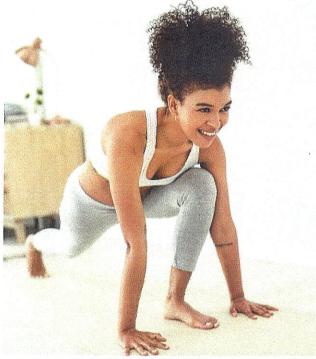
FOREST HILLS OF DC

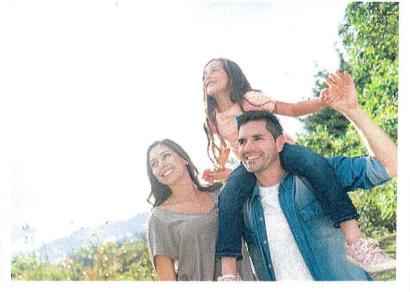
INCLUSIVE SENIOR LIVING

We have you covered. 2022 Employee Benefits Guide









BENEFITS

Medical

Dental

Vision

Life

Disability

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IMPORTANT NOTICES

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage, starting in 2006. Please see page 30 for more details about Medicare Part D.

This guide contains the following notices:

- Children's Health Insurance Program (CHIP)
- Newborns' and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- Medicare Part D Coverage
- HIPAA Special Enrollment
- HIPAA Privacy
- COBRA Rights

Important Contact Information

BENEFIT PROVIDER	GROUP NUMBER	WEB ADDRESS/EMAIL	PHONE
Medical Kaiser Permanente	26410	healthy.kaiserpermanente.org	1-800-777-7904
Medical Aetna	108448	aetna.com	1-800-872-3862
Dental Guardian	00023414	guardianlife.com/dental- insurance	1-800-541-7846
Vision Guardian	00023414	guardianlife.com/vision- insurance	1-844-557-2646
Life / AD&D Guardian	00023414	guardianlife.com/life-insurance	1-800-525-4542
STD / EAP Lincoln Financial		lfg.com	1-877-275-5462
COBRA Hamilton Insurance Agency	.	cobra@hamiltoninsurance.com	800-275-6087 x 208
Hamilton Customer Service Rep Lori Carrico	- -	lcarrico@hamiltoninsurance.com	800-275-6087 x 216
Benefit Service Center Servarus Systems	<u>.</u>	Service@ServarusSystems.com	1-855-363-0841

Eligibility and Benefits

ELIGIBILITY

You are eligible to participate in Forest Hills of DC employee benefits program if you are a full-time employee regularly working at least 30 hours per week. Newly hired employees may participate in the benefits program on the first of the month following 60 days. The plan year is from July 1, 2022 - June 30, 2023.

ELIGIBLE DEPENDENTS

Your eligible dependents include:

- Spouse / Domestic Partner
- ▶ A dependent child (natural, adopted and step children) under the age 26 regardless of student status, marital status or residence. Coverage will terminate at the end of the month in which the dependent turned 26.
- Disabled children of any age who live with you and depend on you for support due to a mental or physical disability (additional documentation and conditions are required in order to obtain carrier approval).

SECTION 125

Certain benefits described in this guide may be purchased with pre-tax payroll deductions as permitted by Section 125 of the Internal Revenue Code. When you purchase benefits with pre-tax dollars, you reduce your taxable income, so fewer taxes are taken out of your paycheck. You can actually have more spendable income than if the same deductions were taken on an after-tax basis.

PRE-TAX NOTE

When you pay for your dependent's benefits on a pre-tax basis, you are certifying that the dependent meets the IRS' definition of a dependent [IRC §§ 152, 21(b)(1) and 105(b)]. Dependents that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the ineligible dependent's pre-tax coverage.

COORDINATION OF BENEFITS

Coordination of Benefits applies if you or your covered dependents are insured under more than one health insurance plan. The plans coordinate with each other on payments so that there are no duplicate payments for the same medical service. The order in which payments are made is determined as follows:

- ▶ The plan that covers the patient as an employee (non-dependent) is considered the primary plan, initially responsible for payment.
- ► The plan that covers the patient as a dependent is the secondary plan.
- When a dependent child is covered by the plan of more than one parent (unless court ordered), generally the plan of the parent whose birthday falls earlier in the year is considered the primary plan.

Benefit Changes

The benefit elections you make during Annual Open Enrollment will remain in effect for the entire year. You will not be able to change or revoke your elections once they have been made unless a life event (status change) occurs. For purposes of health, dental and vision, you will be deemed to have a Status Change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- your dependent is no longer eligible due to attainment of age;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a Family/Life Status Change, the Status Change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this Plan or a plan sponsored by another employer by whom you, your spouse, or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to
 - Medicare or Medicaid;
- you have a Special Enrollment Right;

You must notify the Human Resources Department within 30 days of the Status Change in order to make a change in your benefit elections.

QUALIFYING LIFE EVENT	/4	hedical.	perior i	DOCUMENTATION REQUIRED	
A change in marital status: Marriage Divorce Death of a Spouse	√	√	1	Marriage Certificate Death Certificate Divorce Decree	
A change in the number of your dependents: Birth or Adoption Death of a Dependent	√	√	√	Birth Certificate Notice from Hospital Adoption Agreement Death Certificate	
Termination or commencement of employment by employee, spouse, or dependent.	√	√	1	Letter from the employer confirming prior	
A change in employee's work hours that affects eligibility.	√	√	√	coverage termination date.	
A significant change in your family's health care plan coverage through your spouse's health care plan.	✓	√	✓	Letter from spouse's employer confirming change in coverage and effective date of change.	

Medical and Pharmacy Coverage

	Kaiser Nonstop Wellness	
	IN-NETWORK	
Annual Deductible (Individual / Family)	Covered by HRA Card	
Out of Pocket Maximum (Individual / Family)	Covered by HRA Card	
Preventative Care	\$0 with Non-Stop HRA Card	
Primary Care Office Visit	\$0 with Non-Stop HRA Card	
Specialist Office Visit	\$0 with Non-Stop HRA Card	
X-ray and Lab	\$0 with Non-Stop HRA Card	
Inpatient Hospital Services	\$0 with Non-Stop HRA Card	
Outpatient Hospital Services	\$0 with Non-Stop HRA Card	
Urgent Care	\$0 with Non-Stop HRA Card	
Emergency Room	Deductible, then 30% coinsurance (copay waived if admitted)	
PHARMACY—Retail	teopay waived if admitted)	
Generic	\$0 with Non-Stop HRA Card	
Brand Preferred	\$0 with Non-Stop HRA Card	
Brand Non-Preferred	\$0 with Non-Stop HRA Card	
PHARMACY— Wail Order 90 day supply		
Generic	\$0 with Non-Stop HRA Card	
Brand Preferred	\$0 with Non-Stop HRA Card	
Brand/Generic Non-Preferred	\$0 with Non-Stop HRA Card	
/IEDICAL RATES - PER PAY		
mployee Only	\$55,54	
mployee + Spouse	\$336.96	
mployee + Child	\$260.43	
mployee + Children	\$260.43	
amily	\$573.24	

For full benefit details refer to the summary of benefits

Kaiser Permanente

Core Hospitals

What Is A Core Hospital?

Kaiser believes that coordinating hospital care with your personal physician's care leads to better health results. To ensure the highest level of coordination, Kaiser works with a core group of hospitals throughout the greater Washington DC area to create a seamless transition between your outpatient and inpatient care.

Not all hospitals can be part of Kaiser Permanente's Core Hospital Group. To qualify, each hospital has been carefully evaluated - and is regularly reassessed - for the quality of care, comfort, and services it provides. Staff at core hospitals share our commitment to your health and well-being. We work together for the best possible outcome.

If you become a patient at one of these core hospitals, you care will be guided around the clock by hospitalists from the Mid-Atlantic Permanente Medical Group. Hospitalists are physicians who exclusively care for Kaiser Permanente members in hospitals. From the time you arrive at the hospital until you are discharged, our hospitalists will make sure you are provided with the same quality, coordinated care that you receive from your Permanente primary care physician. Our hospitalists communicate directly with your primary care physician to help assure there are no gaps between the care you receive in the hospital and your follow-up outpatient care. Our goal is to make your transition out of the hospital as smooth as possible. Only at our core hospitals can you receive this special Kaiser Permanente hospital-to-home care.

Your Medical History Is In The Hospital With You

At core hospitals, Permanente hospitalists and specialty physicians have your Kaiser Permanente electronic health history at their fingertips, including your medication history, lab results, allergies, doctors' notes, and X-rays. They also update your medical record with the details of your hospital stay, so you won't have to worry about transferring any records to other Permanente physicians after you leave the hospital.

Your Hospital Team

When you stay in one of our core hospitals, you'll have a team taking care of you that includes a Permanente hospitalist and other Kaiser Permanente staff. Whether you continue your care in a skilled nursing facility, need at-home health services, or need follow-up appointments with your Permanente primary care physician or specialist, your team will help assure that the transition is as easy as possible. In addition to your Kaiser Permanente physicians at the hospital, a Kaiser Permanente patient care coordinator will assist with your hospital stay and discharge. Once you are discharged, you can concentrate on your recovery while your Kaiser Permanente team facilitates your transition to follow-up care.

Our Core Hospitals: Where Permanente Physicians Are On

In these hospitals, you can have peace of mind knowing you are being cared for by Kaiser Permanente physicians you can trust, who have your medical history immediately at hand. They care for you and coordinate that care with hospital staff 24 hours a day, seven days a week.

Hospital addresses and Web addresses are subject to change. The continued availability and/or participation of any hospital with Kaiser Permanente cannot be guaranteed and, therefore, the availability of Kaiser Permanente hospitalists at any location is also not guaranteed. Your admitting physician can inform you about changes in participating hospitals, including those listed to the right. Inpatient behavioral health and substance abuse services may be provided at other hospitals participating with Kaiser Permanente.

Core Hospitals in Maryland

Baltimore

Greater Baltimore Medical Center

6701 North Charles St. Baltimore, MD 21204 gbmc.org

St. Agnes Hospital

900 South Caton Ave. Baltimore, MD 21229 stagnes.org

Suburban Maryland Holy Cross Hospital

1500 Forest Glen Rd. Silver Spring, Maryland 20910 holycrosshealth.org

Suburban Hospital

(Johns Hopkins affiliate) 8600 Old Georgetown Rd. Bethesda, MD 20814

Core Hospitals in Virginia Virginia Hospital Center

1701 North George Mason Dr. Arlington, VA 22205-3698 virginiahospitalcenter.com

Reston Hospital Center

1850 Town Center Pkwy. Reston, VA 20190 restonhospital.com

Mary Washington Hospital

(labor and delivery only) 1001 Sam Perry Blvd. Fredericksburg, VA 22401 marywashingtonhealthcare.com

Stafford Hospital

(MAPMG physicians expected to be onsite in February 2014) 101 Hospital Center Blvd. Stafford, VA 22554 marywashingtonhealthcare.com

Core Hospitals in Washington, DC

Children's National Medical Center

111 Michigan Ave., N.W. Washington, D.C. 20010 childrensnational.org

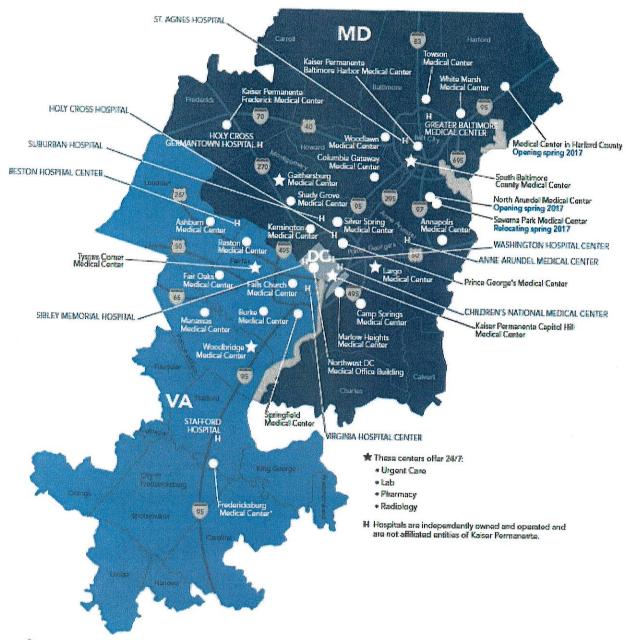
Sibley Memorial Hospital

(Johns Hopkins affiliate) (labor and delivery only) 5255 Loughboro Rd., N.W. Washington, D.C. 20016 sibley.org

Washington Hospital Center

110 Irving St., N.W. Washington, D.C. 20010 whcenter.org

Kaiser Permanente **Location Map**



"Not available for Medicare Plus enrollnes.

Please check kp. org/facilities for the most up to data listing of the services located at Keiser Permanente medical centers, or call Mamber Services. All Severna Park services and providers will relocate to the new North Anundel Medical Center spring 2017.

Non-Stop Wellness

NONSTOP WELLNESS - FREQUENTLY ASKED QUESTIONS

I DON'T UNDERSTAND WHAT THIS PROGRAM IS, CAN YOU EXPLAIN?

• Nonstop Wellness is a healthcare program that wraps around three of the VitalHealth plan offerings for the 2022-2023 plan year. Nonstop Wellness allows members of the Center for Nonprofit Advancement to help fund their employee's health coverage, primarily by eliminating out-of-pocket expenses (e.g. deductibles, copays, and coinsurance), providing robust first dollar coverage for the member. The Nonstop Wellness program combines and ACA-compliant high deductible health plan from Kaiser or Aetna with a section 105 medical expense reimbursement plan (MERP) - and provided the member with a Visa card to pay for covered medical expenses and prescription that are received through in-network providers and families.

HOW DO I USE THE NONSTOP WELLNESS VISA CARD TO PAY FOR SERVICES?

The first thing to remember is our golden rule - always seek care from in-network providers and make sure any services or prescriptions you receive are covered by your Kaiser or Aetna plan. Next, when you visit a provider or pharmacy be sure to present your Kaiser or Aetna ID card before paying for any services or prescriptions. This is so the provider or pharmacist can process any payments through the carrier beforehand. And finally, when asked for payment at the pharmacy or when you receive a bill from your provider, simply pay for those costs using Nonstop Visa card. No need to pay for anything out of your own pocket, as long as the doctor is in-network and your service or prescription is covered by your Kaiser or Aetna plan.

HOW DO I FIND OUT WHAT SERVICES MY PLAN COVERS?

There are two primary ways you can determine what services are covered by your chosen medical plan. The first is the Aetna or Kaiser Summary of Benefits and Coverage (SBC), which will show what services your plan covers. You can request a copy of this document from the benefits contact person at your organization. Alternatively you can call/email Aetna or Kaiser and ask if a specific service, prescription, or provider is covered under your chosen medical plan. We also recommend that you read the In-Network Provider and Covered Services flier for more information on what these terms mean under the nonstop Wellness program

HOW DO I FIND OUT WHAT SERVICES ARE IN-NETWORK?

• There are three ways to determine if a provider or facility is considered in-network for your chosen medical plan. First, you can simply call/email Kaiser or Aetna and ask! The second is to sign up for online access to the Kaiser or Aetna member portal. Once logged in you can search for in-network providers for your specific plan. And finally, you can contact your provider directly and ask them if they are considered in-network for your Kaiser or Aetna plan. We also recommend you read the In-Network Providers and Covered Services flier for more information on what these terms mean under the Nonstop Wellness program

CAN I USE MY FSA WITH NONSTOP WELLNESS?

• Under the Nonstop Wellness program you should not use your FSA to pay for in-network, covered qualifying medical expenses as Nonstop will cover these costs. Paying for medical expenses using both Nonstop Wellness and your FSA would be considered "double dipping" and could lead to disqualification from the Nonstop Wellness program. As such, it is recommended that you allow Nonstop Wellness to pay for your qualifying medical expenses, and use your FSA to pay for vision and dental costs (which are not covered by Nonstop Wellness), as well as any out-of-network medical costs you may need.

WHAT ARE THE HOURS FOR NONSTOP WELLNESS CUSTOMER SERVICE?

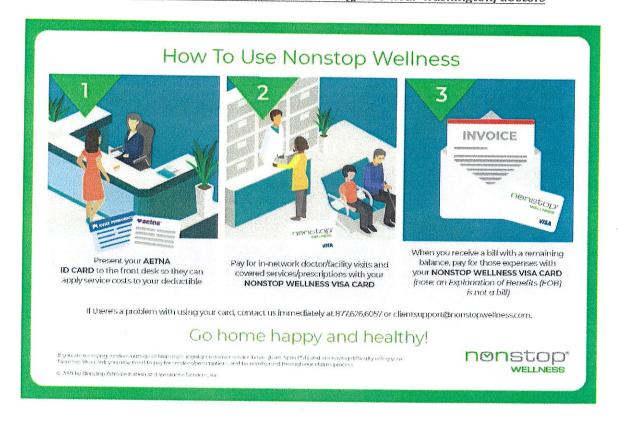
You can reach Nonstop Wellness customer support at 877-626-6057 from 9am-8pm ET, Monday-Friday. Alternatively you can send us an email at clientsupport@nonstopwellness.com and we will typically get back to you within 24-48 business hours

Medical Plan Overview

Your Aetna/Kaiser medical plan is paired with an HRA account administered by Non-Stop Wellness.

Under this plan, claims are paid with the HRA Visa Card administered through Non-Stop Wellness. This means NO out-of-pocket co-insurance, plan deductibles, or co-pays; with the exception of Emergency Room visits result in admission to the hospital.

Search for providers: https://www.aetna.com/individuals-families/find-a-doctor.html
https://thrive.kaiserpermanente.org/care-near-washington/doctors



90 DAYS

If you leave your position or become otherwise ineligible for benefits, you have 90 days from your last day of coverage to submit any outstanding claims or provider bills to Nonstop for payment.

1 YEAR

Keep all documentation (bills, receipts, and Explanation of Benefits) related to any services or prescriptions you paid for with your Nonstop Visa card for one full year. If Nonstop contacts you to substantiate a charge on your Nonstop Visa card, we will ask for this documentation to verify the charge was for a covered medical service or prescription.

5 Things to Remember



Allowed Changes

The following table summarizes how the "qualifying family status changes or special enrollment events" apply to your plan benefits.

CHANGE IN STATUS EVENT	CHANGE IN MEDICAL ELECTION ALLOWED
Change in marital status	Yes
Change in number of dependents	Yes
Change in employment status	Yes
You may choose to continue your benefits while out on leave of absence, if you are on leave without pay you will need to submit payment to the corporate office during your leave of absence. If you do not wish to continue your benefits while on leave you will not be able to re-enroll upon returning to work, and will only be able to do so if you experience a qualified event or if the company is in Open Enrollment.	Yes
Change in work schedule	Yes
Change in dependent's eligibility	Yes
Change in residence or worksite	Yes
Medicare or Medicaid entitlement	Yes
Significant change in cost of coverage	Yes
Gain or loss of other coverage (when loss is involuntary and beyond your control) or significant curtailment of coverage	Yes
Qualified Medical Child Support Order (QMCSO)	Yes

The following table summarizes the documents required for a qualifying family status change along with the deadlines for making coverage election changes.

QUALIFYING FAMILY STATUS CHANGE	DOCUMENTATION REQUIRED	FORM DEADLINE	
Marriage	Marriage certificate	Within 30 days of marriage	
Divorce or legal separation	Copy of divorce decree or copy of court documentation indicating legal separation	Within 30 days of divorce or legal separation	
Birth, adoption, placement for adoption, or confirmation of legal guardianship of a child	Copy of birth certificate or documentation from the hospital or appropriate court document for adoption or legal guardianship.	Within 30 days from the date of birth, adoption or placement for adoption; or within 30 days of confirmation of legal guardianship or of returning to work from a leave of absence	
Death of dependent	Copy of death certificate	Within 60 days of death	
Dependent's gain or loss of employment	Letter from dependent's employer indicating spouse's hire date or termination date and type of coverage (i.e. employee and spouse) as applicable	Within 30 days of spouse gaining or losing employment	
Dependent's employment status changes from part-time to full-time or full-time to part -time	Letter from dependent's employer indicate a change in employment status, effective date of the change and which family members (if any) have benefits coverage through dependent's employer	Within 30 days of status change	
Significant change in health coverage for you or your spouse attributable to your spouse's employment	Letter from employer stating the specific health coverage change	Within 30 days of the change in health coverage	
Dependent immigration/deportation	ID page from passport, Visa stamp, Form 094 and deportation documentation	Within 30 days of entry into (or exit out of) the United States	
Gain or loss (involuntary loss that is beyond your control) of other health coverage	Letter or documentation from other health coverage provider indicating the gain or loss of other coverage, type of coverage and effective date of change	Within 30 days of the effective date of the coverage change	

Please note that if you have proof that you have made reasonable efforts to obtain the required applicable documentation within the respective timeframes set forth above, but have not yet obtained such documentation, you may be eligible for an exception which would extend the due date stated above. Exceptions are reviewed and granted on the merit of each case.

Medical and Pharmacy Plan Provider



Find in-network doctors, specialists, urgent care centers and more—nationwide—including a map and directions to the location

CHECK PLAN INFORMATION INCLUDING

- Effective date
- Copays
- Deductible
- Out-of-pocket status
- Explanation of Benefits (EOBs), and
- Recent claims activity

ERAS, EFTS, AND ELECTRONIC EOBS

Receive payments directly to your account. And review claims payment information online any time.

COORDINATION OF BENEFITS

Get timely payments with electronic coordination of benefits (COB) when a patient is covered under more than one insurance plan.

USE THE TREATMENT COST ESTIMATOR TO CALCULATE COSTS FOR SERVICES AND PROCEDURES

Estimate how much your patients will owe for an office visit. Or look up how much we reimburse for services.

REFUNDING OVERPAYMENTS

Whether we notify you about an overpayment or your office identifies it, we provide simple steps to refunding.

ELECTRONIC TRANSACTION TOOLS

Check eligibility and claims status. And send precertification and referrals.

DIGITAL MEMBER ID CARDS

Instead of a plastic ID card, your patients may give your office a photocopy or printed version of ID card or electronic version of ID card, shown on a smartphone or tablet. Please accept these alternate for mats.

You can get a patient's digital member ID card by submitting an eligibility inquiry on our secure provider website, or through Availity. ID cards can be saved and printed.

OUT-OF-NETWORK BENEFITS

Some of our plans pay for services from doctors who are not in our network. We pay based on "usual and customary charges."

Medical and Pharmacy Coverage

	Aetna Nonstop Wellness	
	IN-NETWORK	
Annual Deductible (Individual / Family)	Covered by HRA Card	
Out of Pocket Maximum (Individual / Family)	Covered by HRA Card	
Preventative Care	\$0 with Non-Stop HRA Card	
Primary Care Office Visit	\$0 with Non-Stop HRA Card	
Specialist Office Visit	\$0 with Non-Stop HRA Card	
X-ray and Lab	\$0 with Non-Stop HRA Card	
Inpatient Hospital Services	\$0 with Non-Stop HRA Card	
Outpatient Hospital Services	\$0 with Non-Stop HRA Card	
Urgent Care	\$0 with Non-Stop HRA Card	
Emergency Room	\$300 copay; after deductible (copay waived if admitted)	
PHARMACY—Retail		
Generic	\$0 with Non-Stop HRA Card	
Brand Preferred	\$0 with Non-Stop HRA Card	
Brand Non-Preferred	\$0 with Non-Stop HRA Card	
РНАRMACY— Mail Order 90 day supply		
Generic	\$0 with Non-Stop HRA Card	
Brand Preferred	\$0 with Non-Stop HRA Card	
Brand/Generic Non-Preferred	\$0 with Non-Stop HRA Card	
MEDICAL RATES - PER PAY		
Employee Only	\$82.74	
Employee + Spouse	\$544.30	
imployee + Child	\$399.12	
mployee + Children	\$399.12	
amily	\$848.64	

For full benefit details refer to the summary of benefits

Aetna Additional Plan Benefits

CONVENIENT CARE YOU CAN COUNT ON

MINUTECLINIC®

Your plan gives you access to all covered MinuteClinic services at no or low cost to you.* MinuteClinic is found inside select CVS Pharmacy® and Target® locations and is the largest provider of retail health care in the United States. Some locations offer expanded health services and wellness products, as well as one-on-one support and guidance from a professional care team. They can help you with certain chronic conditions such as diabetes, sleep apnea, high blood pressure, asthma, COPD and more.

TELEHEALTH

If you can't get care through your in-network doctors (in person or virtually), you have additional options for telehealth. With the 24-Hour Nurse Line,** you can talk to a registered nurse any time. Get helpful information and maybe even save a trip to the doctor's office. You can also connect directly with a doctor about common health issues through Teladoc® services. Teladoc offers 24/7 access to board-certified doctors by phone and video online and through your Aetna member website and Aetna Health app.

Chat with a nurse 24-Hour Nurse Line:

Call 1-800-556-1555

(TTY: 711).

Teladoc: Call 1-855-Teladoc

(1-855-835-2362), visit Teladoc.com/Aetna

DISEASE MANAGEMENT

Maybe you're working with your doctor to manage a condition. Or maybe you just received a diagnosis and are learning more about it. Either way, we're here to support you with the Aetna Health Connections disease management program. It can help you follow your doctor's treatment plan — in the way that works best for you.

PREVENTATIVE CARE COVERAGE AT NO EXTRA COST

Get many checkups, screenings, vaccines, prenatal care services, contraceptives and more with no out-of-pocket costs.

Coverage includes routine screenings and checkups, as well as some counseling to prevent illness, disease and other health problems. Many of these services are covered as part of physical exams. You won't have to pay out of pocket for these preventive visits when they are provided in network. They include:



COVERED PREVENTATIVE SERVICES TYPICALLY INCLUDE:

- Screening
- Medicine and supplements
- Counseling
- Immunizations

Aetna Additional Plan Benefits

HELPING YOU TAKE CHARGE.

Staying healthy is important. So is taking control of your health care and benefits. But with everything else you have going on, managing it all can be a challenge. The Aetna Health app can help.

- View your health plan summary and get detailed information about what's covered.
- View claims details and pay claims for your whole family.
- Search for providers, procedures and medications.
- Get cost estimates before you get care.
- Track spending and progress toward meeting your deductibles for you and your family.
- Speak with a doctor by phone or video 24/7 from anywhere with Teladoc®.
- Access your ID card whenever you need it.



AETNA DISCOUNT PROGRAMS

DISCOUNT OFFERS ARE NOT INSURANCE. They are not benefits under your insurance plan. You get access to discounts off the regular charge on products and services offered by third party vendors and providers. Aetna makes no payment to the third parties - you are responsible for the full cost.

HEALTHY VISION

- Discounts on designer frames, prescription lenses, lenses options like scratch coating or tint, non-disposable contact lenses, and more!
- Great rates on eye exams
- Lots of locations You can visit many doctors in private practice. Plus, national chains like LensCrafters®, Target Optical® and Pearle Vision®. Check your member website at Aetna.com for a full list.
- Savings on LASIK laser eye surgery

A FIT, FABULOUS YOU

- Health coaching
- Gym memberships
- Healthy food options like meal delivery
- Wearable fitness devices
- Group fitness on demand

A NATURAL HEALTH BOOST

- Therapeutic messages
- Acupuncture
- Chiropractic care
- Nutrition services

HOW TO GET STARTED

Log in to your member website at Aetna.com, once you're an Aetna member. It's the place to take care of your benefits. Your place to save, too. You can:

- Find a vision, hearing or natural therapy professional
- Sign up for a weight-loss program
- Buy health products

HEARING YOUR WORLD BETTER

- Discounts on a large choice of hearing aids
- A three-year supply of batteries, then you can join a discount battery mail-order program
- Free in-office service of hearing aids for one year
- Free routine cleanings and battery door replacements for one year after purchase from the original provider

Prescription Drugs—Discount Program

GOODRX MOBILE APP

To help you save on your prescription drug costs we encourage you to download and use the GoodRx Mobile App. Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than \$100 between two pharmacies across the street from each other.

Use the drug price search to compare prices (just like you do for travel or electronics on other sites) for your prescription at pharmacies near you. GoodRx doesn't sell the medications; instead, they will tell you where you can get the best deal on them.

GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you. It's as easy as downloading an app and using it the next time you need a prescription or over-the-counter medication.

Download the GoodRx App on your mobile device by scanning the QR code for your device!













Dental Coverage

It's important to have regular dental exams and cleanings so problems are detected before they become painful and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health.

	Guardia Low	n Dental Plan	Guardian Dental High Plan	
SERVICE	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK
Annual Deductible (Individual / Family)	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150
Calendar Year Maximum	\$1,000	\$1,000	\$2,000	\$2,000
Maximum Rollover	Threshold: \$500 Rollover Amount: \$250 In-Network only Rollover: \$350 Account Limit: \$1,000		Threshold: \$800 Rollover Amount: \$400 In-Network only Rollover: \$600 Account Limit: \$1,500	
Diagnostic and Preventative Services <i>(e.g. x-rays, cleanings)</i>	100%	100%	100%	100%
Basic and Restorative Services (e.g. fillings)	80%	80%	90%	80%
Major Services e.g. crowns, bridges)	50%	50%	60%	50%
DENTAL RATES - PER PAY				
Employee Only	\$2.78		\$3.56	
imployee + Spouse	\$16.94		\$21.89	
mployee + Child	\$18.46		\$22.42	2
mployee + Children	\$18.46		\$22.42	
a mily \$3			\$43.65	

Dental Plan Provider

8 Guardian°

BEHIND EVERY BRIGHT FUTURE IS A GUARDIAN™

Guardian makes it easy for members to access quality preventive dental care because of its clear connection to overall health, as well as the savings gained by avoiding major services and dental procedures down the line. With good oral care, people are 67% less likely to have heart disease, 50% less likely to have osteoporosis, and 29% less likely to have diabetes.

WHY DENTAL INSURANCE CAN BE A GOOD INVESTMENT FOR INDIVIDUALS, FAMILIES, AND BUSINESSES

The majority of dental care is preventive. So, even a basic dental insurance plan that focuses on preventative care can be a good investment.

Oral health issues are among the most common — and preventable — health concerns impacting the American public. The Centers for Disease Control and Prevention (CDC) calculates that 80% of the U.S. population has had at least one cavity by age 34, and more than 50% show signs of periodontal (gum) disease.1 And while everyone wants a nice smile, a growing body of research2 shows that maintaining good oral health can help adults avoid or better manage serious health-related issues:

Diabetes

Periodontal infections contribute to problems with glycemic control, which compromises the health of diabetic patients.

Heart disease

The inflammation associated with periodontal disease has a high potential to contribute to coronary artery disease. Good oral health can help lower that risk.

Pregnancy

Studies have indicated that mothers with high levels of certain oral bacteria were found to have children with similarly high levels of bacteria, along with a higher risk of tooth decay.

Self-esteem

A smile is important. Research shows that healthy teeth and gums are important to a person's self-esteem and how they feel about themselves.

FREQUENTLY ASKED QUESTIONS

Using your plan How do I find a preferred dentist?

Visit www.guardianlife.com/dental-insurance to access our online directory 24 hours a day.

How much will I have to pay for dental services?

The chart on the following page gives you an overview of many of the covered services along with the percentage of what you will pay for each class of services, both in- and out-of-network.

Is there a lot of paperwork?

There is no paperwork when you see a participating dentist, you are free from filing claims. However, if you use a nonparticipating dentist, you may be required to pay all costs at the time of care, and then submit a claim form in order to be reimbursed for covered services.

Who can I call with questions about my dental plan?

Call Dental Customer Service toll free at: 1-800-541-7846 between 5 a.m. and 5:30 p.m. PST, Monday—Friday.

Vision Coverage

	Guardian Vision			
SERVICE	IN-NETWORK	OUT OF NETWORI		
Exam	\$10 copay	Covers up to \$50		
Frames	\$130 retail max + 20% off balance	Covers up to \$48		
LENSES				
Single Lenses	\$10 copay	Covers up to \$48		
Bifocal lenses	\$10 copay	Covers up to \$67		
Trifocal Lenses	\$10 copay	Covers up to \$86		
CONTACT LENSES				
Elective	\$130 allowance + 15% off balance	Covers up to \$105		
vledically Necessary	Covered in Full	Covers up to \$210		
REQUENCY				
xam	Every 12 mor	nths		
enses	Every 12 months			
rames	Every 12 months			
ontact Lenses	Every 12 months			
ISION RATES - PER PAY				
mployee Only	\$0.60			
mployee + Spouse	\$3.28			
mployee + Child	\$4.26			
nployee + Children	\$4.26			
mily	\$6.96			

For full benefit details refer to the summary of benefits

Vision Plan Provider



WHAT IS VISION INSURANCE?

Insurance for vision helps protect the health of your eyes. How? Vision insurance plans cover routine eye examinations and help pay for glasses, frames, and contact lenses. Even if your eyes don't need correction, modern life — and digital screens — can create stress and problems for your eyes. Regular eye examinations are also important for general health because they can detect diseases like glaucoma and diabetes. That's why everyone in the family needs it.

WHY ADULTS NEED COVERAGE

More than 83% of Americans report using digital devices for more than 2 hours per day, and 60% report digital eye strain.¹

WHY CHILDREN NEED COVERAGE

Poor eyesight can lead to misdiagnosis of learning and psychiatric disorders, which can result in behavioral prob-

WHO IS IT FOR?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you still see clearly. Most of us eventually need vision correction.

WHAT DOES IT COVER?

It covers routine eye exams and helps pay for glasses, contact lenses - things not typically covered by health insurance.

WHY SHOULD I GET IT?

Vision care is vital to overall health, and coverage helps encourage an annual eye exam. It also makes glasses and contacts easier to afford.

YOU DEPEND ON YOUR EYES EVERY DAY. TAKE CARE OF THEM.

Corrective lenses, preventive care, and annual exams help ensure that your eyes perform at their best. Studies suggest that 75% of us need vision correction, and nearly 64% choose eyeglasses. No matter what shape your eyes are in now, at some point in your life, you'll likely need vision correction. That's why more and more people who care about their health ensure they have access to quality vision care.

ACCESS TO A STRONG NETWORK OF PROVIDERS

Our plans offer thousands of locations for you to choose from, plus convenient retail and online vision service options such as Costco, Walmart, and Visionworks. So it's easy to get the exams, frames, lenses, and care you need.

FIND A PROVIDER

Access the directory at www.guardiananytime.com/fpapp/vision or call 1-877-814-8970

Basic Life and AD&D Insurance

	LIFE BENEFIT - GUARDIAN
Employer Contributions:	1.00%
Benefit Amount:	2x annual salary to a maximum of \$300,000
Benefit Maximum:	\$300,000
Benefit Reduction:	50% at age 70
Enhanced Employee AD&D:	100% of Life Benefit to a maximum of \$300,000
Definitions	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.
Seatbelt Benefit—Air Bag Benefit— Common Carrier Benefit	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to \$10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Additional Benefits	
LifeKeys sM	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
TravelConnect sM	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

Disability Insurance

GROUP SHORT TERM DISABILITY INSURANCE—LINCOLN FINANCIAL GROUP

Employer Contribution:	1.00%
Minimum Weekly Benefit Amount:	10%
Maximum Weekly Benefit Amount:	\$1,200
Benefit Duration:	10 weeks
Injury Benefits Begin:	You must be out of work for 20 days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day 21.
Sickness Benefits Begin:	You must be out of work for 20 days due to an illness before you can collect disability benefits. You can begin collecting benefits on day 21.
Pre Existing Limitation:	3/12

GET ANYTIME ACCESS TO FORMS AND BENEFIT INFORMATION AT LINCOLNFINANCIAL.COM

To access the forms and benefits information you need, simply:

- 1. Go to LincolnFinancial.com and click the "Register" link in the "Log In/Register" dropdown menu in the top navigation panel.
- 2. Select "Employee Benefits" and follow the instructions.
- 3. Once you register, you can review coverage, claim status, and policy information. You can also print forms and report claim information such as a child delivery or a return-to-work date.

We're standing by to help



866-783-2255 Monday through Thursday, 8 a.m. to 8 p.m., ET Friday, 8 a.m. to 6 p.m., ET



Email disabilityclaims@lfg.com



Fax 877-843-3950

Employee Assistance Program

HELP AND SUPPORT FOR PERSONAL AND WORK-LIFE MATTERS

EmployeeConnect Plus gives you and your loved ones the support, resources and information you need to handle life's demands.

GUIDANCE CONSULTANTS

When going through a difficult time, having someone to talk to can make a big difference in your state of mind. You and your loved ones have access to confidential counseling from trained counselors for:

- · Stress, anxiety and depression
- Relationship/marital conflicts
- Parenting questions
- Job pressures
- Grief and loss
- Substance abuse

GUIDANCE RESOURCES ONLINE

Whenever you need guidance on important life matters, visit GuidanceResources.com or download the GuidanceNow mobile app. You'll find help on relationships, work, school, children, legal, financial concerns and more. You have access to:

- Timely articles, HelpSheetsSM, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches
- Pet insurance discounts and care locator

FINANCIAL SERVICES

Everyone needs a bit of financial advice now and then. With *EmployeeConnect Plus*, you can speak with a ComPsych® financial expert to discuss:

- Managing personal financial challenges
- Credit card and debt management
- Budgeting
- Tax questions
- Financing for college
- Estate planning
- Investment options
- Mortgages, loans and refinancing
- Retirement planning

LEGAL SERVICES

You can easily feel overwhelmed when faced with legal issues. Fortunately, help is just a phone call away. EmployeeConnect PlusSM gives you access to a ComPsych® staff attorney. Get valuable legal help with:

- Family law
- Bankruptcy and credit issues
- Landlord/tenant issues
- · Civil actions and small claims
- DUI/DWI
- Wills, living wills and trusts
- Name changes
- Contracts
- Probate matters
- Immigration

Along with unlimited phone access to staff attorneys, you can receive one free 30-minute consultation with a local network attorney (per legal issue), and 25% off network attorneys' customary legal fees.

WORK-LIFE SERVICES

When you need help resolving issues at home or work, *EmployeeConnect Plus* is here for you. Work-life specialists will research your question and will send you information based on your needs. Find help with:

- Childcare and before- and after-school care
- Elder care and assisted living services
- Relocation information
- Event planning and home improvement





To find out more:
Visit GuidanceResources.com (Web ID = Lincoln),
download the GuidanceNowSM mobile app, or
call 855-327-4463.



On April 7, 1986, a federal law was enacted (Public Law 99272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation of coverage").

You have the right to choose this coverage for yourself and any other insured if you lose group health coverage for any of the following reasons: 1) Death

- 2) Termination or reduction of hours
- 3) Divorce or legal separation
- 4) Eligible for Medicare

Additionally, a dependent child is eligible when they cease to be a "dependent child".

You will be notified of your rights under COBRA and will have 60 days to participate in this coverage. If your dependents become ineligible under your policy they may continue this coverage for 36 months. This also applies to divorce, separation, retirement, and death. As the employee, you may continue the coverage for 18 months, this may be extended for up to 29 months if you are deemed disabled by the Social Security Administration.

Qualifying Event for You	Maximum COBRA Period
Your termination of employment (except for termination for gross misconduct) or reduction of your hours to less than full-time.	You have the right to continue medical coverage for up to 18 months.
Qualifying Event for Your Spouse and Children	Maximum COBRA Period
Your termination of employment (except for termination for gross misconduct) or reduction of your hours to less than full-time.	Your covered dependents have the right to continue medical coverage for up to 18 months.
 Divorce (or legal separation) between you and your spouse, if it causes loss of coverage You become entitled to Medicare, if it causes loss of coverage Dependent child becomes eligible for coverage Your death 	Your covered dependents that would otherwise lose coverage have the right to continue medical coverage for up to 36 months.
Extension of COBRA Coverage	Maximum COBRA Extension Period
You or one of your covered dependents is determined by the Social Security Administration to be disabled within the first 60 days of an 18-month period of COBRA coverage.	COBRA may be extended from 18 months up to 29 months. You MUST provide the COBRA Administrator with a copy of the Social Security disability determination letter within 60 days of the date of the determination and before the end of the 18-month period.
A second qualifying event occurs within the 18 - 29 month period.	Your covered dependents may have the right to extend health care coverage for up to 36 months for the first qualifying event, if the COBRA administrator is notified within 60 days of the second qualifying event.

COBRA Rates								
	Medical Aetna Nonstop Wellness	Medical Kaiser Nonstop Wellness	Dental Guardian Low Plan	Dental Guardian High Plan	Vision Guardian			
Employee	\$914.24	\$613.68	\$30.74	\$39.34	\$6.61			
Employee + Spouse	\$1,934.31	\$1,235.64	\$62.04	\$79.85	\$12.53			
Employee + Child	\$1,613.46	\$1,066.49	\$65,39	\$81.03	\$14.69			
Employee + Children	\$1,613.46	\$1,066.49	\$65.39	\$81.03	\$14.69			
Family	\$2,606.89	\$1,757.82	\$105.55	\$127.95	\$20.68			

COBRA Continuation Coverage Notice

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

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 four 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, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

YOU MAY HAVE OTHER OPTIONS AVAILABLE TO YOU WHEN YOU LOSE GROUP HEALTH COVERAGE.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay for COBRA continuation coverage.

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

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

IF YOU'RE THE SPOUSE OF AN EMPLOYEE, YOU'LL BECOME A QUALIFIED BENEFICIARY IF YOU LOSE YOUR COVERAGE UN-DER THE PLAN BECAUSE OF THE FOLLOWING QUALIFYING EVENTS:

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

COBRA Continuation Coverage Notice

YOUR DEPENDENT CHILDREN WILL BECOME QUALIFIED BENEFICIARIES IF THEY LOSE COVERAGE UNDER THE PLAN BECAUSE OF THE FOLLOWING QUALIFYING EVENTS:

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

- · The end of employment or reduction of hours of employment;
- · Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

THERE ARE ALSO WAYS IN WHICH THIS 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE CAN BE EXTENDED:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes 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, and treatment of physical complications of the mastectomy, including lymphedema.

Written notice about the availability of these mastectomy-related benefits must be delivered to participants in a group health plan upon enrollment and then each year afterwards.

DOES WHCRA APPLY TO INDIVIDUALS WHO HAVE NOT BEEN DIAGNOSED WITH CANCER BUT WHO MUST UNDERGO A MASTECTOMY DUE TO OTHER MEDICAL REASONS?

Despite the title, nothing in the law limits entitlement to WHCRA benefits to cancer patients. If an individual is receiving benefits in connection with a mastectomy and the group health plan covers mastectomies, then the individual is entitled to WHCRA benefits.

Also, despite the title, nothing in the law limits WHCRA entitlements to women.

DOES WHCRA MANDATE MINIMUM HOSPITAL LENGTHS OF STAY IN CONNECTION WITH MASTECTOMY OR BREAST RECONSTRUCTION?

No, but many State laws applicable to insured coverage provide more protections than WHCRA. Thus, if a plan provides coverage through an insurance company, covered individuals may be entitled to minimum hospital stays under State law. If your plan is insured, check with your State insurance department for more information.

MAY GROUP HEALTH PLANS IMPOSE DEDUCTIBLES OR COINSURANCE REQUIREMENTS ON THE COVERAGE SPECIFIED IN WHCRA?

Yes, but only if the deductibles and coinsurance are consistent with those established for other medical/surgical benefits under the plan or

CAN MY PLAN REFUSE TO COVER RECONSTRUCTIVE SURGERY BENEFITS BECAUSE THE MASTECTOMY WAS PERFORMED WHEN THE PARTICIPANT WAS COVERED UNDER A DIFFERENT INSURANCE COMPANY?

If the plan provides coverage for mastectomies and the participant is receiving benefits under the plan that is related to a mastectomy, then the plan generally is required to cover reconstructive surgery upon request. In addition, the plan generally is required to cover the other benefits specified in WHCRA. It does not matter that the participant was not enrolled in the current plan and/or was not covered by the same insurance company at the time of the mastectomy.

There are additional related protections under the Affordable Care Act. For plan years beginning on or after January 1, 2014, a group health plan generally cannot limit or deny benefits relating to a health condition that was present before enrollment in the plan (a preexisting condition). For more information see the Affordable Care Act section of this publication at page 9 or visit the Affordable Care Act Web page of the Department of Labor's Employee Benefits Security Administration (EBSA) at dol.gov/ebsa/healthreform/ or the Department of Health and Human Services' Website at HealthCare.gov.

IS MY PLAN REQUIRED TO PROVIDE PREVENTIVE SERVICES RELATED TO THE DETECTION OF BREAST CANCER?

Under the Affordable Care Act, plans must provide certain preventive services, such as breast cancer mammography screenings for women 40 years of age and older, with no copayment, coinsurance or deductible (or other cost-sharing). For more information, visit HealthCare.gov/whatare-my-preventive-care-benefits/.

WHCRA does not require coverage for preventive services related to the detection of breast cancer.

WHAT INFORMATION SHOULD BE INCLUDED IN THE NOTICE PROVIDED WHEN PARTICIPANTS ENROLL IN THE PLAN?

The enrollment notice must state that, for an individual who is 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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

The enrollment notice must also describe any deductibles and coinsurance limitations applicable to such coverage. Under WHCRA, coverage of breast reconstruction and other benefits specified in WHCRA may be subject only to deductibles and coinsurance limits consistent with those established for other medical/surgical benefits under the plan or coverage.

WHAT INFORMATION SHOULD BE INCLUDED IN THE ANNUAL NOTICE TO PARTICIPANTS IN THE PLAN?

The annual notice should describe the four categories of coverage required and should contain information on how to obtain a detailed description of the mastectomy-related benefits available under the plan. To satisfy this annual notice requirement, the plan may provide the same notice it provided to individuals upon enrollment in the plan if it contains the appropriate information as described above.

HOW MUST THE PLAN PROVIDE THESE NOTICES TO PARTICIPANTS?

These notices must be delivered in accordance with the Department of Labor's disclosure rules applicable to furnishing Summary Plan Descriptions. For example, the notices may be provided by first class mail or any other means of delivery prescribed in the regulation. A separate notice must be furnished to a group health plan beneficiary where the last known address of the beneficiary is different than the last known address of the covered participant.

To avoid duplication of notices, a group health plan can satisfy the WHCRA notice requirements by contracting with another party that provides the required notice. For example, in the case of an insured group health plan, the plan will satisfy the notice requirements with respect to a particular participant if the issuer timely provides the notice including the information required by WHCRA.

The Newborns' and Mothers' Health Protection

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. Group health plans that are subject to the Newborns' Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. Many states have enacted their own version of the Newborns' Act for insured coverage. In these states, State law can govern in lieu of the Federal requirements.

WHAT GROUP HEALTH PLANS MUST COMPLY WITH THE NEWBORNS' ACT?

If a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act applies if the coverage is "self-insured" by an employment-based plan.

If the coverage is provided by an insurance company or HMO (an "insured" plan), and your State has a law regulating coverage for newborns and mothers that meets specific criteria, then State law, rather than the Newborns' Act, applies. If this is the case, the State law may differ slightly from the Newborns' Act requirements, so it is important to know which law applies to the coverage offered by your plan.

For those plans with coverage that is insured by an insurance company or HMO, contact your State insurance department for the most current information on the State laws that pertain to hospital length of stay in connection with childbirth.

For those plans covered by the Federal law, the following questions apply:

WHEN DOES THE 48-HOUR (OR 96-HOUR) PERIOD START?

If a woman delivers her baby in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. As an example: if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

However, if the woman delivers outside the hospital and is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission. For example, if a woman gives birth at home by vaginal delivery, but begins bleeding excessively in connection with childbirth and is admitted to the hospital, the 48-hour period starts at the time of admission.

WHO IS THE ATTENDING PROVIDER?

An attending provider is an individual licensed under State law who is directly responsible for providing maternity or pediatric care to a mother or newborn child. A nurse midwife or a physician assistant may be an attending provider if licensed in the State to provide maternity or pediatric care in connection with childbirth. A health plan, hospital, insurance company, or HMO, however, would not be an attending provider.

The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

MAY A GROUP HEALTH PLAN REQUIRE AN INDIVIDUAL TO GET PERMISSION (SOMETIMES CALLED PRIOR AUTHORIZATION OR PRECERTIFICATION BASED UPON MEDICAL NECESSITY) FOR A 48-HOUR OR 96-HOUR HOSPITAL STAY?

A plan cannot deny a mother or her newborn child coverage for a 48-hour stay (or 96-hour stay) because the plan claims that the mother or her attending provider has failed to show that the 48-hour stay (or 96-hour stay) is medically necessary.

However, plans generally can require an individual to notify the plan of the pregnancy in advance of an admission in order to use certain providers or facilities or to reduce the individual's out-of-pocket costs.

UNDER THE NEWBORNS' ACT, MAY GROUP HEALTH PLANS IMPOSE DEDUCTIBLES OR OTHER COST-SHARING PROVISIONS FOR HOSPITAL STAYS IN CONNECTION WITH CHILDBIRTH?

Yes, but only if the deductible, coinsurance, or other cost-sharing for the latter part of a 48-hour (or 96-hour) stay is not greater than that imposed for the earlier part of the stay. For example, with respect to a 48-hour stay, a group health plan is permitted to cover only 80 percent of the cost of the hospital stay. However, a plan covering 80 percent of the cost of the first 24 hours could not reduce coverage to 50 percent for the second 24 hours.

DOES THE NEWBORNS' ACT REQUIRE A PLAN TO OFFER MATERNITY BENEFITS?

No. The Newborns' Act does not require plans to provide coverage for hospital stays in connection with childbirth. However, other legal requirements, including Title VII of the Civil Rights Act of 1964, may require this type of coverage.

Questions regarding Title VII should be directed to the Equal Employment Opportunity Commission. See the agency's Website at eeoc.gov.

ARE GROUP HEALTH PLANS REQUIRED TO TELL PARTICIPANTS AND BENEFICIARIES ABOUT THE NEWBORNS' ACT AND ANY APPLICABLE STATE LAW PROTECTIONS?

A group health plan that provides maternity or newborn infant coverage must include in its SPD a statement describing the Federal or State law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child. If the Federal Newborns' Act law applies in some areas in which the plan operates and State laws apply in others, the SPD must describe the Federal and State law requirements that apply in each area covered by the plan.

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. Additional information can be found for all states on the DOL website. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – MEDICAID	FLORIDA – MEDICAID					
Website: http://myalhipp.com/	Website: http://flmedicaidtplrecovery.com/hipp/					
Phone: 1-855-692-5447	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					
ARKANSA -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					
COLORODO – MEDICAID	IOWA – MEDICAID					
Medicaid Website: http://www.colorado.gov/hcpf	Website: http://www.dhs.state.ia.us/hipp/					
Medicaid Customer Contact Center: 1-800-221-3943	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					
Website: http://chfs.ky.gov.dms/defualt.htm Phone: 1-800-635-2570	Medicaid Website: humanservices/dmahs.clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html					
	CHIP Phone: 1-800-701-0710					
LOUISANA – MEDICAID	CHIP Phone: 1-800-701-0710 NEW YORK – MEDICAID					
LOUISANA – MEDICAID Website:						
LOUISANA – MEDICAID	NEW YORK – MEDICAID					

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

MAINE – MEDICAID	NORTH CAROLINA - MEDICAID					
Website: <u>http://www.maine.gov/dhhs/ofi/public-assistance.index.html</u> Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100					
MASSACHUSETTS – MEDICAID AND CHIP	NORTH DAKOTA – MEDICAID					
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid					
MINNESOTA – MEDICAID	OKLAHOMA – MEDICAID					
Website: <u>http://mn.gov/dhs/ma/</u> Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-699-9075					
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: https://www.dhs.pa.gov/providers/Providers/Pages/Medica I/HIP Program.aspx Phone: 1-800-692-7462					
NEBRASKA – MEDICAID	RHODE ISLAND – MEDICAID					
Website: <u>http://www.ACCESSNebraska.ne.gov</u> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: <u>http://www.eohhs.ri.gov/</u> Phone:1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)					
NEVADA – MEDICAID	SOUTH CAROLINA MEDICAID					
Website: <u>http://dhcfp.nv.gov</u> Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820					
SOUTH DAKOTA – MEDICAID	WASHINGTON - MEDICAID					
Website: <u>http://dss.sd.gov</u> Phone: 1-888-828-0059	Website: <u>https://www.hca.wa.gov/</u> Phone: 1-800-562-3022					
TEXAS – MEDICAID	WEST VIRGINIA – MEDICAID					
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)					
UTAH – MEDICAID	WISCONSIN – MEDICAID AND CHIP					
Website: <u>https://medicaid.utah.gov/</u> CHIP Website: <u>http://health.utah.gov/chip</u> Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm Phone: 1-800-362-3002					
VERMONT – MEDICAID	WYOMING – MEDICAID					
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/programs and-eligibility/ Phone: 1-800-251-1269					
VIRGINIA – MEDICAID AND CHIP						
Vebsite: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282						

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

- U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)
- U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov
- 1-877-267-2323, Menu Option 4, Ext. 61565

Medicare Part D Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Forest Hills of DC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. 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:

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.

Forest Hills of DC has determined that the prescription drug coverage offered by Kaiser or Aetna 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 Forest Hills of DC coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Forest Hills of DC coverage, be aware that you and your dependents will 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 Forest Hills of DC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information 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 Forest Hills of DC 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 or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

HIPAA & the Affordable Care Act Wellness Program Requirements

For outcome-based programs, the reasonable alternative standard (or waiver of the otherwise applicable standard) must be offered to any individual who does not meet the initial standard based on the measurement, test or screening. If the reasonable alternative standard is, itself, another outcome -based wellness standard, the reasonable alternative cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances and an individual must be given the opportunity to comply with the recommendations of their personal physician as a second reasonable alternative standard (if the physician joins in the request). It is not reasonable for plans to seek physician verification that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy a standard under an outcome- based wellness program.

For all health-contingent wellness programs (whether activity-only or outcome-based), all of the facts and circumstances are taken into account when determining whether a plan has provided a reasonable alternative standard, including but not limited to the following:

- If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.
- The time commitment required must be reasonable (for example, requiring attendance nightly at a one hour class would be unreasonable).
- If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.
- If an individual's personal physician states that a program standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost-sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

WHAT DISCLOSURE IS REQUIRED FOR THE AVAILABILITY OF A REASONABLE ALTERNATIVE STANDARD?

Plans and issuers must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program (both activity-only and outcome-based wellness programs). This disclosure must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.

In addition, for outcome based-wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome- based standard, for example a notice that an individual did not meet the BMI target range to qualify for the reward.

HOW DO THE WELLNESS PROGRAM RULES APPLY TO A GROUP HEALTH PLAN THAT OFFERS A REWARD TO INDIVIDUALS WHO PARTICIPATE IN VOLUNTARY TESTING FOR

EARLY DETECTION OF HEALTH PROBLEMS?

The plan does not use the test results to determine whether an individual receives a reward or the amount of an individual's reward.

Such a program is considered a participatory wellness program since it does not base any reward on the outcome of the testing. Thus, it is allowed under the HIPAA nondiscrimination provisions as long as the program is made available to all similarly situated individuals, without being subject to the five requirements that apply to health-contingent wellness programs.

CAN A PLAN PROVIDE A PREMIUM DIFFERENTIAL BETWEEN SMOKERS AND NONSMOKERS?

The plan is offering a reward based on an individual's ability to stop smoking. This is considered an outcome-based wellness program. For the plan to implement this type of program, the plan's nonsmoking program would need to meet the five requirements for wellness programs that require satisfaction of a standard related to a health factor.

Accordingly, this wellness program is permitted if:

- The premium differential is not more than 50 percent of the total cost of employee-only coverage (or 50 percent of the cost of coverage if dependents can participate in the program);
- The program is reasonably designed to promote health and prevent disease;
- Individuals eligible for the program are given an opportunity to qualify for the discount at least once per year;
- The program provides a reasonable alternative standard, without physician verification that the individual met the standard, to all individuals who do not meet the otherwise applicable standard (those who use tobacco products). For example, the reasonable alternative standard could include discounts in return for attending educational classes or for trying a nicotine patch; and
- Plan materials describing the terms of the premium differential (and any disclosure that an individual did not satisfy the wellness program standard) describe the availability of a reasonable alternative standard to qualify for the lower premium.

New Health Insurance Marketplace **Coverage Options**

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 on October for coverage starting as early as January.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your 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.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lost 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 Human Resources.

Employer Name: The Methodist Home of DC dba Forest Hills of DC

Employer Identification Number (EIN) #: 53-0207036

Employer Address: 4901 Connecticut Ave, NW

City: Washington

State: DC

Zip: 20015

Who can we contact about employee health coverage at this job? Human Resources

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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'	fits checked "WAIVED" at this time. I understand the required to provide evidence of insurability for life	nat i may be required t a or disability benefits.	to wait untii	the next	open enr	ollment p	period (i	if applica	ible) or until	a Qualifyi	ng Event for medic	cal or dent	al cover	age, or be
	I choose to waive the following coverages: \Box M		□ Vision	n										
	Reason for Waiver: Coverage Elsewhere Ca						_		□ Not Inte					
	My signature certifies that I have been informed become effective on the date of the new benefit ye	about the benefit opt	ions availab	ole under f	the com	pany Ben	efits Pro	ogram ar	nd I have m	ade the a	bove elections. I u	understand	i my ele	ctions will
	My signature also certifies that all statements and may void all coverage applied for on this applicati above enrollments from my paycheck. I agree that during the plan year unless I have a Qualified Statu	J information provided	l herein are	: complete	and true	to the b	best of r	my know	/ledge. I und	lerstand a	nd agree that any	misstatem	nents or	omissions
	above enrollments from my paycheck. I agree that during the plan year unless I have a Qualified Statu willfully presents false information in an applicat	it I am solely responsi	ible for the	premium wingly and	payment d willfull	is associa is associa	guis. 1 ii sted with •= = false	th the en	utnorize pay irollment, l u	roll deauc	tions of the contri	ibutions as ange my ir	ssociate Isurance	d with the elections
	willfully presents false information in an applicat terms. The recorded answers on this Form are, to you have any questions concerning the benefits a enrollment card.	tion for insurance is go the best of my know	uilty of a cr	rime and r helief, full	may be s	ubject to molete a	.5 ฮ เฉเจะ ว fines ฮ เทศ true	and confi	duient ciaim finement in p	prison. I h	ent of a loss or be have carefully read	enefit or w	the know n and a	wingly and gree to its
	you have any questions concerning the benefits a enrollment card.	and services that are	provided by	y or exclu	ded und	er this ag	greeme	nt, pleas	se contact a	members	tor primary supp thip services previ	entative b	inea by efore si	the IKS. IT Igning this
	Employee Signature	Date	1t	Emplo	yer Sign	ature						Date:		

Notes

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Hamilton Insurance Agency 4100 Monument Corner Drive, Ste. 500 Fairfax, VA 22030