Impact Employment Solutions

Temporary Staffing

ENROLLMENT FORM PACKET

IMPORTANT:

Open Enrollment Period is from **March 4 thru March 22, 2019**.
Any changes need to be submitted by that date to your local Staffing Office.

This packet contains the following forms:

Allied Medical Enrollment Application - If you are currently enrolled and do not need to make any changes in coverage, you do not need to return an enrollment form. Coverage will continue as is.

If changes are needed please fill out the attached Enrollment Change Form, if you need to enroll at this time, please complete and return the attached Enrollment Form.

Return Forms to your local Staffing Office By Friday, March 22, 2019.

136 N. Huron, Toledo, OH 43604 PH: (419)243-5848 FAX (419)243-6348

Impact Employment Solutions, Inc.
Impact Employment Solutions of Florida, LLC; d/b/a Pro Image Solutions
Impact Employment Solutions of Kentucky, LLC; d/b/a The Job Shop
IES Med Plus of Kentucky, LLC
Impact Employment Solutions of Georgia, LLC

TEMPORARY STAFFING

BENEFITS ENROLLMENT GUIDE

Please review this packet carefully!

MEC & ACP-16 Plans

EFFECTIVE APRIL 1, 2019

This is a passive enrollment. If you are satisfied with your current coverage elections and do not want to make any changes you do nothing. If you need to add/change/waive coverage please complete the appropriate forms.

Enrollment forms must be returned to the Staffing Office.

FOR NEW HIRES:
Deadline for return of forms is 31 days from date of hire

FOR CURRENT EMPLOYEES:
Deadline for return of forms is March 22, 2019

About this Guide

This Guide summarizes the key features of your employers Benefit Plans. If any conflict arises between the information stated here and any Plan provisions, the terms of the actual Plan documents or other applicable documents will govern in all cases. Provisions of the Plans and eligibility for coverage do not constitute a contract of employment with any individual. Plans described in this Guide are subject to change at the discretion of your employer

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Welcome to the 2019 Open Enrollment process. In this Benefits Enrollment Guide, we have included explanations of the benefits programs, customer service phone numbers, web addresses and comparison charts. This Guide is not just an enrollment guide; it is a resource to use throughout the year for services and benefits that you may elect as an employee. In this Guide, you will find the information you need to make informed decisions regarding the selection and continued management of your benefits. Finally, instructions on how to enroll for your benefits and Enrollment Forms are included for your completion.

Your Benefits Checklist - The checklist below will assist you with the benefit enrollment process.

☑ **Review the materials** in this Benefits Enrollment Guide for basic information.

☑ **Choose to enroll in one of the Medical/Rx Programs, or to Waive Coverage.**

1. If you are satisfied with your current coverage elections and do not want to make any changes you do nothing. You may change your enrollment to the MEC Plan or ACP Plan, or you may waive coverage by completing the Enrollment Form and returning it to your local Human Resources Department.
2. If you are a new enrollee, you **MUST** complete the Enrollment Form.
3. If you do not wish to elect Medical/Rx, please indicate **Waiving Coverage** on the Enrollment Form and return to your local Human Resources Department.

☑ **Return the Enrollment Form to your Human Resources Department** (even if you decide to decline any or all of the benefits being offered to you) **no later than 31 days from the date you became eligible for coverage for new hires or March 22, 2019 for currently enrolled employees.**

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact your Human Resources Department.

MEDICAL: ALLIED BENEFIT SYSTEMS, INC.

www.alliedbenefit.com

1) ACP Plan (Affordable Care Plan – No Network)
2) MEC Plan (Minimum Essential Coverage – No Network)
   Phone 866-455-8727

PRESCRIPTION DRUG: CVS HEALTH (CAREMARK)

www.caremark.com
Phone 800-831-4440

Health Care – Continue Two Options for 2019!

MEC Plan: (Minimum Essential Coverage) Provides Preventive Care and limited Office Visit and Pharmacy coverage. This Plan satisfies the Individual Mandate under the Affordable Care Plan (ACA). The Individual Penalty has been eliminated beginning in 2019.

ACP Plan: (Affordable Care Plan) simplifies the way you receive health care benefits. Covered expenses are paid at specified levels without a Preferred Provider Network. This plan uses the same reimbursement rates as the Federal Government under the Medicare Fee Schedule. This plan satisfies affordability of not exceeding 9.5% of your income.

PRESCRIPTION DRUG: CVS / Caremark is our Pharmacy provider.

a. The MEC Plan will be $5 per Generic script, and a Discount Only for any Brand script.

b. The ACP Plan will be a Discount Only for all prescription drugs, subject to the deductible and out of pocket maximum.

c. Pharmacies in network include not only CVS, but also Walgreens, Rite Aid, Kroger, Target, and many other stores.

		MEC		ACP
		No Network		No Network
Deductible	*Single/Family*	$0		$2,000 / $4,000
Coinsurance		100% of Medicare Reimbursement Rate		90% of Medicare Reimbursement Rate
Prescription Drug Out of Pocket Limit	Single/Family	Not applicable		Not applicable
Maximum Out of Pocket Limit Includes Deductible & Coinsurance	Single/Family	Not applicable		$6,750 / $13,500
Inpatient Hospital		Not Covered		90% after deductible
Emergency Room		100% - 2 visits per calendar year		90%
Office Visits	Primary Care Physician	100% - 3 visits per calendar year		Deductible Waived 100%
	Specialist	100%		Deductible Waived 90%
	Urgent Care	100% - 2 visits per calendar year		90%
Prescription Drugs		Retail	Mail Order	Discount Only
	Generic / Formulary / Non-Formulary	$5 Generic Only	$10 Generic Only	
	Specialty Drug			
		Limited to 12 prescriptions per year		
Teladoc Talk to a doctor 24/7 with no cost		Included		Included
Meets IRS Requirement		Meets Individual		Meets Employer and Individual
Balance Billing		Yes		Yes

Benefit Overview

Medical Plans:

MEC Plan - Allied is our medical payor, customer service and claims processor for the MEC plan. You may use any provider, there are no networks or deductibles. However, it is possible that you may be balance billed. **The MEC plan will be offered to staffing employees that are regularly scheduled to work 30 or more hours per week.**

ACP Plan - Allied is our medical payor, customer service and claims processor for the ACP plan. You may use any provider, there are no networks. Hospital charges are subject to a deductible and out-of-pocket maximum. Otherwise, there is no deductible and coverage is first dollar. However, it is possible that you may be balance billed. **The ACP plan will also be offered to staffing employees that are regularly scheduled to work 30 or more hours per week.**

Prescription Drug Plan:
CVS / Caremark is our prescription drug carrier. We provide both retail and mail order options for purchasing prescription drugs. The prescription drug coverage is automatic with your enrollment in the ACP or MEC plan.

Identification Cards:
All participants in the medical/Rx plan will receive identification cards from Allied and can be used for medical services and prescription drugs. The cards are personalized with a member specific identification number. These cards will be mailed to your employer and distributed accordingly. Your Identification Cards will not have your Social Security Number on them for security purposes.

NOTE: All members will receive two copies of their Allied/Caremark ID card. If you need additional cards please contact Allied at the member services number on the back of the ID card. **Please provide your new Allied card to your physician and pharmacist for correct claim processing.**

Your Benefit Cost
Your cost will vary depending upon the type and level of coverage you elect and if you are enrolling dependents. It is our goal to attract and retain diverse employees with a variety of family situations and to make benefit plan coverage attractive and affordable for each.

A Few Words about Taxes

Your benefit program allows you to pay for your medical/prescription drug benefit on a pre-tax basis, meaning you pay with dollars that haven't had federal, state (unless your state does not allow this), or Social Security taxes deducted. This also means that your taxable income will be reduced. Because Medical/Rx premiums are paid with pre-tax dollars, you save money. In most cases, as much as 20% to 30% of the cost you would have paid on an after-tax basis.

MEC Plan

	WEEKLY PRICING:	MONTHLY PRICING:
Single	$19.96	$86.50
EE/Spouse	$40.38	$175.00
EE/Child/ren	$33.92	$147.00
Family	$53.08	$230.00

ACP Plan Based on EE Rate of Pay

	WEEKLY PRICING:	MONTHLY PRICING:
$8 Band		
Single	$23.66	$102.53
EE/Spouse	$179.89	$779.53
EE/Child/ren	$127.97	$554.52
Family	$284.20	$1,231.53
$9 Band		
Single	$26.62	$115.35
EE/Spouse	$182.85	$792.35
EE/Child/ren	$130.93	$567.35
Family	$287.16	$1,244.35
$10 Band		
Single	$29.58	$128.18
EE/Spouse	$185.81	$805.18
EE/Child/ren	$133.89	$580.18
Family	$290.01	$1,257.18
$11 Band		
Single	$32.54	$141.01
EE/Spouse	$188.77	$818.01
EE/Child/ren	$136.85	$593.00
Family	$293.08	$1,270.01
$12 Band		
Single	$35.50	$153.83
EE/Spouse	$191.73	$830.83
EE/Child/ren	$139.81	$605.83
Family	$296.04	$1,282.83

Waiting & Enrollment Periods

INITIAL ENROLLMENT PERIOD

MEC Blue Plan:

Employees: If you were employed before the Plan's effective date and not in your eligibility period, you are eligible for coverage immediately. If you were employed after the Plan's effective date or are in your eligibility period, you become eligible for coverage the 60th day of full-time employment. Your coverage will not be effective until you sign and date the enrollment form within 31 days of the date of hire.

ACP-16 Plan:

Employees: If you were employed before the Plan's effective date and not in your eligibility period, you are eligible for coverage immediately. If you were employed after the Plan's effective date or are in your eligibility period, you become eligible for coverage the 90th day of full-time employment. Your coverage will not be effective until you sign and date the enrollment form within 31 days of the date of hire.

Family Members: Coverage for your eligible family member becomes effective on the date you first acquire the family member, but in no event before the date you become covered under the Plan. Your family member's coverage will not be effective until you submit an enrollment form.

Your newborn child will be covered from the moment of birth, if you already have family coverage and you enroll your newborn for coverage within 31 days of the child's birth. The enrollment form must include the baby's name, sex and date of birth and must be received by Human Resources within 31 days of the date eligible.

You will receive an enrollment form to fill out. This form will allow your employer to deduct your contributions from your pay. You or your family members must enroll within 31 days of becoming eligible. Your enrollment form must be received by Human Resources within 31 days of the date eligible. If your enrollment form is not submitted within the time periods specified, neither you nor your family member(s) shall be considered eligible for coverage under the Plan at this time, but will be considered a "Late Enrollee".

ANNUAL OPEN ENROLLMENT PERIOD

You and your eligible family members are eligible, on a once per year basis, to enroll in this Plan. During this annual open enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. This is the time when you have the option to change your coverage. The choice you make during this annual enrollment period will become effective the first of the following year. If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next open annual enrollment period unless you qualify for Special Enrollment or a Late Enrollment as described below.

LATE ENROLLMENT

If you do not return your enrollment form during the initial enrollment period, you and your eligible dependents may be considered Late Enrollees and coverage may be deferred until next late entrant enrollment period/open enrollment period. If at the time of your initial enrollment you elect coverage for yourself and later request coverage for your eligible dependents, they may be considered late enrollees.

You must sign and return your enrollment form before the end of the next late entrant/open enrollment period. However, you and your eligible dependents may not be considered late enrollees under the circumstances described below in the special enrollment section.

SPECIAL ENROLLMENT RIGHTS

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

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

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

REHIRE WAITING PERIOD PROVISION:

When an employee misses two weeks of deductions and is terminated from the plan; Allied sends out COBRA notice. If the employee is rehired within 90 days they will come on as an "ongoing" employee (ie; coverage will be effective the new date of hire and there will be no waiting period).

If the Employee is rehired after 90 days, they will be considered a new hire and will have to satisfy the waiting period before being eligible to enroll in benefits.

Enrollment Guidelines

Who Can Enroll

Newly-hired and returning employees are eligible for the following, if you work an average of 30 or more hours per week and are a regularly scheduled full time employee.

If you do not enroll within 31 days of becoming eligible for coverage, you may not enroll until the next open enrollment period.

-Medical/Prescription Drug coverage (ACP or MEC Plan)

Who Can You Cover

In addition to yourself, you may enroll your eligible dependents in the Medical/Rx, Dental, Vision and Voluntary Life plans. Eligible dependents include:

- Your spouse,
- Your dependent children up to age 26 - Natural, adopted children or children placed for adoption. We will continue to cover dependents as long as they meet the eligibility requirements and are enrolled. You can choose to enroll your children in your plan, your spouse's plan, or both. If your children are enrolled in both your plan and your spouse's plan, the plan covering the parent whose birthday falls first in the year will be primary.
- Stepchildren
- Children under legal guardianship approved by court of competent jurisdiction or subject to a Qualified Medical Child Support Order (QMCSO).
- Qualified Child Support Order
  A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Order (QDRO) is a court order requiring a parent to provide dependent life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or QDRO if the child meets the plan's definition of an eligible dependent and you request coverage for the child in writing within 31 days of court order. If you do not request coverage for the child in the 31 day period, you will need to wait until the next annual enrollment period. Under a QMCSO or QRDO, if you're the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.
- Other children under age 26 for which you have been granted legal guardianship and for whom you provide at least 50% support (this may include grandchildren, nieces and nephews); however, coverage may end prior to age 26 if legal guardianship terminates or you are no longer providing at least 50% support.
- Your children of any age who are incapable of self-support because they became mentally or physically handicapped before age 18. Your child must be dependent on you for care and support. If mentally and physically handicapped before age 18, they must be unmarried to remain on your coverage after age 26.

If You and Your Spouse Both Work for Your Employer
If you and your spouse both work for your employer, you cannot both enroll for family coverage in any of the plans. One of you can elect "employee only" coverage and the other can cover eligible children under the Medical Plans or one of you may elect family coverage and the other may waive coverage. You cannot be covered as an employee and as a spouse. In addition, a dependent child may not be covered by more than one employee.

Coordination of Benefits
"Coordination of Benefits" is a term used in the insurance industry to refer to the process of paying benefits covered by more than one Plan. Coordination of benefits affects both Medical (not prescription drugs) and Dental Plans. The plan that pays benefits first is called the primary plan. The Plan that pays benefits after the primary plan is called the secondary plan.

The Plan that covers you as an employee is primary; the Plan that covers you as a spouse is secondary. For children covered by two Plans, the Plan of the parent whose birthday comes first in the calendar year is primary. Special rules apply in divorce situations.

Benefits under this Plan, if primary, will not be reduced due to benefits payable under other Plans. However if this Plan is secondary, benefits will only be paid up to the amount that would have been paid if your employers plan was primary, including the amount paid by the primary carrier. If you have access to coverage under your spouse's group health plan, you may wish to consider the effect that coordination of benefits has on benefits you would receive if either or both of you were enrolled in both Plans. You may want to enroll in only one of the plans.

When Coverage is Effective
If you are newly eligible, your coverage will be effective the first of the month following 60 days of employment. If you fail to enroll within the first thirty (31) days of employment, you will not be enrolled in the benefit plans, and will be considered a Late Enrollee. Late Enrollees must wait until the first of the following year to make the appropriate change in coverage. Evidence of Insurability may be required to enroll in some benefits if you decline coverage during your original enrollment period. If you are an existing employee making changes at your annual Open Enrollment, the changes are effective January 1st.

When Coverage Terminates
If you leave the company, your benefit coverage ends the day following your termination.
Changing Your Coverage
Once you make your elections for the plan, they stay in effect for the entire plan year – January 1 (or your effective date, if later) through December 31. In general, you may not change your elections until the next annual open enrollment period unless you have a family status change. (NOTE: There will be another Open Enrollment to be effective 4/1/2019. Ongoing Open Enrollments will be effective April of each year.

Limited Changes During the Year (When Can I Change My Benefits?)
The plan allows pre-tax advantages for you that are subject to IRS Code Section 125 regulations. This means the election you make now for any benefits must remain the same all year unless you have a qualifying change in personal status. Qualifying status changes include:

- Marriage or divorce
- Death
- Birth or adoption of a child
- Change in your work site
- Coverage of you, your spouse, or dependent child by Medicare or Medicaid
- Involuntary loss of medical coverage for you, your spouse, or dependent child
- Significant change in your spouse's coverage through his/her employer as determined by Plan administrator
- A change in employment status for you or your spouse (i.e., beginning or terminating employment, change in hours if it affects benefit eligibility or the beginning of or return from an unpaid leave)

Any change that you may make during the plan year must be consistent with the change in your family status. For example, if you have a new baby, you can add the child as a dependent under the plans. However, you cannot elect to remove your spouse from the plan unless there is a qualifying status change for your spouse that would allow that to happen.

Changes in coverage must be made within 31 days of the qualifying status change. If you do not enroll within 31 days, you will be a Late Enrollee. Late Enrollees must wait until the first of the following year to make the appropriate change in coverage.

NOTE: Evidence of Insurability may be required to enroll in some benefits if you decline coverage during your original enrollment period.

Medical Coverage

Allied is our medical provider, customer service and claims processor, and CVS Health/Caremark will be our Pharmacy provider. We are offering two programs, the MEC BLUE and the ACP Plans.

OPTION 1: MEC Blue Plan

Schedule of Covered Expenses and Provisions

Covered Expenses are covered at specified levels *"without" Preferred Provider Networks* that adjust and discount benefit payments. Benefits are reimbursed at a flat transparent rate. Specifically, the plan will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the plan reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.

MEC BLUE Highlights:

- **No Deductible**
- **No Network**
- **No Coinsurance**
- **No Office Visit Copays**
- **Plan pays claims at 100% of Medicare rate schedule**
- **Generic Prescriptions are covered; discounts on brands**
- **You are eligible to receive benefits from any licensed medical professional through the MEC Plan. Care and procedures are covered at specific levels without Preferred Provider networks. You can choose your own provider.**
- **Members must be aware that they may be billed directly from a health care provider that does not accept the MEC reimbursement as payment in full. Additional balances may be the responsibility the member. The MEC reimburses covered expenses at 100% of the Medicare Fee Schedule.**

I. MEDICAL CARE BENEFITS:

COVERED EXPENSES and PROVISIONS	MEC BLUE BENEFITS
Plan Year Deductible *(taken before benefits are payable unless waived)*	$0
Deductible Carry-Over	N/A
Plan Year Benefit Maximum	Unlimited
Allied Customer Care	Allied Customer Care 1-800-288-2078
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.
Coordination of Benefits	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.

II. PRESCRIPTION DRUG BENEFIT:

COVERED EXPENSES and PROVISIONS	MEC BLUE BENEFITS
Your Prescription Drug Benefit is administered by Caremark. For prescription drug questions please call 1-866-885-4944 or visit www.caremark.com.	
Prescription Drug Card Benefit *(up to 30-day supply per prescription)* Generics are mandatory when available; failure to accept generics will increase patient cost. Note: Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations Limited to a maximum benefit of 12 prescriptions per person per Calendar Year	$5 co-pay/Generic, Discount on Preferred Brand and Non-Preferred Brand
Mail-Order Drug Benefit *(up to 90-day supply per prescription through mail order)* Generics are mandatory when available; failure to accept generics will increase patient cost. Note: Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations Limited to a maximum benefit of 12 prescriptions per person per Calendar Year. A 90 day supply represents 3 prescriptions of the Calendar Year Maximum.	$10 co-pay/Generic, Discount on Preferred Brand and Non-Preferred Brand
Mail-Order Requirement	Optional
Specialty Drug Pharmacy Benefit *(includes certain injectable medications)*	Not Covered
Note: *Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations*	

III. PREVENTIVE CARE SERVICES:

COVERED EXPENSES and PROVISIONS	MEC BLUE BENEFITS
Covered Expenses are covered at specified levels "*without*" *Preferred Provider Networks* that adjust and discount benefit payments. Benefits are reimbursed at a flat transparent rate. Specifically, the plan will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the plan reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.	
Preventive Care Services - (*must be billed with a routine diagnosis).* This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, PSA test, bone density tests (for women age 60 and older, every 5 Plan Years). *This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.* This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.	*100% of the Medicare Reimbursement Rate.*

Preventive Care Services – Enhanced - (*must be billed with a routine diagnosis).* • Mammograms, once every Plan year (age 40 or older) • Choice between a sigmoidoscopy or a colonoscopy once every 5 Plan years (age 50 or older)	*100% of the Medicare Reimbursement Rate*
Family Planning - Permanent Procedures for Women *Includes: Sterilization.*	*100% of the Medicare Reimbursement Rate*
Family Planning – Temporary Procedures *Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.*	*100% of the Medicare Reimbursement Rate*
Breast Pumps and Supplies (Includes breast pumps and supplies purchased through a retail supplier). *Limited to a maximum payment of $450 (includes pump and supplies) per person per pregnancy.*	*100% of the Medicare Reimbursement Rate*

IV. COVERED SERVICES:

COVERED EXPENSES and PROVISIONS	MEC BLUE BENEFITS
Covered Expenses are covered at specified levels *"without" Preferred Provider Networks* that adjust and discount benefit payments. Benefits are reimbursed at a flat transparent rate. Specifically, the plan will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the plan reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.	
Physician Services Medically Necessary Services in a Physician's Office are covered expenses. Payment of charges billed on a Form CMS-1500 will be limited to the Medicare fee schedule.	*100% of the Medicare Reimbursement Rate* *Maximum of 3 visits per Calendar Year*
Outpatient/Office/Independent Laboratory Diagnostics, Radiology, and Pathology Administration and Interpretation Services *Does not include above services performed in conjunction with Chiropractic Care and Emergency Room Services. This benefit does not include MRI, PET, or CT scans.*	*100% of the Medicare Reimbursement Rate* *Maximum of 2 Visits per calendar year*
Emergency Room Services and Urgent Care Services Performed at a Hospital or Facility *(includes Physician charges)*	*100% of the Medicare Reimbursement Rate* *Maximum of 2 visits per calendar year*

NOTE: This Plan satisfies the Individual Mandate under the Affordable Care Plan (ACA). The Individual Penalty has been eliminated beginning in 2019.

OPTION 2: AFFORDABLE CARE PLAN (ACP)

Schedule of Covered Expenses and Provisions

Covered Expenses are covered at specified levels *"without" Preferred Provider Networks* that adjust and discount benefit payments. Benefits are reimbursed at a flat transparent rate. Specifically, the plan will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the plan reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.

ACP Highlights:

- **Deductible applies to Facility Procedures only**
- **No Network**
- **90% Coinsurance**
- **No Office Visit Copays**
- **Plan pays claims at 100% of Medicare rate schedule**
- **Discount Drug Card Benefit**
- **You are eligible to receive benefits from any licensed medical professional through the Affordable Care Plan. Care and procedures are covered at specific levels without Preferred Provider networks. You can choose your own provider.**
- **Members must be aware that they may be billed directly from a health care provider that does not accept the ACP reimbursement as payment in full. Additional balances may be the responsibility the member. The ACP reimburses covered expenses at 100% of the Medicare Fee Schedule.**

ACP Schedule of Covered Expenses and Provisions

The Affordable Care Plan (ACP) simplifies the way that you receive health care benefits. Covered Expenses are covered at specified levels *"without Preferred Provider Networks* that adjust and discount benefit payments. ACP benefits are reimbursed at a flat transparent rate. Specifically, the ACP will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the ACP reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.

I. MEDICAL CARE BENEFITS:

COVERED EXPENSES and PROVISIONS	ACP Benefits
Calendar Year Deductible *(taken before benefits are payable unless waived)*	$2,000 per person $4,000 per family
Deductible Carry-Over	N/A
Out-of-Pocket Maximum per Calendar Year(Co-insurance and deductibles count towards the Out-of-Pocket Maximum) *After amount is reached, the Plan will pay 100% of the amount that Medicare would pay a provider for Covered Services, for the remainder of that Calendar Year.* The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum. • "Non-compliance penalty" (for failure to abide by pre-certification requirements). • Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit.	$6,450 per person $12,900 per family
Calendar Year Benefit Maximum	Unlimited
Precertification Penalty for Non-Compliance: Certain benefits are subject to a 50% reduction up to a Maximum penalty of $500 per occurrence for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section for additional information.	Allied Customer Care 1-855-442-3477
Pre-Authorization Penalty for Non-Compliance: Certain benefits are subject to a 50% reduction up to a Maximum penalty of $500 per occurrence for failure to follow the Pre- Certification Program provisions. Please refer to Pre-Certification Program section for additional information.	Allied Customer Care 1-855-442-3477

Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.
Coordination of Benefits	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.

II. PRESCRIPTION DRUG BENEFIT:

COVERED EXPENSES and PROVISIONS	ACP Benefits
Your Discount Prescription Drug Benefit is administered by Caremark. For prescription drug questions please call Allied Customer Care at 1-855-442-3477or visit www.caremark.com	
Specialty Drug Pharmacy Benefit *(includes certain injectable medications)* *Certain high cost special and biotech drugs will require Pre-Authorization as specialty drugs. You will be notified when this situation applies*	Specialty drugs are payable at 90% of the Medicare allowable amount after Deductible.
Discount Drug Card Benefit	Discount Drug Card Only *(drugs to be purchased from pharmacy at reduced cost and submitted for reimbursement at 90%).*
Note: Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations	

III. PREVENTIVE CARE SERVICES:

COVERED EXPENSES and PROVISIONS	ACP Benefits
The Affordable Care Plan (ACP) simplifies the way that you receive health care benefits. Covered Expenses are covered at specified levels *"without" Preferred Provider Networks* that adjust and discount benefit payments. ACP benefits are reimbursed at a flat transparent rate. Specifically, the ACP will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the ACP reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.	
Preventive Care Services - *(must be billed with a routine diagnosis).* This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years). *This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.* This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.	*100% of the Medicare Reimbursement Rate* Deductible Waived
Preventive Care Services – Enhanced - *(must be billed with a routine diagnosis).* • Mammograms, once every Calendar year (age 40 or older) • Choice between a sigmoidoscopy or a colonoscopy once every 5 Calendar years (age 50 or older)	*100% of the Medicare Reimbursement Rate* Deductible Waived
Family Planning - Permanent Procedures for Women *Includes:* • *Sterilization.*	*100% of the Medicare Reimbursement Rate* Deductible Waived

Family Planning – Temporary Procedures *Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.*	*100% of the Medicare Reimbursement Rate* Deductible Waived
Breast Pumps and Supplies (Includes breast pumps and supplies purchased through a retail supplier). *Limited to a maximum payment of $450 (includes pump and supplies) per person per pregnancy.*	*100% of the Medicare Reimbursement Rate* Deductible Waived

IV. PHYSICIAN SERVICES:

COVERED EXPENSES and PROVISIONS	ACP Benefits
The Affordable Care Plan (ACP) simplifies the way that you receive health care benefits. Covered Expenses are covered at specified levels *"without" Preferred Provider Networks* that adjust and discount benefit payments. ACP benefits are reimbursed at a flat transparent rate. Specifically, the ACP will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the ACP reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.	
TELADOC Teladoc provides access to a national network of U.S. board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone, by calling 1-855-442-3477, or online video consultations by accessing www.teladoc.com. Teladoc does not replace the existing primary care physician relationship, but enhances it as a convenient, affordable alternative for medical care.	100% Deductible Waived
Physician Office Visits - Exam charge only *Unless listed separately within this schedule.* *Includes allergy injections, serum, and administration.*	*100% of the Medicare Reimbursement Rate* Deductible Waived
Urgent Care - Exam Charge Only	*100% of the Medicare Reimbursement Rate* Deductible Waived
Second Surgical Opinion	*100% of the Medicare Reimbursement Rate* Deductible Waived
Surgery and Other Physician Services Incurred at a Physician's Office or Urgent Care Facility	*100% of the Medicare Reimbursement Rate* Deductible Waived
Emergency Room Physician Care	*100% of the Medicare Reimbursement Rate* Deductible Waived
Physical, Speech, and Occupational *Limited to 30 treatments per Calendar year for any one type of therapy and up to 60 treatments per Calendar year for any combinations of these therapies.*	*100% of the Medicare Reimbursement Rate* Deductible Waived
Diabetes Self-Management Education Program	*100% of the Medicare Reimbursement Rate* Deductible Waived
All Care Rendered by a Chiropractor *All services provided by a chiropractor are limited to a combined maximum of 20 visits per Covered Person per Calendar Year, regardless of the place of service or services provided.*	*100% of the Medicare Reimbursement Rate* Deductible Waived
Anesthesia and its Administration *(Inpatient/Outpatient)*	*100% of the Medicare Reimbursement Rate* Deductible Waived

Other Physician Services	
Other Physician Services *Does not include labs and X-rays; please see Section V for additional benefit coverage information.*	*100% of the Medicare Reimbursement Rate* Deductible Waived

V. OUTPATIENT/OFFICE (PHYSICIAN'S OFFICE AND FACILITY) LABORATORY/RADIOLOGY/PATHOLOGY SERVICES, INCLUDING ADMINISTRATION AND MRI, PET, AND CT SCANS:

COVERED EXPENSES and PROVISIONS	ACP Benefits
The Affordable Care Plan (ACP) simplifies the way that you receive health care benefits. Covered Expenses are covered at specified levels "*without" Preferred Provider Networks* that adjust and discount benefit payments. ACP benefits are reimbursed at a flat transparent rate. Specifically, the ACP will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the ACP reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.	
Office Diagnostics, Radiology, and Pathology Administration and Interpretation Services *Does not include above services performed in conjunction with the following:* • *Chiropractic Care.* • *Emergency Room Services. Does not include MRI, PET or CT scans.*	*100% of the Medicare Reimbursement Rate* Deductible Waived
Outpatient/Independent Laboratory Diagnostics, Radiology, and Pathology Administration and Interpretation Services *Does not include above services performed in conjunction with the following:* • *Chiropractic Care.* • *Emergency Room Services. Does not include MRI, PET or CT scans.*	*90% of the Medicare Reimbursement Rate*
Office Imaging Services (MRI, PET, and CT scans)	*100% of the Medicare Reimbursement Rate* Deductible Waived
Outpatient/Independent Laboratory Imaging Services (MRI, PET, and CT scans)	*90% of the Medicare Reimbursement Rate*

VI. FACILITY SERVICES:

COVERED EXPENSES and PROVISIONS	ACP Benefits
The Affordable Care Plan (ACP) simplifies the way that you receive health care benefits. Covered Expenses are covered at specified levels "*without" Preferred Provider Networks* that adjust and discount benefit payments. ACP benefits are reimbursed at a flat transparent rate. Specifically, the ACP will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the ACP reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.	
Emergency Room Services	*90% of the Medicare Reimbursement Rate*
Inpatient Hospital Services *Coverage is limited to:* • *Room and board not to exceed the semi-private room rate.* • *Necessary services and supplies including an intensive care unit and a cardiac care unit.* • *If admitted through the Hospital Emergency Room, this benefit will be covered at the In-Network level.* *Note: Room and board subject to the payment of semi-private room rate, unless the Hospital only has private rooms.*	*90% of the Medicare Reimbursement Rate*
Pre-Admission Testing	*90% of the Medicare Reimbursement Rate*
Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures	*90% of the Medicare Reimbursement Rate*

Outpatient Hospital Facility Charges	*90% of the Medicare Reimbursement Rate*
Renal Dialysis	*90% of the Medicare Reimbursement Rate*
Urgent Care Services facility fees	*90% of the Medicare Reimbursement Rate*

VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

COVE ED EXPENSES and PROVISIONS	ACP Benefits
The Affordable Care Plan (ACP) simplifies the w y that you receive health care benefits. Covered Expenses are covered at specified levels "*without" Preferred Provider Networks* that adjust and discount benefit payments. ACP benefits are reimburs ed at a flat transparent rate. Specifically, the ACP will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have corresponding Medicare Reimbursement Rate, the ACP reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit le el.	
BEHAVIOR HEALTH ENHANCED BENEFIT (Mental/Nervous/Substance Use Disorders)	
Treatment Through Allied Care Solutions *Allied Care Solutions is your single source for Support, Resources and Information. This program is designed to help you manage life's daily challenges. We can refer you to professional counselors and services that can help you and your eligible family members resolve a broad range of personal concerns, such as marriage and relationships, stress and anxiety, depression, substance abuse, anger management, family problems, grief and loss, legal and financial services and dependent care. Allied Care Solutions is a no-cost confidential program that is available to you and your family 24 hours a day, 365 days a year. At some point in our lives, each of us faces a problem or situation that is difficult to resolve. Your Company understands how work and personal challenges can affect your well-being and encourages you to call Allied Care Solutions at* 1-855-442-3477*or visit http://www.alliedbenefit.com/acs.aspx (user name is your Company name).* **Contact Allied Care Solutions at** **1-855-442-3477.** **By calling Allied Care Solutions, you may be eligible to receive certain services payable at no cost to you with no claims submission required.**	
Treatment for Mental/Nervous and Substance Use Disorders - Outpatient	*Paid same as any other service according to type of service, provider and place of service.*
Treatment for Mental/Nervous and Substance Use Disorders not provided through Allied Care Solutions referenced above - Inpatient *Note: Inpatient mental/nervous and substance use disorder services must be pre-authorized through Allied Care Solutions in order to avoid $1,000 penalty per occurrence*	*Paid same as any other service according to type of service, provider and place of service.*

VIII. OTHER COVERED SERVICES:

COVERED EXPENSES and PROVISIONS	ACP Benefits
The Affordable Care Plan (ACP) simplifies the way that you receive health care benefits. Covered Expenses are covered at specified levels *"without" Preferred Provider Networks* that adjust and discount benefit payments. ACP benefits are reimbursed at a flat transparent rate. Specifically, the ACP will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the ACP reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.	
Other Covered Services/Items	*90% of the Medicare Reimbursement Rate* *Unless included in a separate category.*
Abortion	*Not Covered*
Acupuncture (*in lieu of anesthesia administered in conjunction with a surgery)*	*90% of the Medicare Reimbursement Rate*
Artificial Limbs, Eyes and Larynx	*90% of the Medicare Reimbursement Rate*
Assisted Reproduction	*Not Covered.*
Casts, Splints, Trusses, Crutches and Braces	*90% of the Medicare Reimbursement Rate*
Chemotherapy	*90% of the Medicare Reimbursement Rate*
Contact Lenses or Glasses Following Cataract Surgery *Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.*	*90% of the Medicare Reimbursement Rate*
Covered Medically Necessary Prescription Drugs *if not available through the Prescription Drug Benefit*	*90% of the Medicare Reimbursement Rate*
Dental Treatment	*See Oral Surgery benefit*
Durable Medical Equipment *Includes:* • *Cost to rent up to the purchase price.* • *Equipment for administration of oxygen.* • *Equipment repair or replacement.*	*90% of the Medicare Reimbursement Rate*
Family Planning - Men's Permanent Procedures *Includes:* o *Male vasectomy.*	*90% of the Medicare Reimbursement Rate*
Home Health Care *Limited to a maximum of 60 home care visits (one per day) per Covered Person per Calendar Year.* *Each 4 hours of service by a home health aide in a 24 hour period will be considered 1 home health visit.* *One visit by any other provider of services will be counted as 1 visit.*	*90% of the Medicare Reimbursement Rate*
Hospice Care *Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.*	*90% of the Medicare Reimbursement Rate*
Infertility Testing *Limited to Covered Expenses necessary to diagnose this condition, but not any charges in connection with the promotion of conception.* *Infertility means the inability to conceive a child, or the inability to sustain a successful pregnancy.*	*90% of the Medicare Reimbursement Rate*
Mastectomy Related Treatment *Includes charges in accordance with the provisions detailed under the definition of "Reconstructive Breast Surgery."*	*90% of the Medicare Reimbursement Rate*

The Affordable Care Plan (ACP) simplifies the way that you receive health care benefits. Covered Expenses are covered at specified levels *"without" Preferred Provider Networks* that adjust and discount benefit payments. ACP benefits are reimbursed at a flat transparent rate. Specifically, the ACP will reimburse Covered Expenses using the same reimbursement rates as the Federal government under Medicare fee schedules. If a Covered Expense does not have a corresponding Medicare Reimbursement Rate, the ACP reserves the right to process that claim at the Reasonable and/or Usual and Customary benefit level.	
Obesity Surgery or Non-Surgical Obesity Treatment	*Not Covered*
Oral Surgery, excludes teeth and is *limited* to a maximum benefit payment of $5,000 per Calendar Year. **NOTE**: Maximum benefit limitation does not apply to Dependent children under age 19.	*90% of the Medicare Reimbursement Rate*
Organ or Tissue Transplant Procedures *The Covered Person, who is the transplant recipient, must receive 2 opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.*	*90% of the Medicare Reimbursement Rate*
Orthotics	*Not Covered.*
Orthopedic Shoes	*Not Covered.*
Private Duty Nursing Services	*Not Covered.*
Professional Ambulance Service *Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.*	*90% of the Medicare Reimbursement Rate*
Prosthetic Medical Appliances *Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.*	*90% of the Medicare Reimbursement Rate*
Routine Newborn Nursery Care *(including circumcision)*	*90% of the Medicare Reimbursement Rate*
Skilled Nursing Facility *Includes Extended Care Facility.* *Limited to 60 days per Covered Person per Calendar Year.* *Limited to the usual charge of the facility for semi-private care, including room and board and all other services.*	*90% of the Medicare Reimbursement Rate*
TMJ *(Temporomandibular Joint Dysfunction)*	*Not Covered*
Wigs *for initial purchase from hair loss resulting from the treatment of cancer.*	*90% of the Medicare Reimbursement Rate*

Please Refer to the Pre-Certification Program, Prescription Drug Benefit, Transplants, and Exclusions sections for additional coverage details.

Important Insurance Terms

Please take a moment to learn about the following terms that have special meaning under the Benefit Plans.

Deductible — The deductible is the portion of your eligible medical expenses that you pay each year before the Plan starts paying benefits.

Coinsurance — Once you meet the deductible, the Plan will pay a percentage of your covered expenses, subject to "reasonable and customary" limits. The coinsurance amount depends on whether or not you receive services in- or out-of-network.

Co-payment — Your co-payment, or "co-pay," refers to a set dollar amount you pay for certain services such as a doctor's office visit and prescription drugs. You will be required to pay the established amount each time you obtain services or supplies for which a co-payment is required. Co-payments do not accumulate to meet your deductible or out-of-pocket maximum.

Grandfathered Plan – This Plan is a Non-Grandfathered Health Plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a non-grandfathered health plan means that the Plan includes certain consumer protections of the Affordable Care Act that may not apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.

OB/GYN Provider Access: You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to the Administrator's website, www.cigna.com.

Out-Of-Pocket Maximum — The Plan has a limit on the amount of money you are required to pay for eligible expenses each year. After your share of covered expenses (deductible and coinsurance) reaches a certain limit, the Plan pays 100% of covered medical expenses for the rest of the year. In 2014, other co-payments, outpatient mental health, and chemical dependency treatment expenses apply toward the Medical Plan maximum out of pocket. In 2015 prescription drug co-payments will also apply toward the Medical Plan maximum out of pocket.

Usual and Customary Charges — Charges calculated within the usual range of charges for similar services to people who have similar medical conditions in that location.

Women's Preventive Services — Preventive care services include: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling.

Prescription Drug Coverage

Caremark is our prescription drug carrier. We provide both retail and mail order options for purchasing prescription drugs. The prescription drug coverage is automatic with your enrollment in the medical plan.

MEC Co-payments (see MEC Schedule of Benefits)			
Retail (30-day Supply)	**Co-Pay**	**Mail Order (90-day Supply)**	**Co-Pay**
Generic	$5	Generic	$10
Formulary	**	Formulary	**
Non-Formulary	**	Non-Formulary	**

**Discount Only Applicable to Formulary and Non-Formulary Scripts

ACP Discount Drug Card
Discount Drug Card Only
Specialty Drug Pharmacy Benefit (includes certain injectable medications) – Specialty drugs are payable at 90% of the Medicare allowable amount after Deductible.
Discount Drug Card Benefit - Drugs to be purchased from pharmacy at reduced cost and submitted for reimbursement at 90%
Note: Certain prescriptions shall be covered at 100% as per Federal Regulations

HOW TO LOCATE A PHARMACY: You may access participating pharmacies on the carrier website or by calling the number on the back of your prescription drug ID card:

- Access the website at www.Caremark.com;
- Log-in and register to access pharmacy locations, directions, and benefit information

RETAIL PRESCRIPTIONS: Please present your new ID Card when you go to fill a script. If you do not present your ID card and pay the cash price at an in- or out-of-network pharmacy, you may submit a paper claim for reimbursement consideration. Please be advised that the reimbursement will be at the Caremark discounted rate (which may be lower than the cash price you paid) minus your co-pay.

Prescription Drug Definitions

1. **Generic Drug** – means a prescription drug known by its chemical name rather than by a brand name. These drugs contain the same active ingredients as name brand drugs but are sold at a lower price, thus they will cost you the lowest co-payment available.
2. **Home Delivery** – means the maintenance prescription drugs are delivered directly to you or your dependent by mail.
3. **Home Delivery Pharmacy** – means a U.S. pharmacy that has a written contract with us or our authorized representative for home delivery of maintenance prescription drugs.
4. **Maintenance Prescription Drug** – means a prescription that you or your dependent will take or use for more than 30 days.
5. **Non-Formulary (Non-Preferred Drugs)** - from a cost perspective, non-preferred drugs will usually have the highest co-payment.
6. **Pharmacy** – means a licensed establishment where drugs are dispensed by a pharmacist licensed in that state. Pharmacy also includes a hospital pharmacy.
7. **Participating Provider Pharmacy** – means a U S pharmacy that has a written contract with us or our representative Pharmacy Benefit Manager.
8. **Preferred Brand Drug** – means a brand name prescription drugs selected by our authorized representative for their high degree of overall clinical and cost effectiveness prescribed for use in treating common health conditions. These medications are usually brand-name drugs but have usually been on the market longer or are not as widely promoted. They will cost you less than non-preferred drugs.
9. **Prescription** – means the request for a drug by a doctor licensed to prescribe drugs and each authorized refill.
10. **Prescription Drug** – means a prescription legend drug that is:
11. Medicine required by federal law to bear the legend "Caution: Federal law prohibits dispensing without a prescription"; or
12. Any other drug which, under the applicable state law, may only be dispensed upon the prescription order of a doctor.
13. Needles and syringes when used for allergy or diabetes injections;
14. Injectable insulin;
15. Injectable prescription drugs including allergy injectables;
16. Prescription vitamins;
17. Diabetic supplies such as glucose strips, alcohol swabs, and lancets; and
18. Contraceptive pills and contraceptive patch.
19. **Specialty Drugs or Biotech Drugs** – these are drugs that are often biotech drugs such as Enbrel or Interferon. These drugs must be handled and delivered under special conditions. There scripts are handled by a special unit of Caremark that offers counseling and guidance on the use of the drugs. See "Caremark Specialty Pharmacy" below.

Expenses Not Covered Under Prescription Drug Coverage

The Plan has chosen to provide many benefits. There are some things, however, that will not be covered as prescription drugs benefits. They are:

1. Fertility Drugs regardless of intended use.
2. State Restricted Drugs – drugs that require a prescription by state law but not by federal law.
3. Experimental or Investigational Drugs – drugs labeled "Caution – limited by federal law to investigational use."
4. Non-Legend Drugs – drugs that do not bear the federal legend except as specified.
5. Rogaine – topical Minoxidil, Rogaine, in any form used for the treatment of alopecia.
6. Government or Other Party Liability – Drugs that person is entitled to receive from Worker's Compensation, or other Governmental entity; or other third party with primary liability.
7. Institutional Pharmacy Services (May be covered under Medical Portion of Plan).
8. Vitamins (except for prenatal vitamins for a Covered Person who is pregnant).
9. A drug or medicine that can be purchased legally without a written prescription including medicine that is available as an Over-the-Counter (OTC) medication.
10. Devices or durable medical equipment of any type, even though such devices may require a prescription. (These include, but are not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device.)
11. Immunization agents or biological sera; blood or blood plasma.
12. A drug or medicine labeled, "Caution —limited by federal law to investigational use".
13. A charge for prescription drugs that properly may be received without charge under local, state or federal programs.
14. Ostomy supplies.

Health Care Reform (Affordable Care Act)

Federal Health Care Reform law changes that may affect you!

Health care reform is based on two bills: The Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act (HCERA) signed into law on March 30, 2010. Together, these two bills (along with their amendments) make up what most people now refer to as the "health care reform law." Within this law, there are many separate provisions that must be implemented by various key dates from 2010 to 2019.

Note: This is not a summary of *all* health care reform changes that will affect your group health plan.

Grandfathered Health Plan Status – This plan does not believe that it is a grandfathered plan. The Plan will be in compliance with Health Care Reform laws.

No pre-existing condition waiting period – A pre-existing condition is a condition, disability or illness (either physical or mental) that you had before you enrolled in a health plan. Starting in 2014, you can no longer be denied coverage or be subject to additional charges due to a pre-existing condition.

W-2 reporting – The health care reform law requires employers to report the cost of employer-sponsored group health coverage. You will find this info on your W-2 form. This is a reporting requirement only, and will not impact your taxable income.

Preventive Care – The health plan covers 100% of the preventive care services required by the Affordable Care Act, when you get these services from doctors in your plan's network. You may have to pay part of the costs if you use a doctor outside of the network. **Note:** Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. It is important that your doctor codes the following as preventive care, or there may be additional expense to you.

Extension of dependent coverage to age 26 - The federal health care reform law allows you to keep your children on your health plan until they turn 26 years old. That means that the maximum dependent age will be age 25, per the federal law, as of January 1, 2011. To be eligible for this coverage, children do not need to be financially dependent on you for support, claimed as dependents on your tax return, residents of your household, enrolled as students or unmarried. Children-in-law (spouses of children) and grandchildren are not eligible.

Lifetime and Annual Limits of Medical Coverage - As of 2014, there are no annual or lifetime limits on the health plan. This pertains to medical and pharmacy benefits only.

Maximum out of pocket – As of 2014 your deductible and co-payments (2015 for prescription drug co-pays) will accumulate toward your annual maximum out of pocket.

Primary Care Providers and Designation of Certain Providers – The Plan does not require designation of Primary Care Providers, Pediatricians or OB/GYN's. You may seek services from any of these providers without prior authorization.

Minimum Value – The health plan meets or exceeds the Affordable Care Act minimum value guidelines.

Affordability – The health plan meets or exceeds the Affordable Care Act guidelines for affordability.

Can I go to the Exchange for coverage? If you are eligible for the health plan and decide to check out Exchange (Marketplace) plans, be aware that because the health plan meets minimum value and affordability requirements established by the Affordable Care Act, you may not qualify for premium assistance, even if your income would qualify you otherwise.

Annual Notifications

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

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

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact your HR Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PRIMARY CARE PROVIDERS AND DESIGNATION OF CERTAIN PROVIDERS
The Plan does not require designation of Primary Care Providers, Pediatricians or OB/GYNs. You may seek services from any of these providers without prior authorization.

PATIENT PROTECTIONS – emergency coverage – If you have a health emergency, you can go to any emergency room. You don't need to get approval from the plan first – even if the emergency room isn't in your plan's network. However, we do require you or your doctor to notify us of your visit after you go to the emergency room. Your plan covers both in-network and out-of-network emergency room services. Your out-of-pocket costs are the same, but you may pay more for out-of-network care in other ways. For example, an out-of-network provider is allowed to bill you for some things that in-network providers can't bill you for.

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

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

These benefits will be provided subjected to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information on WHCRA benefits, call your plan administrator.

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 July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Medicaid) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999

KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**

Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 1-307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

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

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

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

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.

OMB Control Number 1210-0137 (expires 12/31/2019)

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation
Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA). This is a general summary of the FMLA and how it affects your group plan. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions
If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provision of this plan, if any; and
- will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer
Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee
Eligible Employee means an employee who has worked for the Eligible Employer:

-for at least 12 months; and
-for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
-at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave
Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

-The birth of a child of an Eligible Employee and in order to care for the child.
-The placement of a child with the Eligible Employee for adoption or foster care.
-To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition."
-A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

Reinstatement
An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

See your employer for details on this reinstatement provision.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

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

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

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

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member qualifies for COBRA when the Member does not return to work after completion of FMLA. Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group health plan are not eligible for continued coverage.)

You Must Give Notice of Some Qualifying Events - For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Impact Employment Solutions Human Resources Dept.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. The qualified person must submit a written request for the extension to the employer (plan administrator) within 60 days after receiving the Social Security determination. If a request for the extension is not made (a) within 60 days after the Social Security disability determination is received; and (b) before the 18-month continuation ends, the right to the 11-month extension expires. The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Note: Qualified Dependents must request extended continued coverage within 60 days after a second Qualifying Event occurs

Termination of Continued Coverage

Continued coverage ends the earliest of the following:

(1) The date the maximum continuation period ends; or
(2) The date the qualified person enrolls in Medicare; or
(3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period; or
(4) The date the employer's group health coverage is terminated (and not replaced by another group health plan); or
(5) The date the qualified person becomes covered by another group health plan.

Employer Notification Requirement

Qualified persons must be notified of the right to elect continuation of group health coverage within 14 days after a qualifying event. Qualified persons must make written election within 60 days after the later of (1) the date coverage would normally end, or (2) the date of the election notice. The election notice must be returned to the employer within this 60-day period; otherwise the right to elect continuation ends. Persons electing continued coverage have 45 days after the election date to remit the first payment. All remaining payments must be received no later than: (a) 30 days after the first day of each month; or (b) within the 30-day Grace Period (see Grace Period).

Qualified Person Notification Requirement

Qualified persons must notify the employer within 60 days after (a) a divorce or legal separation from the Member, and (b) the date a child ceases to be a Dependent child under the terms of the coverage. Within 14 days following notice by the qualified person of these qualifying events, the employer must provide the qualified person with an election notice. Qualified persons must elect to continue coverage within this 60-day period after receipt of the election notice, otherwise the right to elect ends. Payment must be made within the time limits explained above.

Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

There may be other coverage options for you and your family. Beginning in 2014, you'll be able to buy coverage through the Exchange (Health Insurance Marketplace). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Grace Period
"Grace Period" means the first 30-day period following a contribution due date. Except for the first contribution, a Grace Period of 30 days will be allowed for payment of contributions. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

Plan Changes
Continued coverage will be subject to the same benefits and rate changes as the group coverage.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

Plan Contact Information

Name of Entity/Sender:	Impact Employment Solutions
Contact--Position/Office:	Human Resources, 136 N Huron Street, Toledo, OH 43604
Phone Number:	(419) 243-5848

HIPAA NOTICE OF PRIVACY PRACTICES

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

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Impact Employment Solutions (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on October 1, 2013.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Impact Employment Solutions requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Employees. We may enter into contracts with entities known as Business Employees that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Employees once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Employee to administer claims. Business Employees are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Impact Employment Solutions for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses employeed with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may

deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Employees) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Attention: Privacy Officer
Impact Employment Solutions
136 N. Huron Street
(419) 243-5848

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Your Rights Under USERRA

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- are a past or present member of the uniformed service;
- have applied for membership in the uniformed service; or
- are obligated to serve in the uniformed service;

then an employer may not deny you:

- initial employment;
- reemployment;
- retention in employment;
- promotion; or
- any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date—October 2008

Impact Employment Solutions, Inc.
Impact Employment Solutions of Florida, LLC; d/b/a Pro Image Solutions
Impact Employment Solutions of Kentucky, LLC; d/b/a The Job Shop

IES Med Plus of Kentucky, LLC
Impact Employment Solutions of Georgia, LLC
Maumee Bay Brewing Company

2019 BENEFIT ENROLLMENT FORM
Allied Group # A14130 – TEMPORARY STAFFING & RESTAURANT

INSTRUCTIONS: Employee must complete in full (print or type). Incomplete forms may delay benefit processing. Return form to your HR Department.

SECTION I: EMPLOYEE INFORMATION **LOCATION CODE:** ___________ **(To Be Completed By HR)**

SOCIAL SECURITY NUMBER:	FIRST NAME:	M.I.:	LAST NAME:
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE NO.:	CELL PHONE NO.:	DATE OF HIRE:	DATE OF BIRTH:
GENDER: ☐ MALE ☐ FEMALE	CHECK ONE: ☐ SINGLE ☐ MARRIED		

SECTION II: BENEFIT PLAN ENROLLMENT

MEDICAL: Choose one of the Medical Plans or Opt Out. **WEEKLY DEDUCTIONS and will start 30 days before coverage begins. Once coverage is effective, we will not reimburse the payroll deductions.** **SEE PAGE 2 FOR RATES**

☐ **MEC Plan – No Deductible; Meets IRS Requirements for Coverage**	☐ **ACP Plan - $2,000 Facility (Hospital, etc.) Deductible per Person**
☐ Single	☐ Single
☐ Employee + Spouse	☐ Employee + Spouse
☐ Employee + Child(ren)	☐ Employee + Child(ren)
☐ Family	☐ Family

☐ **Opt Out – Declining Coverage due to having Medicaid, CHIP, Medicare, COBRA or other.**

SECTION III: DEPENDENT INFORMATION

Please list all dependents (including your spouse) **to be added or dropped** under the medical plans. NOTE: If you have more than four dependents, please list them on the back of this form.

Name (Last, First, MI)	Add/ Drop	Medical	Sex	Date of Birth	Soc. Sec. No.	Relationship
	☐ Add ☐ Drop	☐	☐ M ☐ F			
	☐ Add ☐ Drop	☐	☐ M ☐ F			
	☐ Add ☐ Drop	☐	☐ M ☐ F			
	☐ Add ☐ Drop	☐	☐ M ☐ F			

SECTION IV: COORDINATION OF BENEFITS

Do you or any of your dependents have other group medical coverage or Medicare? ☐ Yes (complete below) ☐ No

Name of Individual (family member) with Other Coverage:	Other Carrier and Address:

SECTION VI: SIGNATURE

I understand that my coverage elections on this form are subject to the provisions of each respective plan and the rules of the Internal Revenue Service. I may not change my election under the medical plan unless my family status changes, as defined by the Internal Revenue Service (See Note below), within the plan year. I authorize the company to deduct from my pay in equal installments each pay period, the pre-tax and after-tax contributions required for the benefits elected. I have read and understand this election form as well as the booklets explaining how these plans work.

_______________________________ Signature

_______________________________ Date

NOTE: If you refuse coverage for yourself, you automatically refuse that coverage for any dependents. If you are declining enrollment for yourself or your dependents, including your spouse, because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. You must indicate the reason for declining enrollment to later be eligible under the special enrollment rights. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the event.

TEMPORARY STAFFING & RESTAURANT EMPLOYEES

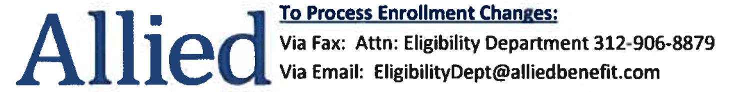
Health Plan Rates Effective 4/1/2019

MEC Plan

	WEEKLY PRICING:	MONTHLY PRICING:
Single	$19.96	$86.50
EE/Spouse	$40.38	$175.00
EE/Child/ren	$33.92	$147.00
Family	$53.08	$230.00

ACP Plan

	WEEKLY PRICING:	MONTHLY PRICING:
$8 Band		
Single	$23.66	$102.53
EE/Spouse	$179.89	$779.53
EE/Child/ren	$127.97	$554.52
Family	$284.20	$1,231.53
$9 Band		
Single	$26.62	$115.35
EE/Spouse	$182.85	$792.35
EE/Child/ren	$130.93	$567.35
Family	$287.16	$1,244.35
$10 Band		
Single	$29.58	$128.18
EE/Spouse	$185.81	$805.18
EE/Child/ren	$133.89	$580.18
Family	$290.01	$1,257.18
$11 Band		
Single	$32.54	$141.01
EE/Spouse	$188.77	$818.01
EE/Child/ren	$136.85	$593.00
Family	$293.08	$1,270.01
$12 Band		
Single	$35.50	$153.83
EE/Spouse	$191.73	$830.83
EE/Child/ren	$139.81	$605.83
Family	$296.04	$1,282.83



To Process Enrollment Changes:
Via Fax: Attn: Eligibility Department 312-906-8879
Via Email: EligibilityDept@alliedbenefit.com

ENROLLMENT CHANGE FORM

EMPLOYEE INFORMATION

This section must be completed to process changes and terminations. If Allied handles your COBRA Administration, please complete the COBRA Initiation Form for all terminations.

Employer Name	Group Number	Location (if applicable)
Temporary Staffing and Restaurants	A14130A	

Employee Name	SSN / UID	Birthdate

Employee Address	City	State	Zip

Date of Hire	Original Effective Date	Termination Date

TYPE OF CHANGE REQUESTED

Employee Name Change

Current Last Name	New Last Name

Address Change

	Address	City	State	Zip
Current Address				
New Address				

Location Change

Current Location	New Location

Addition of Spouse

Spouse First Name	Spouse Last Name	SSN

Qualifying Event Reason for the Enrollment	Birthdate	Effective Date

Addition of Dependent Child

Child First Name	Child Last Name	SSN

Qualifying Event Reason for the Enrollment	Birthdate	Effective Date

Other Insurance Information

Spouse's Employer

Other Insurance Carrier	Other Insurance Policy Number

Change of Life Insurance Election

Current Amount	New Amount

Change of Life Insurance Beneficiary

Primary Beneficiary	Secondary Beneficiary

Employee Signature:______________________________ Date ______________

Employer Signature:______________________________ Date ______________