QUICKSILVER EXPRESS COURIER | FREIGHT | MEDICAL

2022 Employee Benefits Manual

Full-Time Employee Benefits

Welcome

This is a summary of the current employee benefits program offered by Quicksilver. We hope you find it useful! Please refer to your certificate booklets and summary plan descriptions for detailed information.

Getting Started

Here are a few things you should know before enrolling in your benefits:

Benefit Eligibility

Employees working at least 30 hours per week are eligible for the benefits program.

Enrollment And Coverage Change Notice

For most benefit plans, enrollment and changes to existing coverage (other than as a new hire or newly benefit-eligible employee within your eligibility period) are permitted only during the annual open enrollment period or if you have a qualifying life event.

- Open enrollment occurs in November 2021 for a January 1, 2022 effective date.
- Qualifying life events include loss of other coverage, job status change, marriage, divorce, legal separation, birth, adoption, ceasing to be a dependent child, and other events as prescribed by law. Please notify Maggie Rogness of any qualifying event within 30 days.

Open Enrollment

Quicksilver's open enrollment begins on Monday, November 8, 2021 and will remain open for changes through Wednesday, November 19, 2021. If elected, new benefits will begin on January 1, 2022.

- Log in to Paycom to enroll in, change, or cancel your benefits coverage at paycomonline.com/login.
- If you currently do not have benefits coverage and do not enroll, you will not have coverage in 2022.
- If you currently have benefits coverage and take no action, your coverage will continue with no changes.
- Elections need to be completed by November 19, 2021

Benefit plan enrollments or changes are not allowed outside of open enrollment unless you have a qualifying event. What does this mean for you? It means now is the time to:

- Enroll if you want health insurance coverage
- Change your current health coverage or choose a different plan
- Add or remove a spouse or dependent from your coverage
- Cancel all coverage
- Enroll in the Delta Dental plan
- Enroll in the Vision plan (New for 2022!)

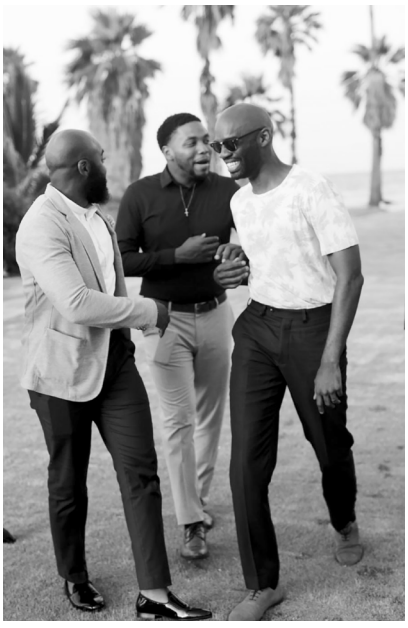
For more information, please contact:

Maggie Rogness
(651)-202-7319
maggie@qec.com

Quicksilver Express Courier
203 E Little Canada Road
Little Canada, MN 55117

Inside This Guide

Table of Contents



This Guide is only a summary provided for your information, so please read your plan certificates for more detail. In case of error, the Master Contracts/Employee Handbook will be used for clarification and all claim adjudication. Quicksilver reserves rights to change, amend, terminate, or otherwise alter any benefit described in this Guide at any time.

Health Plan

Quicksilver is offering the following health plans for the 2022 plan year for you and your family members, including children up to age 26.

Please visit paycomonline.com/login to complete your benefit elections. Watch your email for login instructions to enroll.

Your medical provider is:

BlueCross BlueShield Minnesota

bluecrossmn.com
(651)-662-8000 or
(800)-382-2000

Health Plan Benefits

	In-Network	In-Network
Benefit Coverage	$4,000-100%	$6,500-100%
Deductible (Calendar Year)	$4,000 per person $8,000 family	$6,500 per person $13,000 family
Coinsurance	Deductible then 0% coinsurance	Deductible then 0% coinsurance
Out-of-Pocket Maximum (Calendar Year)	Medical and prescription combined $4,000 per person $8,000 family	Medical and prescription combined $6,500 per person $13,000 family
Benefit payment levels (Most payments are based on allowed amount)	Payment for participating network providers as described.	Payment for participating network providers as described.
Preventive care Prenatal care, Well-child care to age 6, Preventive medical evaluations age 6 and older, Cancer screening, Immunizations and vaccinations, Preventive hearing and vision exams, Omada diabetes and cardiovascular disease	100% covered	100% covered
Physician services E-visits, hospital visits, surgery, clinic, lab, office visits, urgent care, retail health clinic, imaging	Deductible then 0% coinsurance (First 5 e-visits 100% covered)	Deductible then 0% coinsurance (First 5 e-visits 100% covered)
Other professional services Chiropractic/physical/occupational/speech therapy, Chiropractic manipulation, Home health care	Deductible then 0% coinsurance	Deductible then 0% coinsurance
Inpatient hospital services	Deductible then 0% coinsurance	Deductible then 0% coinsurance
Outpatient hospital services Facility diagnostic, lab, therapy, surgery, urgent care	Deductible then 0% coinsurance	Deductible then 0% coinsurance
Emergency care, ER, physician charges, ambulance	Deductible then 0% coinsurance	Deductible then 0% coinsurance
Behavioral health	Deductible then 0% coinsurance	Deductible then 0% coinsurance
Prescription drugs - Classic Network Tier 1: Tier 2: Tier 3: Specialty Medications (31-day limit) Visit the Prescription Drug section of bluecrossmnonline.com for more details.	Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance
Zero Copay Insulin (see page 6 for details)	100% covered	100% covered

Health Plan Contributions

Quicksilver pays a significant portion of your premium if you enroll in our plans. These are your contributions:

	Your Contribution Per Pay Period	
Benefit Coverage	$4,000-100%	$6,500-100%
Employee Only	$109.92	$66.98
Employee + Spouse	$457.76	$361.69
Employee + Child(ren)	$489.38	$388.48
Family	$837.22	$683.19

Prescription Drugs:

This plan uses the preferred (formulary) drug list called KeyRx. To see if your medication is on the list, register as a member at bluecrossmnonline.com. Look for a link on your dashboard.

In case of error and for all claim adjudication, the Master Contract will prevail.

Health Plan (continued)

Health Savings Account (HSA)

Health Savings Accounts (HSAs) are a great way to save money and efficiently pay for medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHP), like the plans offered by Quicksilver. HSA money can be used tax-free when paying for qualified medical, dental or vision expenses. At the end of the year, you keep all unspent money in your HSA.

Your HSA provider is:

FURTHER℠
Formerly SelectAccount

(800)-859-2144
hellofurther.com

Learn more about HSAs at
hellofurther.com/learn

Contributing to Your HSA

You can make tax-free contributions to your HSA using payroll deductions. Anycontributions you make are sent pre-tax to Further (our HSA vendor) and can be accessed anytime. HSA funds initially earn tax-free interest. When your balance reaches $1,000, you may choose to invest it using the mutual funds available through your Further Thrift Saver HSA.

2022 Limits

- The IRS limits HSA contributions for 2022 to $3,650/single and $7,300/family.
- Ages 55 and older may contribute up to an additional $1,000.

Establishing Your HSA

Your HSA must be established before it can be used to pay eligible expenses. To open your HSA, or change your contribution amount, please indicate your preferences when you visit the benefit election portal.

Advantages of HSAs

- HSA contributions are tax-deductible
- HSA funds may be withdrawn tax-free to pay for eligible medical, dental/vision expenses
- HSA funds roll over each year with no limits or penalties
- Your HSA is an asset you keep no matter where you work

Health Plan (continued)

Blue Cross Blue Shield Value Adds

Learn to Live Program

Online programs and clinical assessments for employees and their family members (age 13 or older) struggling with stress, depression or social anxiety. Visit learntolive.com/partners

Mobile Access

Find doctors, check claims, view ID card. Make sure you're registered at myBlueCrossMN. See mktg.bluecrossmn.com/gomobile

Sharecare Fitness Incentive

Real engagement. Real change. Sharecare is a highly innovative health and well-being platform designed to actively engage you in your health to improve outcomes. You'll get personalized recommendations based on RealAge testing and your age, gender, or health condition profile.

Track steps, achieve challenges, and redeem rewards using the Sharecare website or mobile app. Rewards include: Visa E-Rewards Card, Retail Gift Cards (100+ Options), or Premium Merchandise.

Preventive Drug Benefit

High deductible health plans will continue to include 100% coverage for preventive drugs included on the preventive drug lists, when purchased from a participating pharmacy. Selected drugs in the following categories are available at no cost to the members: Diabetes (medications and supplies), High blood pressure, and High cholesterol.

Prescription Drugs

Your health plan uses the preferred (formulary) drug list called KeyRx. To see if your medication is on the list, register as a member at Bluecrossmn.com. Look for a link on your dashboard.

Maternity Management

This program supports moms with high-risk pregnancies. It matches you with a registered nurse who, along with your provider, helps you throughout your pregnancy and for six weeks after birth. Call (866)-489-6948.

Retail Clinics minute clinic

For overall lower costs in most cases, BCBS has joined with MinuteClinic, NOW Care, HealthStation, and Fairview Express Care to provide lower-cost care for many common illnesses and vaccinations.

E-Visits 24/7

Talk on the phone, instant message, or have a video conference with a doctor who can answer your questions, diagnose your condition and prescribe medications. (877)-515-9990 or www.doctorondemand.com/bcbsmn

Tobacco Cessation

The BCBS stop-smoking program is designed to help even those who aren't ready to quit! The number is (888)-662-BLUE (2583).

Zero Copay Insulin Benefit

You can check to see which insulin products are covered under your pharmacy plan: Go to bluecrossmnonline.com > Log in to your account > Select "Prescriptions" > Select "See a list of drugs your plan covers" > Select "Find medicines".

The Zero Copay Benefit applies to tier 1 and tier 2 insulin, and eligible prescriptions must be filled at an in-network retail pharmacy.

BlueCross BlueShield Minnesota

Visit Bluecrossmn.com to learn more about these services, or call (651)-662-8000 or (800)-382-2000

Dental Plan

Quicksilver is offering the following dental plan through Delta Dental, for you and your family members, including children up to age 26.

Your dental provider is:

DELTA DENTAL®

deltadentalmn.org

Log on as a registered member for best results. Or call Delta Dental of Minnesota at (866) 764-5350

Dental Plan Highlights

Benefit Coverage	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Diagnostic & preventive procedures Diagnostic & preventive, sealants, radiographs	100% No deductible	100% No deductible	100% No deductible
Basic services Minor restorative services, emergency treatment, endodontics, periodontics, oral surgery, other basic services	80%	80%	80%
Major services Major restorative, prosthetic repairs/adjustments, prosthetics	50%	50%	50%
Inlays, onlays, crowns	50%	50%	50%

Deductible Per calendar year (Not applicable to diagnostic & preventive services)	$50/single $150/family	$50/single $150/family	$50/single $150/family
Annual Maximum Per covered person per calendar year	$1,500	$1,500	$1,500

Your Contribution Per Pay Period	
Employee Only	$21.03
Employee + Spouse	$42.26
Employee + Child(ren)	$39.74
Family	$68.34

In case of error and for all claim adjudication, the Master Contract will prevail.

Find a Dental Provider

To find a participating provider, visit the Delta website or call Customer Service. Search the Delta PPO or Premier network.

Vision Plan

Quicksilver is offering the Blue Cross Vision plan for you and your family. You pay 100% of the premium if you enroll.

Find a Vision Provider

As a Blue Cross Vision plan member, you'll have access to the Davis Vision network. To find an in-network vision provider, use the Find a Doctor tool at bluecrossmn.com/findaneyedoctor.

Your Vision provider is:

BlueCross BlueShield Minnesota

bluecrossmn.com
(651)-662-8000 or
(800)-382-2000

Vision Plan Highlights

Blue Cross Vision Plan	In-Network Benefit	Out-of-Network Reimbursement
Eye exams	*(every 12 months)* 100% after $10 copay	*(every 12 months)* $40
Frames Davis Vision Fashion level Davis Vision Designer level Davis Vision Premium level Visionworks stores Other participating stores	*(every 12 months)* 100%, no copay 100%, no copay 100% after $25 copay No Copay; 20% off balance over $180 No Copay; 20% off balance over $130	*(every 12 months)* $50
Lenses Single vision Bifocal Trifocal Lenticular	*(every 12 months)* 100% after $25 copay 100% after $25 copay 100% after $25 copay 100% after $25 copay	*(every 12 months)* $40 $60 $80 $100
Contact lenses *(in lieu of glasses)* Collection lenses Disposable Non-disposable Eval., fitting, follow-up care Non-collection lenses Standard - eval., fitting, follow-up care Specialty - eval., fitting, follow-up care Visually required Materials Eval., fitting, follow-up care	*(every 12 months)* up to 4 boxes Up to 2 boxes 100% after $25 copay 100% after $25 copay; materials 100% 100% after $25 copay No Copay; 20% off balance over $180 100%, no copay 100% after $25 copay	*(every 12 months)* Elective: $105 Visually required: $225

Vision Plan Contributions

If you enroll, you pay 100% of your total premium through pre-tax payroll deductions:

Your Contribution Per Pay Period	
Employee Only	$3.18
Employee + Spouse	$6.35
Employee + Child(ren)	$6.17
Employee + Spouse + Child(ren)	$10.00

In case of error and for all claim adjudication, the Master Contract will prevail.

Benefit Plan Contacts

For more information about the benefit program offered by Quicksilver, please contact:

Maggie Rogness
(651)-202-7319
maggie@qec.com

Plan Contacts	Group Number	Provider	Phone	Website
Health Plan - #259400	$6500 – 10440447 $4000 – 10494718	Blue Cross Blue Shield of MN	(800)-382-2000	bluecrossmn.com
Health Savings Account	16962	Further	(800)-859-2144	hellofurther.com
Dental Plan	526754	Delta Dental	(800)-553-9536	deltadentalmn.org
Vision Plan	10623290	Blue Cross Blue Shield of MN	(800)-382-2000	bluecrossmn.com

Other Contacts	Provider	Phone	Website
Employee Assistance Programs (EAPs)	Blue Cross Blue Shield	(800)-432-5155	bluecrossmn.com/eap
E-Visits 24/7	Blue Cross Blue Shield	(877)-515-9990	doctorondemand.com/bcbsmn

Benefit Plan Specifications

Name of plan
Aware HSA $6,500-100% Deductible Plan 10440447
Aware HSA $4,000-100% Deductible Plan 10494718

Plan sponsor and plan administrator
Blue Cross Blue Shield of Minnesota
Quicksilver Express Courier

Employer federal I.D. number
41-158374

Request for information
If you have questions regarding your benefits, please contact the plan administrator. All requests, appeals elections and other communications should be in writing and hand-delivered or sent by certified mail or via secure email with read receipt.

Plan years
All plans: January 1 – December 31

Eligibility requirements
Please review your plan certificates of coverage for more detailed descriptions of benefits and eligibility requirements

Type of plan
There is 1 type of plan addressed in this summary document: Health and Dental Insurance

Type of funding
These plans are funded in part by employee contributions and in part by the employer (plan sponsor) contributions.

Type of administration
The plan sponsor maintains the documentation of plan policies and procedures.

Administrative Information
ERISA Review: For more ERISA information, contact Quicksilver.

Did You Know?

Health plan enrollment and changes are permitted only during open enrollment periods or if you have a qualifying life event, such as marriage, divorce, birth, adoption, death, involuntarily losing other coverage, and some other events.

Sample Document

The benefits described in this document are only summaries. In case of error and for all claim adjudication, the Master Contracts will prevail. The Excelsior Group reserves rights to change, amend, terminate, or otherwise alter any benefit at any time.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

Alabama — Medicaid	Alaska — Medicaid	Arkansas — Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
California — Medicaid	**Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**	**Florida — Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
Georgia — Medicaid	**Indiana — Medicaid**	**Iowa — Medicaid and CHIP (Hawki)**
1-855-MyARHIPP (855-692-7447) or myarhipp.com	1-800-694-3084 or dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-888-549-0820 or www.scdhhs.gov
Kansas — Medicaid	**Kentucky — Medicaid**	**Louisiana — Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**	**MINNESOTA – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid	**MONTANA – Medicaid**	**NEBRASKA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**	**NEW JERSEY – Medicaid and CHIP**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid	NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**	**PENNSYLVANIA – Medicaid**
Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**	**SOUTH DAKOTA - Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**	**VERMONT– Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**	**WEST VIRGINIA – Medicaid**
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**	
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 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 1-866-444-3272

or

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137
(expires 1/31/2023)

Notice of Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Human Resources.

WHCRA Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Company health plans. Therefore, deductibles and coinsurance apply based on the plan you have chosen. (See your health plan certificate for specific information.) If you would like more information on WHCRA benefits, contact your health plan carrier.

MHPAEA Disclosure Requirement

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that criteria for medical necessity determinations made under a plan or insurance coverage with respect to Mental Health/Substance Use Disorder (MH/SUD) benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request. ERISA requires that plan documents, including documents with information on the medical necessity criteria for both Medical/Surgery (M/S) and MH/SD benefits, be furnished to you within 30 days of request. Contact your health plan carrier to request the MHPAEA information applicable to your health coverage.

Michelle's Law Notice

Notice of Extended Coverage to Participants Covered Under a Group Health Plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

Our Health Plan currently permits an employee to continue a child's coverage to the child's 26th birthday (or longer if disabled under certain conditions) if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- Medically necessary leave of absence means a leave of absence or any other change in enrollment:
    - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
    - which is medically necessary; and
    - which causes the dependent child to lose student status under the terms of the Plan.

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to such child to the same extent as it applies to other dependent children covered under the Plan.

Newborns' Act Disclosure

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

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your health insurance carrier 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:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your health insurance carrier has determined that the prescription drug coverage offered by your employer 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 15 to December 7. 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 health insurance coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current health insurance coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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

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

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

Contact your health insurance carrier or your employer 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 your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

- Visit www.medicare.com.
- 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).*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. First in summary, and then more details in three sections: Your Rights, Your Choices, and Our Uses and Disclosures. **Please review it carefully.**

Summary (see more details in the sections following this summary)

A. Your Rights

You have the right to:

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

B. Your Choices

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

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

C. Our Uses and Disclosures

We may use and share your information as we:

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

A. Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

B. Your Choices

For certain health information, you can tell us your choices about what we share.

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

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

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

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

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

- Marketing purposes
- Sale of your information

C. Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

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

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

- We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Reemployment Rights

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

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

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

Right to be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

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

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

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

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction:

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

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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 your employer.

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.

Genetic Information Nondiscrimination Act (GINA) Notice

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

What to do if you believe discrimination has occurred:

There are strict time limits for filing charges of employment discrimination. To preserve the ability of EEOC to act on your behalf and to protect your right to file a private lawsuit, should you ultimately need to, you should contact EEOC promptly when discrimination is suspected: The U.S. Equal Employment Opportunity Commission (EEOC), 1-800-669-4000 (toll-free) or 1-800-669-6820 (toll-free TTY number for individuals with hearing impairments). EEOC field office information is available at www.eeoc.gov or in most telephone directories in the U.S. Government or Federal Government section. Additional information about EEOC, including information about charge filing, is available at www.eeoc.gov.

Wellness Program Disclosure

Rewards for participating in a wellness program, if offered, are available to all employees. If you think you might be unable to meet a standard for a reward under a wellness program offered by your employer, you might qualify for an opportunity to earn the same reward by different means. Contact your employer, who will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice of Patient Protections

When designating a primary care provider

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the health plan carrier may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your employer or health plan carrier.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan carrier.

Family and Medical Leave Act (FMLA)

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

**Special "hours of service" requirements apply to airline flight crew employees.*

Requesting Leave

Generally, employees must give a 30-day advance notice of the need for FMLA leave. If it is not possible to give a 30-day notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division at 1-866-4-USWAGE (1-866-487-9243, TTY: 1-877-889-5627 or www.dol.gov/whd), or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Notice to Employees Regarding Employer Contributions to HSAs

This notice explains how you may be eligible to receive contributions from your employer if you are covered by a High Deductible Health Plan (HDHP) sponsored by your employer and your employer contributes to a Health Savings Account (HSA) for its employees.

If your employer provides contributions to the Health Savings Account (HSA) of each employee who is eligible for such contributions, and you are an eligible employee, you must do the following in order to receive an employer contribution:

1. Establish an HSA on or before the last day in February of the year after the year for which the contribution is being made and;
2. Notify your employer of your HSA account information on or before the last day in February of the year after the year for which the contribution is being made. Please provide to your employer, in writing, the HSA account number, name and address of trustee or custodian, and any routing numbers, if applicable.

If you establish your HSA on or before the last day of February in the year after the year for which the contribution is being made and notify your employer of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for the year for which the contribution is being made by April 15 of the year after the year for which the contribution is being made. If, however, you do not establish your HSA or you do not notify your employer of your HSA information by the deadline, then your employer is not required to make any contributions to your HSA for the applicable year.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

_____

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.

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name _____ 4. Employer Identification Number (EIN) _____

5. Employer address _____ 6. Employer phone number _____

7. City _____ 8. State _____ 9. ZIP code _____

10. Who can we contact about employee health coverage at this job? _____

11. Phone number (if different from above) _____ 12. Email address _____

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

- ☐ All employees. Eligible employees are: _____
- ☐ Some employees. Eligible employees are: _____

With respect to dependents:

- ☐ We offer coverage. Eligible dependents are: _____
- ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee, or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.