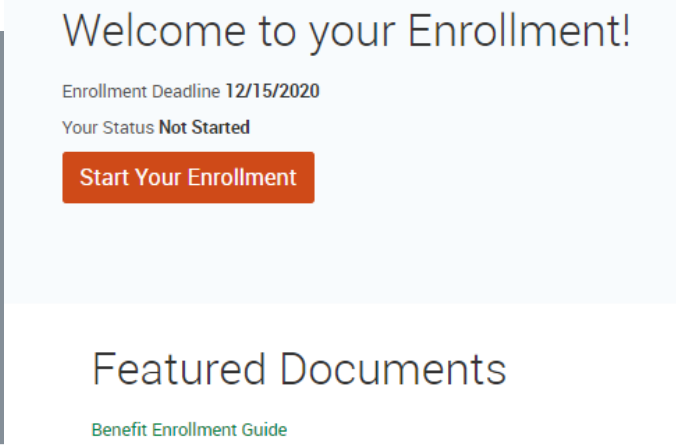


LOG IN

You can login directly to your online enrollment site by using the web address www.utahyouthvillage.bswift.com. You will be directed to your company's login screen, similar to the picture on the left. **Instructions for your Username and Password will be in the bottom right hand corner of your login webpage.** Please contact your HR Department or NFP, at 1.801.224.9600 or 1.800.553.3903 if you have any problems logging in.

GET STARTED

Once you are logged in, you will be directed to your Home Page, similar to the picture on the right. Click the **Start Your Enrollment** button to begin your enrollment.

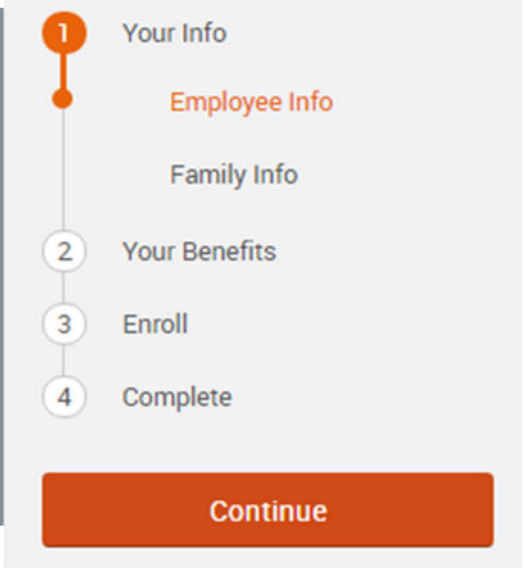


ENROLLMENT 4 STEPS

You must complete all four steps in order for your enrollment to be saved!

STEP 1: VERIFY PERSONAL & FAMILY INFORMATION

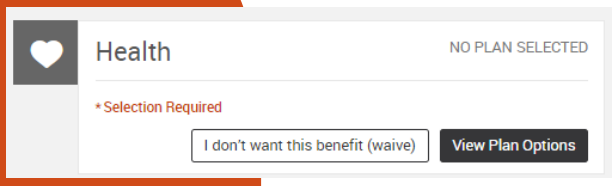
You will be required to verify and update your personal and family information.



BSWIFT

STEP 2: SELECT YOUR BENEFITS

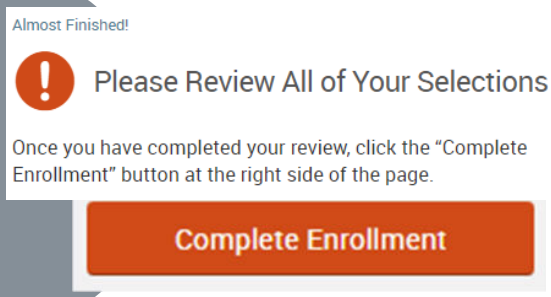
You will see a page listing all the plan types. Select your benefit by type by clicking on the View Plan Options button in each plan type box. Make sure to click on the family members at the top that you would like to be covered for each plan.



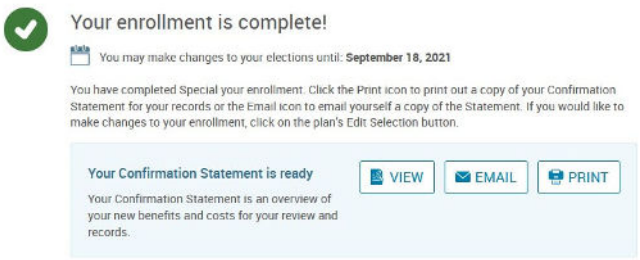
To make a selection, click on the "View Plan Options" link to view and sign up for a plan. If you are not interested in a particular benefit, click on the "I don't want this benefit (waive)" option. Once you have enrolled in or waived a plan you will see the green "Completed" checkmark below the plan panel. Continue making selections for each plan type. If you wish, you may go back and edit a completed benefit by clicking View Plan Options again. When you are satisfied with your benefit elections, click Continue at the right of the page to be taken to the beneficiary designation page. **In order for your elections to be saved, please be sure to complete the last step: Final Confirmation.**

STEP 3: CONFIRM AND SAVE YOUR ELECTIONS!

When you are finished reviewing your elections, read the agreement text for each benefit type, and then check the "I have finished my enrollment and agree to the statement(s) above" checkbox and click the **Complete Enrollment** button on the right.



STEP 4 : COMPLETE YOUR ENROLLMENT



When you reach the **Confirmation Statement**, you have completed your enrollment and your elections will be saved. You may select "View" to review your selections, or you may elect to **Print** or **Email** yourself a copy of this statement by utilizing the printer or email icons on the page.

ADDITIONAL INFORMATION

PREVENTIVE HEALTH CARE

Understanding what's covered

What is preventive care?

Preventive care is a specific group of services recommended when you don't have any symptoms and haven't been diagnosed with a related health issue. It includes your periodic wellness exam (check-up) and specific tests, certain health screenings, and most immunizations. Most of these services typically can take place during the same visit. You and your health care provider will decide what preventive services are right for you, based on your:

- Age
- Gender
- Personal health history
- Current health

Why do I need preventive care?

Preventive care can help you detect problems at early stages, when they may be easier to treat. It can also help you prevent certain illnesses and health conditions from happening. Even though you may feel fine, getting your preventive care at the right time can help you take control of your health.

Make a plan for preventive care.

Use this space to write down the details for your next periodic wellness exam.

Date: _____

Time: _____

Questions for my provider: _____

_____

What's not considered preventive care?

Once you have a symptom or your health care provider diagnoses a health issue, additional tests are not considered preventive care. Also, you may receive other medically appropriate services during a periodic wellness exam that are not considered preventive. These services may be covered under your plan's medical benefits, not your preventive care benefits. This means you may be responsible for paying a share or all of the cost. This may include your plan's deductible, copay or coinsurance amounts, depending on your plan.

Which preventive services are covered?

Many plans cover preventive care at no additional cost to you when you use a health care provider in your plan's network. Use the provider directory on **myCigna.com** for a list of in-network health care providers and facilities.

See the charts on the following pages for the services and supplies that are considered preventive care under most health plans. For more details, please check your plan materials.

Questions?

Talk with your health care provider or call the number on the back of your Cigna ID card.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

855050 h 01/19

Wellness exams

SERVICE	GROUP	AGE, FREQUENCY
Well-baby/well-child/well-person exams, including annual well-woman exam (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	● ● ●	• Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months • Additional visit at 2–4 days for infants discharged less than 48 hours after delivery • Ages 3 to 21, once a year • Ages 22 and older, periodic visits as doctor advises

Routine immunizations covered under preventive care

SERVICE	SERVICE
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP, Tdap, Td)	Meningococcal (meningitis)
Haemophilus influenzae type b conjugate (Hib)	Pneumococcal (pneumonia)
Hepatitis A (Hep A)	Poliovirus (IPV)
Hepatitis B (Hep B)	Rotavirus (RV)
Human papillomavirus (HPV) (age criteria may apply for some vaccine brands)	Varicella (chickenpox)
Influenza vaccine	Zoster (shingles)
Measles, mumps and rubella (MMR)	

You may view the immunization schedules on the CDC website: **cdc.gov/vaccines/schedules/**.

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Abnormal blood glucose and type 2 diabetes screening/counseling	● ●	Adults ages 40–70 who are overweight or obese; women with a history of gestational diabetes mellitus
Alcohol misuse/substance abuse screening	● ● ●	All adults; adolescents age 11–21
Aspirin to prevent cardiovascular disease and colorectal cancer, or to reduce risk for preeclampsia[1]	● ●	Adults ages 50–59 with risk factors; Pregnant women at risk for preeclampsia
Autism screening	●	18, 24 months
Bacteriuria screening	●	Pregnant women
Bilirubin screening (effective on or after 1/1/18 as plans renew)	●	Newborns before discharge from hospital
Breast cancer screening (mammogram)	●	Women ages 40 and older, every 1–2 years
Breast-feeding support/counseling, supplies[2]	●	During pregnancy and after birth
Cervical cancer screening (Pap test) HPV DNA test alone or with Pap test	●	Women ages 21–65, every 3 years Women ages 30–65, every 5 years
Chlamydia screening	●	Sexually active women ages 24 and under and older women at risk
Cholesterol/lipid disorders screening[1]	● ● ●	• Screening of children and adolescents ages 9–11 years and 17–21 years; children and adolescents with risk factors, ages 2–8 and 12–16 years • All adults ages 40–75
Colon cancer screening[1]	● ●	The following tests will be covered for a colorectal cancer screening, ages 50 and older: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually • Flexible sigmoidoscopy every 5 years • Double-contrast barium enema (DCBE) every 5 years • Colonoscopy every 10 years • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - Requires prior authorization • Stool-based deoxyribonucleic acid (DNA) test (i.e., Cologuard) every 3 years
Congenital hypothyroidism screening	●	Newborns
Critical congenital heart disease screening	●	Newborns before discharge from hospital

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions *(continued)*

SERVICE	GROUP	AGE, FREQUENCY
Contraception counseling/education (including fertility awareness-based methods); contraceptive products and services[1,3,4]	●	Women with reproductive capacity
Depression screening/Maternal depression screening	● ● ●	Ages 12–21; all adults, including pregnant and postpartum women
Developmental screening	●	9, 18, 30 months
Developmental surveillance	●	Newborn, 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
Discussion about potential benefits/risk of breast cancer preventive medication[1]	●	Women at risk
Dental caries prevention Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride[1] Application of fluoride varnish to primary teeth at time of eruption (in primary care setting)	●	Children older than 6 months Children to age 6 years
Domestic and interpersonal violence screening	●	All women (adolescent/adult)
Fall prevention in older adults (physical therapy)	● ●	Community-dwelling adults ages 65 and older with risk factors
Folic acid supplementation[1]	●	Women planning or capable of pregnancy
Genetic counseling/evaluation and BRCA1/BRCA2 testing	●	Women at risk • Genetic counseling must be provided by an independent board-certified genetic specialist prior to BRCA1/BRCA2 genetic testing • BRCA1/BRCA2 testing requires precertification
Gestational diabetes screening	●	Pregnant women
Gonorrhea screening	●	Sexually active women age 24 years and younger and older women at risk
Hearing screening (not complete hearing examination)	●	All newborns by 2 months. Ages 4, 5, 6, 8, 10. Adolescents once between ages 11–14, 15–17 and 18–21
Healthy diet and physical activity counseling	● ● ●	Ages 6 and older - to promote improvement in weight status; Overweight or obese adults with risk factors for cardiovascular disease
Hemoglobin or hematocrit	●	12 months
Hepatitis B screening	● ● ●	Pregnant women; adolescents and adults at risk
Hepatitis C screening	● ●	Adults at risk; one-time screening for adults born between 1945 and 1965
High blood pressure screening (outside clinical setting)[2]	● ●	Adults ages 18 and older without known high blood pressure
HIV screening and counseling	● ● ●	Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women (adolescent/adult), annually
Iron supplementation[1]	●	6–12 months for children at risk
Lead screening	●	12, 24 months
Lung cancer screening (low-dose computed tomography)	● ●	Adults ages 55 to 80 with 30 pack/year smoking history, and currently smoke, or have quit within the past 15 years. Computed tomography requires precertification.
Metabolic/hemoglobinopathies (according to state law)	●	Newborns
Obesity screening/counseling	● ● ●	Ages 6 and older, all adults
Oral health evaluation/assess for dental referral	●	6, 9 months. Ages 12 months, 18 months-6 years for children at risk
Osteoporosis screening	●	Age 65 or older (or under age 65 for women with fracture risk as determined by a Clinical Risk Assessment Tool). Computed tomographic bone density study requires precertification
PKU screening	●	Newborns
Ocular (eye) medication to prevent blindness	●	Newborns

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions *(continued)*

SERVICE	GROUP	AGE, FREQUENCY
Prostate cancer screening (PSA)	●	Men ages 50 and older or age 40 with risk factors
Preeclampsia screening (blood pressure measurement)	●	Pregnant women
Rh incompatibility test	●	Pregnant women
Sexually transmitted infections (STI) counseling	● ● ●	Sexually active women, annually; sexually active adolescents; and men at increased risk
Sexually transmitted infections (STI) screening	●	Adolescents ages 11–21
Sickle cell disease screening	●	Newborns
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation	● ● ●	Ages 6 months–24 years
Syphilis screening	● ● ●	Individuals at risk; pregnant women
Tobacco use cessation: counseling/interventions[1]	● ●	All adults[1]; pregnant women
Tobacco use prevention (counseling to prevent initiation)	●	School-age children and adolescents
Tuberculosis screening	● ● ●	Children, adolescents and adults at risk
Ultrasound aortic abdominal aneurysm screening	●	Men ages 65–75 who have ever smoked
Urinary incontinence screening	●	Women
Vision screening (not complete eye examination)	●	Ages 3, 4, 5, 6, 8, 10, 12, and 15 or as doctor advises

● = Men ● = Women ● = Children/adolescents

1. Subject to the terms of your plan's pharmacy coverage, certain drugs and products may be covered at 100%. Your doctor is required to give you a prescription, including for those that are available over the counter, for them to be covered under your Pharmacy benefit. Cost sharing may be applied for brand-name products where generic alternatives are available. Please refer to Cigna's "No Cost Preventive Medications by Drug Category" Guide for information on drugs and products with no out-of-pocket cost.
2. Subject to the terms of your plan's medical coverage, home blood pressure monitoring supplies, breast-feeding equipment rental and supplies may be covered at the preventive level. Your doctor is required to provide a prescription, and the equipment and supplies must be ordered through CareCentrix, Cigna's national durable medical equipment vendor. Precertification is required for some types of breast pump equipment. To obtain home blood pressure monitoring equipment, breast pump and breast pump supplies, contact CareCentrix at **844.457.9810**.
3. Examples include oral contraceptives; diaphragms; hormonal injections and contraceptive supplies (spermicide, female condoms); emergency contraception.
4. Subject to the terms of your plan's medical coverage, contraceptive products and services such as some types of IUDs, implants and sterilization procedures may be covered at the preventive level. Check your plan materials for details about your specific medical plan.

These preventive health services are based on recommendations from the U.S. Preventive Services Task Force (A and B recommendations), the Advisory Committee on Immunization Practices (ACIP) for immunizations, the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children and, with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration. For additional information on immunizations, visit the immunization schedule section of **www.cdc.gov**. This document is a general guide. Always discuss your particular preventive care needs with your doctor.

Some plans choose to supplement the preventive care services listed above with a few additional services, such as other common laboratory panel tests. When delivered during a preventive care visit, these services also may be covered at the preventive level.

Exclusions

This document provides highlights of preventive care coverage generally. Some preventive services may not be covered under your plan. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). For the specific coverage terms of your plan, refer to your plan documents. If there are any differences between the information displayed here and the official plan documents, the terms of the plan documents will control.

WELCOME TO CIGNA

Simple ways to make the most of your plan

When you know more about your plan, you can make better choices around health and spending. Let's dive in.

Cigna resources to improve your whole-person health

First, register on myCigna.com[1]

When your plan year begins, register on myCigna.com. That way you're ready to go whenever you need to find in-network health care providers, estimate costs and see your incentives.

Access virtual care

Conveniently connect with board-certified doctors, therapists and psychiatrists via video or phone.[2]

Connect with Cigna One Guide®

Our friendly guides have forward-thinking technology to answer questions on your plan, offer personalized advice and connect you to the right care. They can also proactively reach out.[3]

Ensure in-network care

myCigna and Cigna One Guide can help you stay in-network, maximize savings and avoid any surprises.

Get preventive care

Get preventive care, such as check-ups and biometric screenings at no additional cost to you. It's even available[4] virtually for maximum convenience.

Prioritize behavioral support

214,000 behavioral health and substance use providers[5] can help, either in person or virtually. We also have 24/7 therapy including Talkspace and Ginger for Cigna, and digital tools such as iPrevail and Happify™.[6]

Call our 24/7 Health Information Line

Talk with a clinician who can help you choose the right care, whenever you need it – late nights, holidays and more.

Simplify with mail-order medications

Express Scripts® is one of the largest pharmacies in the United States, and offers convenience, savings and stress-free prescription management.

Bounce back with RecoveryOne™ for Cigna®

Virtual physical therapy from the comfort of home that's convenient and available at no cost to you.

Utilize case management programs

Complex medical conditions can be overwhelming. Our trained teams can help coordinate care, understand benefits and reach goals through online coaching.

Together, all the way.®

Cigna®

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Make sure to get approval from your plan before getting care (known as prior authorization) for routine hospital stays or outpatient procedures.

Learn more at **myCigna.com** or by calling the number on the back of your card.

First, register on myCigna.com or the myCigna® App

Once you've registered, you can:

- Understand what's covered in your plan
- Find in-network doctors, hospitals and facilities and sort them by location, reviews and Cigna's quality rating
- Get cost estimates for appointments, procedures and medications
- Compare costs for 30- and 90-day medications and see if lower-cost alternatives are available
- Find retail pharmacies that offer a 90-day supply
- Manage and track claims
- Get alerts when new plan documents are available
- View or print a copy of your Cigna ID card
- Access a variety of health and wellness resources, including an online health assessment, health tracking tools and My Health Assistant digital coaching

Cigna One Guide

Combining digital technology with our personalized customer service, over the phone or on the myCigna App,[7] the Cigna One Guide support tool can:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find the right hospitals, dentists and other health care providers in your plan's network
- Get cost estimates
- Understand your bills
- Navigate the health care system

Virtual care[2]

Virtual care can be a convenient and affordable option for a wide range of care. For appointments, you can work with an in-network provider or connect with an MDLIVE®[2] provider at **myCigna.com**.

Right from your phone, tablet or computer, you can:

- Connect 24/7 with board-certified doctors and pediatricians for minor medical conditions, such as seasonal allergies, colds and flu, or upper respiratory infections
- Schedule appointments with licensed therapists or psychiatrists for behavioral or mental health conditions, such as stress and depression
- Have a prescription sent directly to your pharmacy, if appropriate

Virtual Wellness Screenings

Virtual wellness screenings are convenient and covered at no cost to you.[8]

Here's how they work:

- Complete your MDLIVE online health assessment
- Choose an in-network lab and schedule an appointment[9]
- Choose an MDLIVE provider and schedule your virtual visit
- Go to your lab appointment and you'll get a notification when the results are available in the MDLIVE customer portal
- Attend your virtual visit; you'll receive a summary of your screening results for your records

24/7 Health Information Line

At no extra cost, you can speak to a clinician to make more informed decisions about your care. Whether it's reviewing home treatment options, following up on a doctor's appointment or finding the nearest urgent care center in your plan's network, you can call the number on your Cigna ID card, day or night.

Specialty medications

We can help you understand, manage and treat complex conditions that require a specialty medication. Our therapy management teams, made up of health advocates with nursing backgrounds as well as pharmacists, are specially trained to help with your specific needs.

- Personalized, 24/7 support
- Condition-specific education on medication therapy and side effects
- Help with the medication approval process
- Financial assistance programs, if needed

For more information, call **800.351.3606**.

Preventive care

It's important to catch any issues while they're still small. That's why we cover eligible preventive care services at no extra cost, including:[4]

- Screenings for blood pressure, cholesterol and diabetes
- Testing for colon cancer
- Clinical breast exams and mammograms
- Pap tests
- Additional covered procedures listed on **myCigna.com**

Since your physical and emotional health are connected, make sure to talk about how you're feeling at your annual check-up.

RecoveryOne for Cigna includes:[6]

- Virtual physical therapy at no additional cost[10]
- A private video consult with a virtual physical therapist
- Customized plans to meet your needs – from the comfort and convenience of wherever you are
- A multimedia app that guides you through your personalized exercises
- Video, voice and chat conversations with your support team

Behavioral care

214,000 in-network behavioral health care providers. 67,000 of those are virtual.[5] Whether you're dealing with a behavioral health condition, going through a rough time or looking for substance use support, you can find the one that fits your needs, either in person or virtually. To find a virtual provider:

- Go to **myCigna.com** > Find Care & Cost
- Search for "Virtual Counselor" under "Doctor by Type"
- Call to make an appointment with your selected provider

Online visits with Cigna Behavioral Health network providers cost the same as in-office visits. Costs vary by plan.[11]

In-network care

Save money when you use doctors, hospitals and health facilities that are part of your plan's network. Chances are there's a network doctor or facility right in your neighborhood. It's easy to find quality, cost-effective care at **myCigna.com**.

Case management programs

Take advantage of our personal services to help you with your personal health needs. A Cigna case manager, trained as a nurse, can work closely with you and your doctor to check on your progress. You can get help with conditions and illnesses such as cancer, end-stage renal disease, neonatal care and pain management.

You also have access to My Health Assistant on **myCigna.com** to help you:

- Control stress
- Lose weight and eat better
- Enjoy exercise
- Quit tobacco
- Manage diabetes, Chronic obstructive pulmonary disease, asthma and other conditions

Enroll online today. Go to **myCigna.com** > Wellness > My Health Assistant – Online Coaching Program.

TIPS TO HELP YOU SAVE MONEY

Find where to get prescription drugs

- Find the complete list of covered medications on **myCigna.com**
- Use cost comparison tools on myCigna to compare prices and purchase mail-order prescriptions
- Use generics when possible
- Know what brand-name drugs are covered in your plan
- Ask your doctor about a 90-day supply for your maintenance medication(s) through our home delivery pharmacy service[11]

Know where to go for care

- Use an emergency room for true emergencies
- Don't wait: Locate an in-network convenience care clinic or urgent care center near you, before you need it
- Don't be fooled: Some emergency rooms look like urgent care centers, so know what type of facilities are in your area

Choose the right provider

- Know which providers are in your network by going to **myCigna.com** > Find Care & Costs
- Opt to connect with a board-certified doctor, therapist or psychiatrist via video or phone[2]
- Use in-network national labs to help save money

Be proactive about your health

- Get information on the cost of medications and treatments to avoid surprises
- Use your preventive care benefits, learn your core health numbers and make use of the health improvement tools at **myCigna.com**

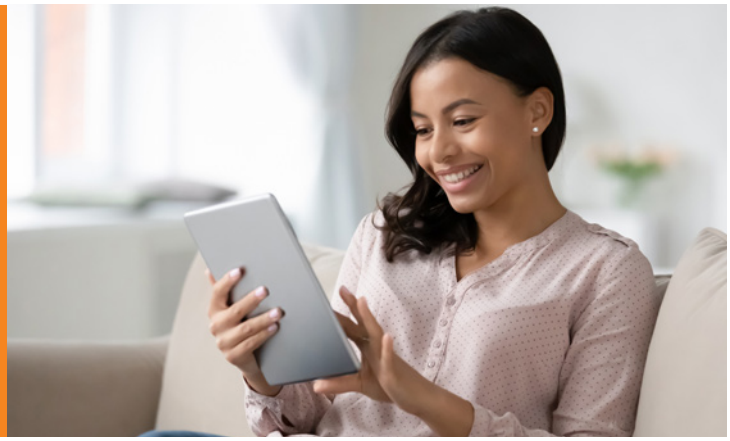
Find your way to better health.

Get more information on all the programs that are available to you.

When your plan year begins, register on myCigna.com.

Call the 24/7 customer service number on the back of your ID card.

Download the myCigna App.[7]



1. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com. 2. Cigna provides access to virtual care through participating in-network providers. Not all providers have virtual capabilities. Cigna also provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. All health care providers are solely responsible for the treatment provided to their patients; providers are not agents of Cigna. Refer to plan documents for complete description of virtual care services and costs. 3. Not available with all plans. 4. Not all preventive care services are covered and different plans may cover different things. For example, immunizations for travel are usually not covered. See your plan materials for a complete list of covered preventive care services. 5. Cigna unique provider data as of June 2021. Subject to change. 6. The program and services are provided by an independent company and not by Cigna. Program and services are subject to all applicable program terms and conditions. Program availability is subject to change. 7. The downloading and use of any mobile App is subject to the terms and conditions of the App and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply. 8. Not applicable to exempt plans. See your plan documents for details. 9. Limited to labs contracted with MDLIVE for virtual wellness screenings. 10. Cost and usage of this program is covered by your plan administrator; no additional out-of-pocket expense applies. 11. Not all plans offer all of these programs and services. Please log into the **myCigna** App or website, or check your plan materials, to learn more about what your plan offers. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative. The providers in Cigna's pharmacy network don't work for Cigna and are solely responsible for any treatment they provide.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, contact a Cigna representative.

REQUIRED NOTICES & FEDERAL MANDATES

REQUIRED NOTICES

Federal regulations require employers to provide certain notifications and disclosures to all eligible employees. This section of your benefit guide is dedicated to those disclosures for 11.01.21 – 10.31.22. If you have any questions or concerns please contact your Human Resources

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) of 1993 was designed to provide eligible employees with up to 12 workweeks per year of job-protected leave, to address critical personal and family matters. It is the policy of your employer and its U.S. subsidiaries to provide eligible employees with a leave of absence in accordance with the provisions of FMLA.

You are eligible for an FMLA leave of absence under this policy, if you meet the following requirements:

- You have completed at least 12 months of employment (need not be consecutive, but employment prior to a continuous break in service of seven or more years may not be counted).
- You have worked at least 1,250 hours during the 12-month period immediately preceding the commencement of the requested leave.
- You are employed at a work site where 50 or more employees are employed by the Company within 75 miles of that work site ("eligible employees").

To the extent permitted by law, leave taken pursuant to FMLA will run concurrently with Workers' Compensation, Short Term Disability, and all other Company leave policies.

The "break in service cap" doesn't apply if it:

- is attributable to fulfillment of National Guard or Reserve military service obligations; or
- is addressed in a written agreement, including a collective bargaining agreement, that expresses the employer's intent to rehire the employee after the break in service, such as a break to pursue education or raise children.

Procedure for Applying for FMLA Leave

If you desire and require an FMLA leave of absence under this policy, you must notify your manager and your Human Resources Department, and call your FMLA Administrator at least 30 calendar days in advance to the start of the leave, when the need for such leave is reasonably foreseeable (such as in the case of a birth, the placement of a child for adoption, or a planned medical treatment for a serious health condition). However, if the date of the birth, placement, or planned medical treatment requires leave to begin in less than 30 calendar days, you must provide such notice to the aforementioned parties as soon as it is both possible and practicable. Failure to provide timely notice may result in a delay or denial of FMLA leave.

IRS CODE SECTION 125

Premiums for medical, dental, vision insurance, and/or certain supplemental plans and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC), and are pre-tax to the extent permitted. Under Section 125, changes to an employee's pre-tax benefits can be made ONLY during the Open Enrollment period, unless the employee or qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employees may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse, or dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of the qualifying event.

Examples Of Qualifying Events:

- Legal marital status (for example, marriage, divorce, legal separation, annulment);
- Number of eligible dependents (for example, birth, death, adoption, placement for adoption);
- Employment status (for example, strike or lockout, termination, commencement, leave of absence, including those protected under the FMLA);
- Work schedule (for example, full-time, part-time);
- Death of a spouse or child;
- Change in your child's eligibility for benefits (reaching the age limit);
- Change in your address or location that may affect the coverage for which you are eligible;
- Significant change in coverage or cost in your, your spouse's or child's benefit plans;
- A covered dependent's status (that is, a family member becomes eligible or ineligible for benefits under the Plan);
- Becoming eligible for Medicare or Medicaid; or
- Your coverage or the coverage of your Spouse or other eligible dependent under a Medicaid plan or state Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- You, your spouse or other eligible dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance.

Qualifying Events, which ARE NOT available for a Health Care FSA program, if applicable:

- Coverage by your spouse or other covered dependent permitted under the spouse's or covered dependent's employer's benefit plan due to a Change Event;
- The availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO is added to or deleted from the Medical Program);
- An election made by your spouse or other covered dependent during an open enrollment period under your spouse's or other covered dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your spouse's open enrollment period is in July and your spouse changes coverage); or
- The cost of coverage during the Plan Year, but only if it is a significant increase or decrease.

Available for Dependent Care FSA Only, If applicable:

- Your dependent care provider or cost of dependent care (a significant increase or decrease).

Additional Change Events For Health Care Options:

In addition to the above Change Events, you may also change elections for the Medical, Dental, Vision and Health Care FSA Programs if:

- You, your spouse, or other covered dependent become eligible for continuation coverage under COBRA or USERRA;
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child;
- You, your spouse, or other covered dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- You, your spouse, or other covered dependent become eligible for a Special Enrollment Period.

REQUIRED NOTICES

HEALTH COVERAGE REMINDER

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage or pay a penalty. You may obtain coverage through your employer or through the Marketplace.

- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.

Visit **www.healthcare.gov** for Marketplace information.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

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

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

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact Human Resource Department

MICHELLE'S LAW NOTICE

The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact your Human Resource Department as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

THE GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

Genetic Information Non-Discrimination Act (GINA) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

NOTICE OF ELIGIBILITY FOR HEALTH PLANS RELATED TO MILITARY LEAVE

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service; or
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed within the time period specified by USERRA, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect Continuation Coverage Under USERRA.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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).

REQUIRED NOTICES—COBRA

COBRA Coverage

Federal law requires your employer to offer participants and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

To Qualify For COBRA Coverage:

Participants – As an Employee Participant of your employer covered by our health plans, you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Spouses – As the spouse of an Employee Participant covered by our health plans, you have the right to choose continuation coverage for yourself if you lose group health coverage under our health plans, for any of the following reasons:

- The death of your spouse who was a participant;
- A termination of your spouse's employment (for reasons other than gross misconduct);
- A reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

Dependent Children - Dependent children of the Employee Participant covered by our health plans, have the right to continuation coverage if group health coverage under our plans, is lost for any of the following reasons:

- The death of a parent who was a participant;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;
- Parents' divorce or legal separation;
- A parent who is a participant becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the terms of the our health plans.

Please note that it is the Employee Participant's responsibility to notify the Human Resources/Benefits Department of any communication regarding loss of coverage and communication regarding such between the participant and the insurance carrier. Please note that employees must also provide notice of other events (e.g., divorce) to the Human Resources Department.

Continuation of Coverage Rights Under COBRA

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 Participant, 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 participant, 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.

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 Plans as a "dependent child."

When Is COBRA Continuation Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).
- For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

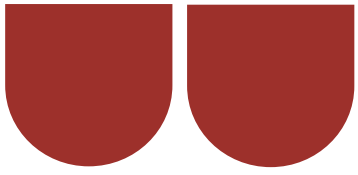
How Is COBRA Continuation Coverage Provided?

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:



REQUIRED NOTICES—COBRA

COBRA Coverage Continued..

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 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 Administrator 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.

REQUIRED NOTICES—WELLNESS

NOTICE REGARDING WELLNESS PROGRAM

The employee wellness program is a voluntary program administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health- related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which could include a blood test for certain medical conditions such as diabetes, heart disease, etc. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may qualify for an incentive. Although you are not required to complete a HRA or biometric screening, the wellness program may specify that only employees who do so will qualify for the incentive. Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

If you choose to participate in a HRA and/or biometric screening, information from your HRA and results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, **please contact your employer or Human Resources.**

REQUIRED NOTICES—CHIP

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, 2021. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since January 31, 2021, 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.

REQUIRED NOTICES—CHIP

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

For more information use this link

STATE	WEBSITE	PHONE
Alabama	http://myalhipp.com/	1-855-692-5447
Alaska	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861
Arkansas	http://myarhipp.com/	1-855-692-7447
California	https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx	1-916-445-8322
Colorado	Health First Colorado Website: http://www.healthfirstcolorado.com CHIP: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus	1-800-221-3943 / State Relay 711 CHIP: 1-800-359-1991 / State Relay 711
Florida	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	1-678-564-1162 Ext. 2131
Indiana	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ All other Medicaid: http://www.indianamedicaid.com	1-800-438-4479 1-800-457-4584
Iowa	Medicaid Website: https://dhs.iowa.gov/ime/members Hawki Website: http://dhs.iowa.gov/Hawki	Medicaid: 1-800-338-8366 Hawki: 1-800-257-8563
Kansas	https://www.kancare.ks.gov/	1-800-792-4884
Kentucky	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov	1-855-459-6328
Louisiana	www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid: 1-888-342-6207 LaHIPP: 1-855-618-5488
Maine	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-442-6003
Massachusetts	https://www.mass.gov/topics/masshealth	1-800-862-4840
Minnesota	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	1-800-657-3739
Missouri	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	1-573-751-2005
Montana	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
Nevada	http://dhcfp.nv.gov/	1-800-992-0900
New Hampshire	https://www.dhhs.nh.gov/oii/hipp.htm	1-603-271-5218 Toll free number for the HIPP Program: 1-800-852-3345, Ext. 5218
New Jersey	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP Website: http://www.njfamilycare.org/index.html	Medicaid: 1-609-631-2392 CHIP: 1-800-701-0710
New York	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	https://medicaid.ncdhhs.gov/	1-919-855-4100
North Dakota	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma	http://www.insureoklahoma.org	1-888-365-3742
Oregon	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania	https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	1-800-692-7462
Rhode Island	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
South Carolina	http://www.scdhhs.gov	1-888-549-0820
South Dakota	http://dss.sd.gov	1-888-828-0059
Texas	http://gethipptexas.com/	1-800-440-0493
Utah	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip	1-877-543-7669
Vermont	http://www.greenmountaincare.org/	1-800-250-8427
Virginia	https://www.coverva.org/hipp/	Medicaid: 1-800-432-5924 CHIP: 1-855-242-8282
Washington	https://www.hca.wa.gov/	1-800-562-3022
West Virginia	http://mywvhipp.com	1-855-699-8447
Wisconsin	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

REQUIRED NOTICES—HIPAA

NOTICE OF HIPAA PRIVACY PRACTICES

The privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) became effective April 14,2003. These federal regulations require covered entities, such as health plans, to provide plan participants with a notice of privacy practices describing the health-related information that is collected, how it is used, and the ways in which the regulations permit it to be disclosed. These privacy notices also provide information on a participant's right to access, review and, if necessary, to have this information amended.

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.

"**We**," "**us**", and "**Plan**" refer to all the health benefit plans and programs presented herein. "Plan Sponsor" refers to **your employer**. ''You" or "yours" refers to individual participants in the Plans. PHI is information that may identify you and that relates to past, present, or future health care services provided to you, payment for health care services provided to you, or your physical or mental health or condition.

Your employer Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:
1. The Plan's uses and disclosures of Protected Health Information (PHI);
2. Your privacy rights with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to:
1. Maintain the privacy of your PHI;
2. Provide you with certain rights with respect to your PHI;
3. Provide you with this Notice of our legal duties and privacy practices regarding your PHI; and
4. Abide by the terms of this Notice as it may be updated from time to time.
We protect your PHI from inappropriate use or disclosure. Our employees and those of our Business Associates are required to protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to determine coordination of benefits or services. We will not disclose your PHI to anyone for marketing purposes.

USES AND DISCLOSURES OF PHI

Primary Uses and Disclosures of PHI: The main reasons for which we may use and may disclose your PHI are in order to administer our health benefit programs effectively and to evaluate and process requests for coverage and claims for benefits.

The following describe these, and other uses and disclosures, together with some examples:

Treatment*: Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. We may disclose your PHI to health care providers to provide you with treatment. For example, we might respond to an inquiry from a hospital about your eligibility for a particular surgical procedure.

Payment*: Payment refers to our activities in collecting premiums and paying claims for health care services you receive. We may use your PHI or disclose it to others for these purposes. For example, if you had insurance coverage from a spouse's employer, we might disclose your PHI to the other insurer to determine coordination of benefits or services. Payment also refers to the activities of a health care provider in obtaining reimbursement for services. We may disclose your PHI to a provider for this purpose.

Health Care Operations Purposes*
1. We may use your PHI or disclose it to others for quality assessment and improvement activities.

2. We may use your PHI or disclose it to others for activities relating to improving health or reducing health care costs, development of health care procedures, case management, and care coordination.

3. We may use your PHI or disclose it to others for the purpose of informing you or a health care provider about treatment alternatives.

4. We may use your PHI or disclose it to others for the purpose of reviewing the competence, qualifications, or performance of health care providers, or conducting training programs.

5. We may use your PHI or disclose it to others for accreditation, certification, licensing, or credentialing activities.

6. We may use your PHI or disclose it to others in the process of contracting for health benefits or insurance covering health care costs.

7. We may use your PHI or disclose it to others for purposes of reviewing your medical treatment, obtaining legal services, performing audits or obtaining auditing services, and detecting fraud and abuse.

8. We may use your PHI or disclose it to others in our business management, planning, and administrative activities. As an example, we might use your PHI in the process of analyzing data about treatment of certain conditions to develop a list of preferred medications.

Business Associates: We contract with various individuals and entities (Business Associates) to perform functions on behalf of the Plans or to provide certain services. To perform these functions, our Business Associates may receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to safeguard your PHI.

Plan Sponsor: We and our Business Associates may also disclose PHI to the Plan Sponsor without your written authorization in connection with payment, treatment, or health care operations purposes or pursuant to a written request signed by you. Such disclosures may only be made to the individuals authorized to receive such information. If PHI is disclosed to the Plan Sponsor for these purposes, the Plan Sponsor agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Other Covered Entities: your employer (including the insured plans) together are called an "organized health care arrangement. "The Plans may share PHI with each other for the health care operations purposes of the organized health care arrangement.

*The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purpose, as defined under the HIPAA rules.

OTHER POSSIBLE USES AND DISCLOSURES OF PHI

In addition to using and disclosing your PHI for treatment, payment, and health care operations purposes, we may (and are permitted) to use or disclose it in the following circumstances:

To Persons Involved in Care and for Notification Purposes:
We may disclose PHI to a family member, relative, close personal friend, or any other person identified by you, provided that the PHI is directly relevant to that person's involvement with your care or payment related to your care. In addition, we may use or disclose PHI to notify a member of your family, your personal representative, or another person responsible for your care of your location, your general condition, or your death.

In Regard to Abuse, Neglect, or Domestic Violence: In certain circumstances, we may disclose your PHI to a government authority that is authorized to receive reports of cases of abuse, neglect, or domestic violence.

To Coroners, Medical Examiners, and Funeral Directors: We may disclose PHI to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other purposes authorized by law. We may disclose PHI to funeral directors to enable them to carry out their duties.

For Public Health Activities: We may disclose PHI to public authorities for the purpose of preventing or controlling disease, injury, or disability. Under some circumstances, when authorized by law, we may disclose PHI to an individual who is at risk of contracting or spreading a contagious disease or condition. We also may disclose PHI to appropriate parties for the purpose of activities related to the quality, safety, or the effectiveness of products regulated by the U.S. Food and Drug Administration.

To Avert a Threat to Health or Safety: We may, under certain circumstances, disclose PHI to avert a serious threat to the health or safety of a person or the general public.

Organ and Tissue Donations: We may, under certain circumstances, disclose PHI for purposes of organ, eye, or other medical transplants or tissue donation purposes.

To Comply with Workers' Compensation Laws: We may disclose your PHI to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs.

For Law Enforcement and National Security Purposes: In certain circumstances, we may disclose PHI to appropriate officials for law enforcement purposes; for example, if it is required by law or legal process. In addition, we may disclose your PHI if you are or were armed forces personnel or to authorized federal officials for conducting national security and intelligence activities.

In Connection with Legal Proceedings: In certain cases, we may disclose PHI in connection with the legal proceedings of courts or governmental agencies. For example, we may disclose your PHI in response to a subpoena for such information but only after certain conditions required by HIPAA are met.

For Health Oversight Activities: We may disclose PHI to a governmental agency authorized by law to oversee the health care system, compliance with civil rights laws, or government benefit. Health oversight activities include audits, inspections, investigations, or legal proceedings.

Military Personnel: If you are in the armed forces, we may disclose your PHI for activities that military authorities consider necessary to the accomplishment of a mission.

Inmates: If you are incarcerated, we may disclose your PHI to appropriate authorities who tell us they need it for your health care, your safety, the health or safety of other persons, or general administrative purposes.

Research: Under certain circumstances, we may disclose PHI for research purposes.

Health Information: We may contact you with information about treatment alternatives and other health-related benefits and services.

As Required by Law: We may disclose your PHI when required to do so by federal, state, or local law.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures we are required by law to make:

Disclosures to the Secretary of the U.S. Department of Health & Human Services: We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with HIPAA.

Disclosure to You: We are required to disclose to you most of your PHI. We will also disclose your PHI to an individual whom you have designated as your personal representative. However, before we can disclose your PHI to such person, you must submit a written notice of his/her designation along with documents supporting his/her qualification (such as a power of attorney). In limited situations HIPAA permits us to elect not to treat the person as your personal representative if we have reasonable belief that it could endanger you.

OTHER USES AND DISCLOSURES OF YOUR PHI WITH AUTHORIZATION

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. You may revoke an authorization at any time by providing written notice to us. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in reliance on the authorization. To obtain an Authorization for Release of Information, call the **Human Resources Department.** You may revoke an authorization by contacting the Health Information Privacy Officer identified at the end of this Notice.

YOUR RIGHTS

Right to Request Restrictions on Uses and Disclosure

You may ask us to restrict uses and disclosures of your PHI for treatment, payment, or health care operations purposes, or to restrict disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care, or to restrict disclosures for notification purposes. However, we are not generally required to comply with your request for restrictions except in those situations where the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment), and the PHI pertains solely to a health care item or service that was paid out of pocket in full. You may exercise this right by contacting the Health Information Privacy Officer identified at the end of this Notice who will provide you with additional information including what information is required to make a restriction request.

Right to Inspect, Copy, and Amend Your PHI

As long as we maintain records containing your PHI, you have a right to inspect and copy such information. These rights are subject to certain limitations and exceptions. For example, if the requested information contains psychotherapy notes or may endanger someone, it may not be available. You may request a review of any denial to access. If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. If you believe your PHI held and created by us is incorrect or incomplete, you may request that we amend your PHI. You will be required to provide the reason the amendment is necessary. Requests for access to your PHI or amendment of your records should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to a List of Disclosures

You have a right to an accounting of certain disclosures of your PHI by us. The accounting will not include those items which are not required to be provided such as disclosures made at your request or disclosures made for treatment, payment, or health care operations. A request for a list of disclosures should be directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to Request Confidential Communications

We will accommodate a reasonable request by you to receive communications from us by alternative means or at an alternative location if you believe that disclosure of your PHI could pose a danger to you. For example, you may request that we only contact you by mail or at work. Requests for confidential communications should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

REQUIRED NOTICES—HIPAA

Right to be Notified of a Breach

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to Receive Paper Copy

You have the right to receive a paper copy of this Notice from the Plan upon request even if you have previously agreed to receive copies of this Notice electronically. Requests for a paper copy should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI we maintain. If we change this Notice, you will receive a new Notice. Active employees will receive the Notice by distribution in the workplace; inactive employees (including retirees) will receive the Notice by mail.

Complaints: If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below under "Health Information Privacy Officer'' or with the office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Health Information Privacy Officer: You may exercise the rights described in this Notice by contacting the office identified below, which will provide you with additional information.

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- Primary Beneficiary – A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- Contingent Beneficiary – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.
- Domestic partnership (if covered)

Proof of relationship documentation may be required in order to add dependents to your plan(s). Employees will receive request for documentation.

The definition of qualifying dependents may vary by carrier and plan type. If there is any discrepancy, the insurance carrier's certificate of coverage is the prevailing document.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care — That meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network — The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

NOTES

About NFP

NFP is a leading insurance broker and consultant that provides employee benefits, property and casualty, retirement and individual private client solutions through our licensed subsidiaries and affiliates. Our expertise is matched by our commitment to each client's goals and is enhanced by our investments in innovative technologies in the insurance brokerage and consulting space.

NFP has more than 5,600 employees and global capabilities. Our expansive reach gives us access to highly rated insurers, vendors and financial institutions in the industry, while our locally based employees tailor each solution to meet our clients' needs. We've become one of the largest insurance brokerage, consulting and wealth management firms by building enduring relationships with our clients and helping them realize their goals.

For more information, visit www.nfp.com.