2023 - 2024

EMPLOYEE BENEFITS

OPEN ENROLLMENT

January 1st 2022-
December 31st 2022

gdp ADVISORS LLC

Pick the best benefits for you and your family.

GTN Technical Staffing strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all the different benefits offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on March 1st, 2023. If you have questions about any of the benefits mention ed in this guide, please don't hesitate to reach out to HR.

Welcome to Open Enrollment

Who is Eligible?

If you are a full-time employee, and have exceeded your eligibility period, you are eligible to enroll in the benefits described in this guide. Employees may also cover their eligible dependents and pay the applicable premium for their coverage. Eligible dependent(s) include: Spouse, Domestic Partner, Children up to age 26 (regardless of student, marital, or dependent status), and Dependent Children of any age who are incapable of supporting themselves due to mental/physical handicaps (proof of Social Security required).

How to Enroll

Please use EASE to enroll – instructions on the next page.

When to Enroll

Coverage for newly hired employees will be effective first of the month following 30 days. Open enrollment begins on February 8th, 2023 and runs through February 15th, 2023. The benefits you choose during open enrollment will become effective on March 1st, 2023.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. All eligible changes must be communicated to the carrier within 31 days of the Qualifying Event. Qualified changes in status include:

- Marriage, divorce, or legal separation
- Birth or adoption of a child or change in child's dependent status or Commencement or termination of adoption proceedings
- Death of spouse, child, or another qualified dependent
- Change in residence due to an employment transfer for you or your spouse.
- Change in spouse's benefits or employment status, or enrollment/loss of other group coverage.

Health Insurance

Your Medical/Rx benefits will be administered by Assured Benefits Administrators utilizing the United Healthcare network. As a reminder, the plan does provide coverage for both in and out-of- network providers; however, when an out-of-network provider is utilized, the member may be responsible for additional charges. For network providers visit: ***https://uhss.umr.com*** [1]

Services		HDHP	Buy-Up
Annual Deductible			
	Individual	$5,000	$5,000
	Family	$10,000	$10,000
Coinsurance (Plan/Member)			
		100%/0%	100%/0%
Out-of-Pocket Maximum			
	Individual	$5,000	$6,000
	Family	$10,000	$12,000
Physicians Visit			
	Preventive Care	**No Charge**	**No Charge**
	In- Office	Deductible then 100%	$25 Copay
	Specialist	Deductible then 100%	$25 Copay
	Telemedicine	**No Charge**	**No Charge**
	Urgent Care	Deductible then 100%	$75 Copay
	Diagnostic Test (Blood Work)	Deductible then 100%	$25 Copay
	Imaging (CT/PET Scans, MRIs, etc.)	Deductible then 100%	$25 Copay
Emergency Room (True Emergency)			
	Facility Charges	Deductible then 100%	Deductible then 100%
	Physician Charges	Deductible then 100%	Deductible then 100%
Hospital/Surgical			
	In-Patient Hospital	Deductible then 100%	Deductible then 100%
	Out-Patient Hospital	Deductible then 100%	Deductible then 100%

Prescription Drugs			Walmart/Other
	Generic	Deductible then 100%	$15/$25 Copay
	Formulary brand drugs	Deductible then 100%	$35/$50 Copay
	Non-formulary brand drugs	Deductible then 100%	$55/$75 Copay
	Specialty Drugs	Deductible then 100%	20% up to $250 Copay

[1] This contains only a partial description of the benefits, limitations, exclusions, and other provisions of the health care plan. It is not a contract or policy. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

Helpful benefit information to share with your provider.

Your benefit plan provides access to the UnitedHealthcare network shown on your ID card. Providers can use the below resources and your ID card to verify eligibility, benefits and claim status.

Providers: Connect with us

Online	https://uhss.umr.com For eligibility, claim processing and benefit information
Phone	It is very important to call the number on the back of the member's ID card. There are many different provider service numbers that are specific to each UHSS customer.
EDI	Electronic claim submission and payer ID: 39026
Paper claims	UnitedHealthcare Shared Services PO Box 30783 Salt Lake City, UT 84130-3783

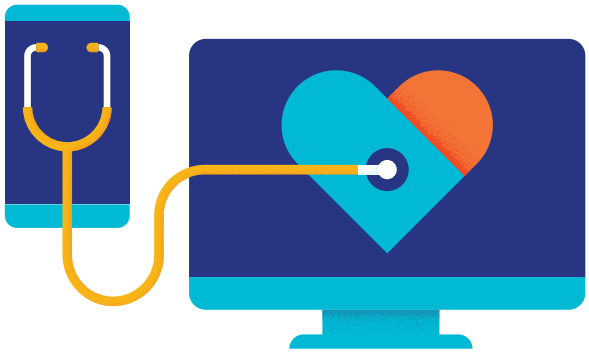
United Healthcare

Welcome to UnitedHealthcare

When it comes to finding a doctor and managing your health, simpler is always better. The UnitedHealthcare Shared Services member website offers a variety of tools and resources that make it easier than ever.

To find a doctor, hospital, lab and other providers in your network visit **whyuhc.com/uhss** and follow these steps:

1. Click on **Find a Doctor/Hospital**
2. Select the network on the back of your ID card
3. Enter an address, city and state or zip code
4. Select the appropriate location and click **Continue**
5. Select the type of **Medical Care**, or enter a name or service and click **Search**
6. To locate a primary care provider, click **People**
7. Next, click on **Primary Care**
8. Choose the type of primary care provider
9. If you already know the doctor name, medical group or hospital you are looking for, select **All Primary Care Providers**
10. In the open search field, enter text and click **Filter**



Look for the blue hearts!

Providers with this designation meet UnitedHealth Premium program criteria for providing quality and cost-efficient care.

continued ▸

United Healthcare

Compare quick care options to help keep costs down.

Getting care at the place that may best fit your condition or situation may save you up to $2,000 compared to an emergency room (ER) visit.* If you have a life-threatening condition, call 911 or go to the ER. For everything else, it may be best to contact your primary care provider (PCP) first. If seeing your PCP isn't possible, it's important to know your other care options, especially before heading to the ER.

START HERE

Care options to consider and approximate	**PCP** Care from the doctor who may know you best	**Convenience care** Basic conditions that aren't generally life-threatening	**Urgent care** Serious conditions that aren't generally life-threatening	**Emergency room** Life- and limb-threatening emergencies
Average cost*	**$160**	**$100**	**$180**	**$2,200**
Hours	Varies by location	Varies by location	Varies by location — may be open nights/weekends	24/7
● indicates the recommended place for care for the following common conditions:				
Broken bone			●	●
Chest pain				●
Cough	●	●		
Fever	●	●		
Muscle strain	●	●		
Pink eye	●	●		
Shortness of breath				●
Sinus problems	●	●		
Sore throat	●	●		
Sprain	●	●	●	
Urinary tract infection	●	●		

United Healthcare

*Source 2019: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated $2,000.00 difference between the average emergency room visit, $2,200 and the average urgent care visit $180.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The choice of provider is yours. This site only serves as a general educational aid concerning provider listings and information about providers. The site is not a substitute for medical or health care advice and does not serve as a recommendation for a particular provider or type of medical or health care. If you believe you are experiencing a medical emergency, please call 911.

This directory's provider information is updated weekly and may have changed. Please check with your provider before scheduling an appointment or receiving services to confirm whether they are participating. If you think any information in this directory is inaccurate, please let us know by clicking on "Report Incorrect Information" on the specific provider's page. Check your official health plan documents to see what services and providers are covered by your health plan.

Insurance coverage provided by or through UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois or their affiliates.

VERUS Rx | VERUSPATH

Dear Member,

As the prescription benefit manager for GTN Technical Staffing , **VerusRx** would like to inform you of an additional benefit being added to your prescription plan effective March 1, 2023 . **VerusRx** and GTN Technical Staffing have partnered to bring additional savings to you through our **VerusPath Program**.

What is VERUSPATH?

VerusPath is a three-tiered program consisting of a suite of services added to your standard pharmacy benefits. Its goal is to drive lower plan costs to your employer, and ultimately, significant savings to each member. These drug savings will apply to Specialty drugs and non-Specialty high-cost Brand Name drugs. For clients new to **VerusRx**, or those who have just added the **VerusPath Program**, we recommend the following:

Obtain a refill on all of your medications prior to your new plan start date. This will prevent any last-minute rush to the pharmacy to obtain your prescription during the plan change.

Pay attention whether if after your start date, your copay at the pharmacy is more than:

GENERIC:	$25.00
PREFERRED BRAND:	$50.00
NON-PREFERRED BRAND:	$75.00

This likely means there has been an error in the way the pharmacy has processed your prescription. Contact **VerusRx** immediately so we can promptly resolve the issue.

If you are taking a **Specialty medication**, you will be contacted directly by a **VerusPath** advocate to assist you in lowering your out-of-pocket costs. If you've worked with a different funding assistance provider in the past, you will be required to **provide your copay assistance information** to the **VerusPath** advocate. Certain steps may need to be repeated, but our advocates are here to simplify all processes.

This change is intended to be as smooth as possible, and requires no action from your membership unless we reach out to you directly. If you are having issues with a specific medication or prescription, please first reach out to us at **+1-800-838-0007**. If you have any plan related questions, we encourage you to speak to your employer, or to us.

Regards,

12221 Merit Drive, Suite 1800
Dallas, Texas 75251
+1-800-838-0007
www.verus-rx.com

VERUS Rx | VERUSPATH

Attention: All members currently on a Brand Name Medication*

If you've been prescribed a Brand Name Medication and your pharmacy informs you the medication cost is higher than your established copay:

GENERIC:	$25.00
PREFERRED BRAND:	$50.00
NON-PREFERRED BRAND:	$75.00

Please contact us immediately so we can help.

Our team of advocates at VerusPath are hard at work to ensure you and your company receive your medications at the lowest possible price.

While these instances are rare, this type of situation can occasionally occur, caused by data issues at the pharmacy. Rest assured, we will do everything in our power to quickly resolve the problem. Simply have the pharmacist contact us at **+1-800-838-0007**. If they are unable to call, please call us directly.

We can help.

*Please refer to your plan's Formulary to establish if your prescription is considered as a Brand Name medication.

12221 Merit Drive, Suite 1800
Dallas, Texas 75251
+1-800-838-0007
www.verus-rx.com

Just one call

Advocate24

To Answer the Important Questions…

Which Doctor is Right for Me?

Recommendations for Primary care providers and Specialists in your area.

Is My Bill Correct?

Advocate24 offers bill review services for Medical, Dental, and Vision bills.

Is This the Best Price for This Procedure?

Our Concierge service offers price comparisons for procedures and prescription drugs at providers near you.

Which Medical Plan is best for me? Does my Insurance Cover This?

Knowing what plans might be the best fit for you and your family, what the plans cover, and how to access care can be daunting. Your Advocate is here to help anytime with understanding coverage and assistance with managing your benefits.

Am I Getting Sick?

With Teladoc, you have access to a doctor at no cost anytime. Day or Night.

gdp ADVISORS LLC

TELADOC

Gilsbar
Enhancing Business. Improving Lives.

866-891-3306

careadvocates@gilsbar.com

Dental Insurance

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings, and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. For network providers visit: www.principal.com/dentist.

	Dental Low	Dental High
Calendar Year Deductible		
Individual Deductible	$50	$50
Family Deductible	$150	$150
Dental Services		
Maximum Annual Benefit (Per person)	$1,000	$1,000
Preventive Services		
Cleanings	No Charge	No Charge
Oral Exams		
Basic Services		
Fillings	50%	80%
Simple Oral Surgery		
Sealants		
Major Services		
Bridges and Dentures - Partial	25%	50%
Root Canal		
Implants	Not Covered	Not Covered
Rollover		
Threshold	$500	$500
Annual Rollover Amount	$250	$250
Carryover Account Maximum	$1,500	$1,500

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Vision Insurance

Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do all these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

GTN Technical Staffing's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

The Preferred Provider directory can be found here: *www.vsp.com*

	Vision	
Copays		
Eye Exam	$10 Copay	Once Every 12 Months
Materials	$25 Copay	Once Every 12 Months
Lenses		
Standard single vision **Standard lined bifocal** **Standard lined trifocal** **Standard lenticular**	Covered 100% After Materials Copay	Once Every 12 Months
Frames		
Frames	$150 Allowance + 20% Discount on Remainder	Once Every 24 Months
Contacts (In lieu of glasses)		
Therapeutic Contact Lenses	Covered 100% After Materials Copay	Once Every 12 Months
Elective Contacts	$150 Allowance + $60 Copay Discount on Fitting Fee *Fitting fee applies*	Once Every 12 Months

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Disability Income Benefits

GTN Technical Staffing offers full-time employees with the option to purchase short-term and long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

At GTN Technical Staffing, we want to do everything we can to protect you and your family. That's why we offer the option to purchase short-term and long-term disability —meaning that you owe nothing out of pocket.

If you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. *Please note, though, that you are not eligible to receive short-term disability benefits if your injury/disability is the result of a work-related injury. Please consult your worker's Compensation carrier for work related injuries.*

	Short Term Disability	Long Term Disability
Benefits Begin		
Accident	8th Day	90 Days
Illness	8th Day	
Benefits		
Benefits Duration	12 Weeks	SSNRA
Percentage of Income Replaced	60%	60%
Maximum Benefit	$500	$6,000

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Basic Life Insurance

Life insurance can help provide for your loved ones if something where to happen to you. GTN Technical Staffing provides full-time employees with $15,000 in group life and accidental death and dismemberment (AD&D) insurance.

GTN Technical Staffing pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information.

	Basic Life/AD&D
Life and AD&D Amount	**$15,000**
Accelerated Benefit Amount	75%
Portable & Convertible	Yes, Statement of Health Required
Age Reduction Schedule	
65	35%
70	15%

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Your Cost

Your Semi-monthly Cost

Medical	HDHP	Buy-Up
Employee Only	$41.92	$54.42
Employee + Spouse	$217.87	$230.37
Employee + Child(ren)	$194.57	$207.07
Employee + Family	$419.63	$432.13

Dental	Dental Low	Dental High
Employee Only	$6.81	$18.38
Employee + Spouse	$14.39	$48.92
Employee + Child(ren)	$15.56	$50.29
Employee + Family	$20.40	$72.44

Vision	
Employee Only	$4.86
Employee + Spouse	$10.38
Employee + Child(ren)	$11.12
Employee + Family	$18.21

Basic Life &AD&D	**Employer Paid – No cost to you!**
Short-Term and Long-Term Disability	**Age Banded Rates, Please see portal for specific rates**

Annual Required Notices

HIPAA Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

COBRA Continuation Coverage

COBRA is:
The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with group health benefit plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status (referred to as "qualifying events").

How Long Must COBRA Continuation Coverage Be Available?
Up to 18 months for termination or reduction of hours
Up to 29 months to employees who are determined to have been disabled at any time during the first 60 days of COBRA coverage and to the disabled employee's nondisabled benefits
Up to 36 months for spouses and dependents due to an employee's death, divorce, or legal separation

What Plans Are Subject to COBRA?
Group health, vision, dental and health care spending account (EMSP) plans are subject to COBRA.

What Specific Events Can Be Qualifying Events?
- Death of employee
- Voluntary or involuntary termination of employment (other than by reason of gross misconduct)
- Retirement
- Reduction in hours
- Divorce or legal separation
- Dependent child ceasing to be a dependent

If you have questions:
Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to Human Resources. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit *www.dol.gov/ebsa* For more information about the Marketplace, visit *www.HealthCare.gov.*

Women's Health Cancer Rights Act (WHCRA) Enrollment Notice
If you have had or plan to have a mastectomy, you may be entitled to certain benefitsunder the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefit 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
- Prosthesis and
- Treatment of physical complications of the mastectomy, including lymphedema

Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the health plan.

Continuation of Health Coverage During Family and Medical Leave (FMLA)
The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This provision is intended to comply with the laws and any pertinent regulations, and its interpretation is governed by them.

For the duration of FMLA leave, the employer must maintain the employee's health coverage. The employee may continue the plan benefit for himself or herself and his or her dependents on the same terms as if the employee had continued to work. The employee must pay the same contributions toward the cost of the coverage that he or she made while working. If the employee fails to make the payments on a timely basis, the employer, after giving the employee written notice, can end the coverage during

the leave if payment is more than 30 days late. Upon return from a FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefit, and other employment terms. The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Newborn's Act Disclosure

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

Special Enrollment Notice

This notice provides information to ensure that you understand your right to apply for group health plan coverage. If you decline enrollment for yourself or eligible dependents because of other health insurance or group health plan coverage, you may be able to later enroll in this plan if you or dependent loses eligibility for that coverage. However, you must request enrollment within 31 days after coverage ends (or after the employer stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you become eligible, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from or determined to be eligible for such assistance. In addition, if you have a new dependent because of marriage, birth, adoption, or place for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days following the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

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 **1877-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 August 10, 2017. 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.asp x	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.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & 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/ime/members/medicaid-a-toz/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/publicassistance/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: http://mn.gov/dhs/people-weserve/seniors/health-care/health-careprograms/programs-and-services/medicalassistance.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: 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: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.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-costhealth-care/program-administration/premium-paymentprogram 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: 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 August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa www.cms.hhs.gov 1-866-444-EBSA (3272) 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.

Important Notice from About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Your Employer coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Your Employer coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact HR for further **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Your Employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if 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% 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.[1]

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 _____

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

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[1] 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.

IMPORTANT CONTACTS

Company	Coverage Area	Phone	Website
ABA Assured Benefits Administrators / United Healthcare	Medical	800-247-7114	www.abadmin.com
VERUS Rx	Pharmacy	1-800-838-0007	www.verus-rx .com
Principal®	Dental Vision Short Term Disability Long-Term Disability Employer Life Accident	800-986-3343	www.principal.com
1POINTE HEALTH	Telemedicine	855-264-0116	www.1pointehealth.com