LUSA GROUP

Plan Year:
January 1, 2023 –
December 31, 2023

Mental Health Hotline 988

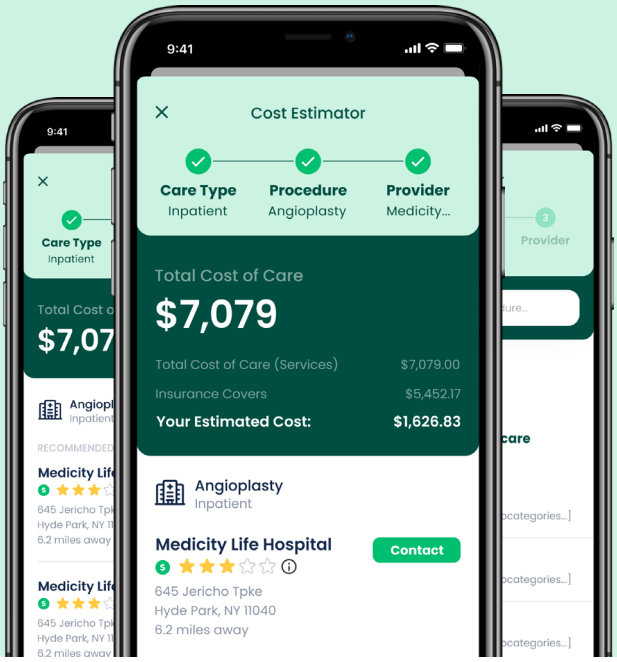
The 988 Suicide and Crisis Lifeline (Lifeline) launched nationwide on July 16, 2022. Similar to dialing 911 for medical emergencies, people in emotional distress or suicidal crisis can call or text 988 and be connected immediately to trained counselors who will listen, provide support and connect them to resources.

The Lifeline provides services in both English and Spanish. This does not take the place of your mental health benefits under your medical plan. **It is a national resource that is FREE to anyone.**

healthEZ

Introducing EZchoice

The new cost containment tool in our member app.



EZchoice makes provider choice easy and costs transparent

- Members can shop 500 common services for quality and cost.
- It is integrated within our member app for the best member experience.
- It will be live by 1/1/23 for No Surprises Act compliance.

With EZchoice, you can be confident that your plan is compliant, costs are transparent and members are not overspending on their medical care.

If you would like to learn more, reach out to your HealthEZ account manager or sales representative.

healthEZ
953-697-2838
healthez.com

Welcome back!
We're here to make your life easier.

HealthEZ is an independent third-party administrator (TPA), which means we manage your employer's health benefits and process your medical claims. We work with your employer to design a custom benefits plan for your organization and we're ready to help you access the services you need. We've been providing our knowledgeable and service-oriented approach for 40 years.

Direct access to member support

Dedicated phone number

LUSA has a dedicated phone number at 844-302-7778 that is answered by a real person between 7 a.m. and 7 p.m. CST. Outside of the hours listed, simply press "3" to reach our 24/7 help line.

24/7 helpline

You have 24/7 access to our team of experienced doctors and nurses. Have a health-related concern or need help finding the right doctor? Give us a call at 844-302-7778. We are here to help you.

Dedicated benefits website

You can use LUSA's dedicated benefits website at LUSABenefits.com to learn about and manage your health plan. View your benefits, review pharmacy information, search to find a doctor and more.

You can set up a myHealthEZ account to access monthly statements, account balances, recently processed bills and HealthEZ's online payment system, EZpay.

Manage your health benefits without all the headaches.

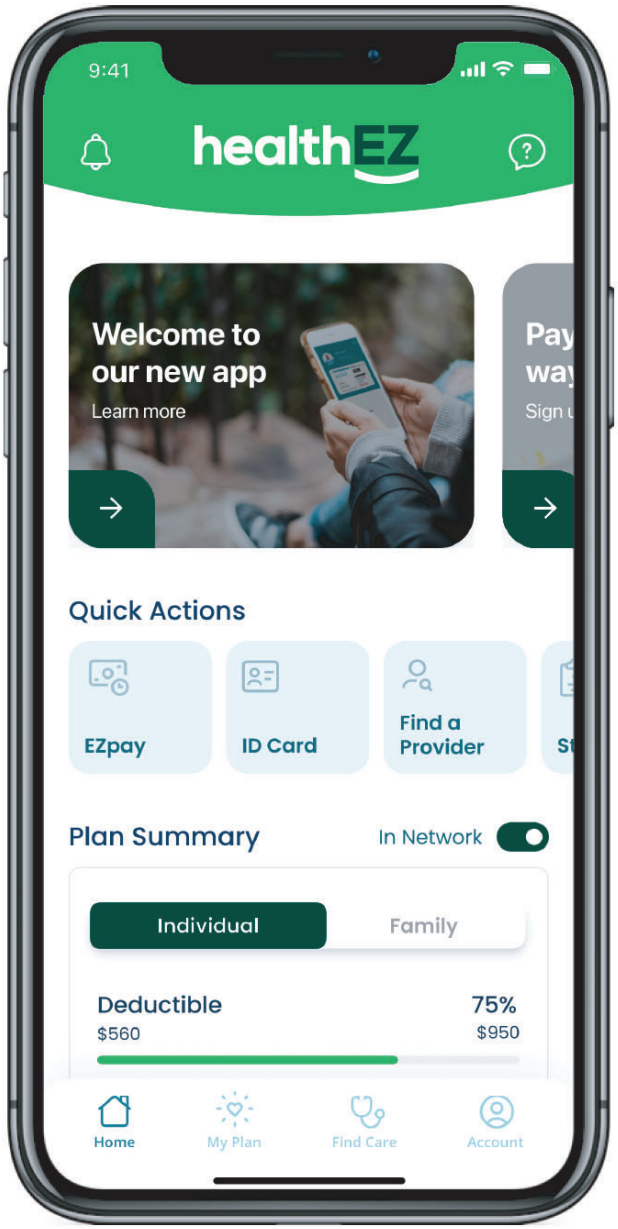
Download the free myHealthEZ app to view your benefits, manage and pay bills, get 24/7 support, locate care providers near you, and access your digital insurance card—right from your phone.

Tap. Pay. Done.
Pay bills, schedule automated payments, and view past statements in one simple, secure location.

24/7 help and support
Find answers faster with access to support materials, or by connecting with a member support representative.

Download on the App Store

GET IT ON Google Play

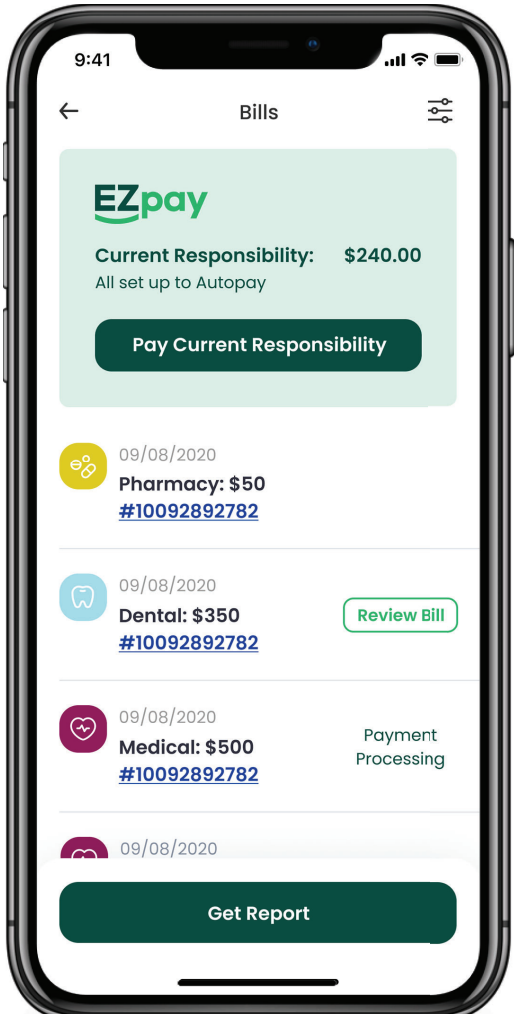


myHealthEZ Account

With or without the myHealthEZ app, you can manage your HealthEZ benefits on your preferred web browser as well. Visit myHealthEZ.com or LUSABenefits.com and click "*Login.*"

If you have not registered an account with HealthEZ yet, enter in your credentials, choose a password, and click "*Activate Your Account*".

Dependents over the age of 19 can create their own myHealthEZ account to manage their plan and request a replacement ID card or download their ID card directly to their own devices.



EZpay

Seamless online payments

EZpay is HealthEZ's online payment system that allows you to easily and quickly pay your portion of medical bills with your payment of choice, including credit and debit cards, and HSA accounts.

After you set up EZpay, every time we process a bill of yours, we will send you an email asking you to approve the payment for the amount due.

EZpay will pay the bill by default if you do not respond to the email in:

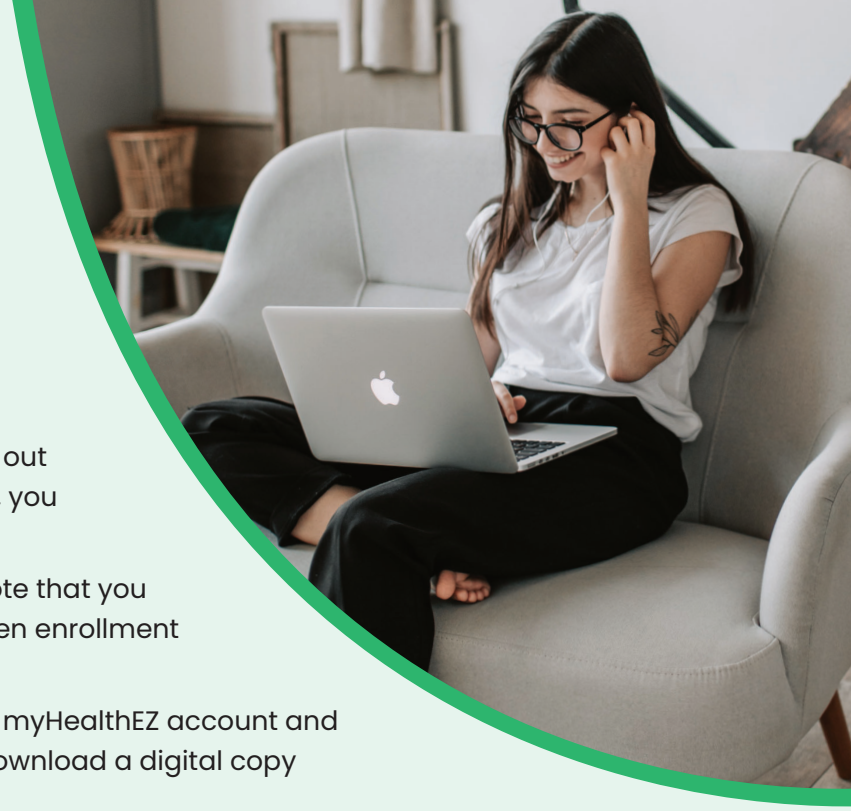
- 2 business days for bills under $250
- 5 business days for bills over $250

EZpay will combine your payment with payment from your health insurance so that we pay your healthcare provider in full.

One simple statement

We consolidate all of your monthly healthcare expenses into one simple statement. This statement eliminates confusion and provides information about year-to-date deductible and out-of-pocket maximums, and itemized transactions during the current billing period.

healthEZ



Medical ID cards

If you are new to the HealthEZ plan, keep an eye out for your medical ID card. Once you recieve that, you can setup your myHealthEZ account.

If you are a current HealthEZ member, please note that you will be receiving a new medical ID card after open enrollment has closed.

If you need a replacement card, log into to your myHealthEZ account and request a new card be printed and mailed, or download a digital copy directly to your device!

Dependents over the age of 19 can create their own myHealthEZ account to manage their plan and request a replacement ID card or download their ID card directly to their own devices.

Your medical network is Aetna.

aetna™

What is a medical network?

Your medical network is a group of healthcare providers. It includes doctors, specialists, hospitals, surgical centers and other facilities. These healthcare providers offer services at a lower rate than out-of-network providers, which you will see reflected on your statements as a discount.

What if I go outside of my medical network?

There may be times when you decide to visit a doctor or clinic that is out-of-network. The costs for these visits and services will always be higher than seeing doctors that are in-network. Out-of-network providers also have a differerent and higher deductible. You will be responsible for paying the difference between the provider's full charge and the amount your health insurance plan pays. This is called balance billing.

How do I know if my provider is in-network?

Please visit LUSABenefits.com, and click "*Find a Doctor.*" After typing in your Zip Code, you will want to select "Doctor by Type" and choose from the drop down. When it asks you to login, click "Continue as Guest." On the next screen, click "Continue." Then choose "PPO, Choice Fund PPO."

Your Pharmacy Benefit Manager is EHiM.

What is a Pharmacy Benefit Manager?

Pharmacy Benefit Managers (PBMs) reduce prescription drug costs and improve convenience and safety for consumers. Your PBM administers your prescription drug plan and offers a network of pharmacies that offer more affordable medications.

What is mail order?

If you take maintenance medications for long-term conditions like arthritis, asthma, diabetes, high blood pressure or high cholesterol you could save money with EHiM's mail order service, Alliance Rx Walgreens Prime. Visit LUSABenefits.com for more information on how to get started and to download the Alliance Rx Walgreens Prime mail order forms.

What are Generic drugs?

Generic drugs are copies of brand-name drugs and are the same as those brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price.

To find out if there is a generic equivalent for your brand-name drug, talk to your doctor or visit EHiMRx.com.

Maternity support

Our Boost Your Baby program matches moms-to-be with a Mommy Mentor to support a healthy pregnancy. It's a non-clinical support system for future moms to use throughout their pregnancy. We promise to: provide good and honest information, be supportive when you need us, make life easy and simple (at least the parts we can), and respect mom & dad's wishes.

Benefits of program include monthly support from a mommy mentor, free breast pump and gifts, nurses available 24/7 for any medical advice or high risk care, and miscarriage support.

Visit boostyourbaby.com, or call 800-808-4848 to learn more.

Care management

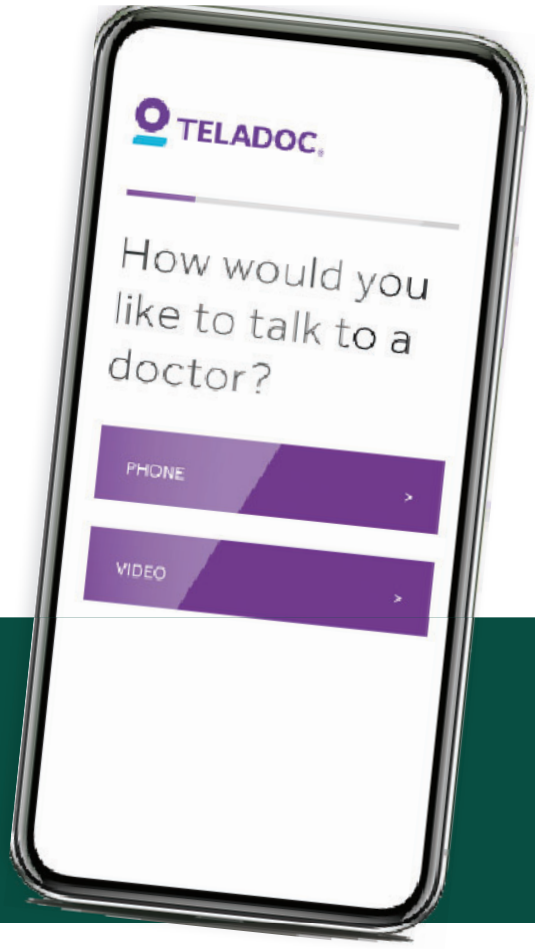
If you need a medical service like a surgery or hospital stay or your doctor diagnoses you with a complex medical condition, a HealthEZ nurse may contact you. The nurse will help you understand your treatment options, coordinate services among your doctors and ensure you have everything you need for a quick recovery and are receiving the right care in the right setting.

We provide tips to members living with chronic health conditions, like diabetes, hypertension and high cholesterol. We can also provide these members with referrals to healthcare providers. Our team of doctors and nurses believe that the key to lasting change is partnering with you to offer realistic advice and support.

TELADOC™

You've got Teladoc virtual health!

All members have access to virtual health appointments with a licensed physician through Teladoc telemedicine services. This benefit can save you a trip to the clinic. There's no need for waiting rooms or travel or taking time off from work. Simply use your computer or smartphone to connect with your doctor.



Visit Teladoc.com or call 1-800-Teladoc to contact a doctor.

Talk to a docotor anytime, anywhere.

General consultations

General consultations are unlimited, and doctors are available every day and at all times (24/7/365). Doctors can consult, diagnose and prescribe medications for things like:

- Allergies
- Upper respiratory infections
- Earaches
- Pink eye
- Urinary tract infections

Mental health services

With Teladoc's mental health services, you can talk to a therapist from the privacy of your home or anywhere you feel comfortable. Simply pick a therapist to speak to and choose a time that is convenient for you.

Teladoc therapists can treat:

- Anxiety
- Depression
- Stress/PTSD
- Panic disorder
- Family & marriage issues

Dermatology care

If you're having problems with your skin, Teladoc Dermatology can help. Instead of waiting weeks to get an appointment at a dermatology clinic, you can get a diagnosis and treatment plan in as quick as two business days.

Teladoc's dermatologists treat a wide variety of skin conditions, including:

- Psoriasis
- Acne
- Moles
- Rosacea

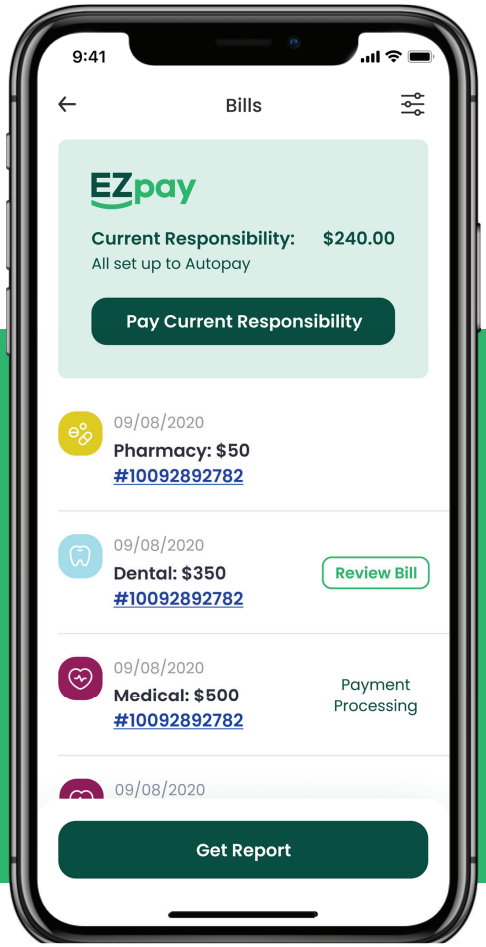
Health Savings Account

A Health Savings Account (HSA) is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses.

By using untaxed dollars in an HSA, you may be able to lower your overall health care costs.

This account belongs to you, regardless if your employment or medical coverage changed. Funds in this account can grow tax free and rollover from year to year.

You are eligible for a Health Savings Account if are enrolled in the HSA Plan.



2023 Maximum Annual Contribution Amounts*

Employee Only: $3,850
Family Coverage: $7,750

**Individuals age 55 or older are eligible to contribute an additional $1,000 per year.*

Add your HSA to EZPay!

Add your Health Savings Account (HSA) to your EZPay account within myHealthEZ to quickly pay your portion of medical bills. Setup payment priority with up to 5 credit and debit cards, and HSA accounts.

EZpay will combine your payment with payment from your health insurance so that we pay your healthcare provider in full.

Summary of Medical Benefits

Copay Plan 1

	In-Network (What the member will pay)	Out-of-Network (What the member will pay)
Calendar Year Deductible Employee only Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance	30%*	50%*
Medical Out-of-Pocket Maximum Employee only Family	 $5,600 $10,200	 $20,000 $60,000
Preventive Care	100% Covered	30%*
Office Visits Primary Services Specialist Services Office Visit Labs, Pathology, Ultrasound and X-Ray	 $40 Copay $40 Copay 100% Covered	 30%* 30%* 30%*
Hospital Services Inpatient Services Complex Imaging: MRI/CT/PET Scans Hospital Labs, Pathology, Ultrasound and X-Ray	 30%* 30%* 100% Covered	 50%* 30%* 30%*
Emergency Services** Emergency Room Emergency Medical Transportation	 $100 Copay, then 30%* 30%*	 $100 Copay, then 50%* 50%*
Urgent Care Services	$65 Copay	30%*
Teladoc Services General Consultations Dermatology	 100% Covered $85 Copay	
Chiropractic Services	30%*	50%*
Mental Health/Chemical Dependency Inpatient Office Visit	 30%* $40 Copay	 50%* 50%*

Summary of Pharmacy Benefits

	Retail 30 Day Supply	Mail Order 90 Day Supply
Prescription Out-of-Pocket Maximum Employee only Family	 $1,000 $3,000	
Prescription Drug Coverage Generic Preferred brand Non-preferred brand Specialty	 $20 Copay $40 Copay $60 Copay $20/$40/$60 Copay	 $40 Copay $80 Copay $120 Copay Not Available

Note: Please refer to your Summary Plan Description for actual coverage, limitation, and exclusion provisions.

* After deductible
** Covered as in-network in true-emergency

Summary of Medical Benefits

Copay Plan 2

	In-Network (What the member will pay)	Out-of-Network (What the member will pay)
Calendar Year Deductible Employee only Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance	30%*	50%*
Medical Out-of-Pocket Maximum Employee only Family	 $5,600 $10,200	 $20,000 $60,000
Preventive Care	100% Covered	30%*
Office Visits Primary Services Specialist Services Office Visit Labs, Pathology, Ultrasound and X-Ray	 $40 Copay $40 Copay 30%*	 30%* 30%* 30%*
Hospital Services Inpatient Services Complex Imaging: MRI/CT/PET Scans Hospital Labs, Pathology, Ultrasound and X-Ray	 30%* 30%* 30%*	 50%* 50%* 50%*
Emergency Services** Emergency Room Emergency Medical Transportation	 $100 Copay, then 30%* 30%*	 $100 Copay, then 50%* 50%*
Urgent Care Services	$65 Copay	30%*
Teladoc Services General Consultations Dermatology	 100% Covered $85 Copay	
Chiropractic Services	30%*	50%*
Mental Health/Chemical Dependency Inpatient Office Visit	 30%* $40 Copay	 50%* 50%*

Summary of Pharmacy Benefits

	Retail 30 Day Supply	Mail Order 90 Day Supply
Prescription Out-of-Pocket Maximum Employee only Family	$1,000 $3,000	

	Retail 30 Day Supply	Mail Order 90 Day Supply
Prescription Drug Coverage Generic Preferred brand Non-preferred brand Specialty	$20 Copay $40 Copay $60 Copay $20/$40/$60 Copay	$40 Copay $80 Copay $120 Copay Not Available

Note: Please refer to your Summary Plan Description for actual coverage, limitation, and exclusion provisions.

* After deductible
** Covered as in-network in true-emergency

Summary of Medical Benefits

Copay Plan 3

	In-Network (What the member will pay)	Out-of-Network (What the member will pay)
Calendar Year Deductible Employee only Family	 $1,500 $4,500	 $3,000 $9,000
Coinsurance	20%*	40%*
Medical Out-of-Pocket Maximum Employee only Family	 $4,500 $10,200	 $9,000 $27,000
Preventive Care	100% Covered	40%*
Office Visits Primary Services Specialist Services Office Visit Labs, Pathology, Ultrasound and X-Ray	 $30 Copay $30 Copay 100% Covered	 40%* 40%* 40%*
Hospital Services Inpatient Services Complex Imaging: MRI/CT/PET Scans Hospital Labs, Pathology, Ultrasound and X-Ray	 20%* 20%* 100% Covered	 40%* 40%* 40%*
Emergency Services** Emergency Room Emergency Medical Transportation	 $100 Copay, then 20%* 20%*	 $100 Copay, then 40%* 40%*
Urgent Care Services	$55 Copay	40%*
Teladoc Services General Consultations Dermatology	 100% Covered $85 Copay	
Chiropractic Services	20%*	40%*
Mental Health/Chemical Dependency Inpatient Office Visit	 20%* $30 Copay	 40%* 40%*

Summary of Pharmacy Benefits

	Retail 30 Day Supply	Mail Order 90 Day Supply
Prescription Out-of-Pocket Maximum Employee only Family	 $1,000 $3,000	

	Retail 30 Day Supply	Mail Order 90 Day Supply
Prescription Drug Coverage Generic Preferred brand Non-preferred brand Specialty	 $20 Copay $35 Copay $50 Copay $20/$35/$50 Copay	 $40 Copay $70 Copay $100 Copay Not available

Note: Please refer to your Summary Plan Description for actual coverage, limitation, and exclusion provisions.

* After deductible
** Covered as in-network in true-emergency

Summary of Medical Benefits

HSA Plan

	In-Network (What the member will pay)	Out-of-Network (What the member will pay)
Calendar Year Deductible Employee only Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance	N/A	30%*
Medical Out-of-Pocket Maximum Employee only Family	 $5,000 $10,000	 Unlimited Unlimited
Preventive Care	100% Covered	30%*
Office Visits Primary Services Specialist Services Office Visit Labs, Pathology, Ultrasound and X-Ray	 No Charge* No Charge* No Charge*	 30%* 30%* 30%*
Hospital Services Inpatient Services Complex Imaging: MRI/CT/PET Scans Hospital Labs, Pathology, Ultrasound and X-Ray	 No Charge* No Charge* No Charge*	 30%* 30%* 30%*
Emergency Services** Emergency Room Emergency Medical Transportation	 No Charge* No Charge*	 30%* 30%*
Urgent Care Services	No Charge*	30%*
Teladoc Services General Consultations Dermatology	100% Covered $85 Copay*	
Chiropractic Services	No Charge*	30%*
Mental Health/Chemical Dependency Inpatient Office Visit	 No Charge* No Charge*	 30%* 30%*

Summary of Pharmacy Benefits

	Retail 30 Day Supply	Mail Order 90 Day Supply
Prescription Drug Coverage Generic Preferred brand Non-preferred brand Specialty	 No Charge* No Charge* No Charge* No Charge*	 No Charge* No Charge* No Charge* Not available

Note: Please refer to your Summary Plan Description for actual coverage, limitation, and exclusion provisions.

* After deductible
** Covered as in-network in true-emergency

Connect with us

LUSA has a dedicated phone number at 844-302-7778 that we answer between 7 a.m. and 7 p.m. CT. When you call, a real person answers. Outside of the hours listed, simply press “3” to reach our 24/7 help line.

service@healthez.com
LUSABenefits.com

844-302-7778

7201 West 78th Street
Bloomington, MN 55439

healthEZ

Emergency Room or Urgent Care? How to Choose

More than 10 percent of all emergency room visits could have either been addressed in an urgent care facility or solved in a doctor's office. But how can you determine which is more appropriate for your condition?

Emergency Room / Urgent Care Tips

- Freestanding ERs are not In-Network with most carriers.
- Go to ERs affiliated with the In-Network hospitals.
- Ask: "Are you contracted and In-Network?" and "Is this an Urgent Care or ER?"
- Use your carrier app or call the member number on your card for an In-Network facility.

When to Use the ER

Emergency rooms are equipped to handle life-threatening injuries and illnesses and other serious medical conditions. An emergency is a condition that may cause loss of life or permanent or severe disability if not treated immediately. You should go directly to the nearest emergency room if you experience any of the following:

- Chest pain
- Shortness of breath
- Severe abdominal pain following an injury
- Uncontrollable bleeding
- Confusion or loss of consciousness
- Poisoning or suspected poisoning
- Serious burns, cuts or infections
- Inability to swallow
- Seizures
- Paralysis
- Broken bones

Patients at the emergency room are sorted according to the seriousness of their condition. For example, a patient with severe injuries from a car accident would likely be seen before a child with an ear infection, even if the child was brought in first.

When to Use Urgent Care

Urgent care centers are usually located in clinics or hospitals, and, like emergency rooms, offer after-hours care. Unlike emergency rooms, they are not equipped to handle life-threatening situations. Rather, they handle conditions that require immediate attention—those where delaying treatment could cause serious problems or discomfort.

Some examples of conditions that require urgent care are:

- Ear infections
- Sprains
- Urinary tract infections
- Vomiting
- High fever

Urgent care centers are usually more cost-effective than ERs for these conditions. In addition, the waiting time in urgent care centers is usually much shorter.

Reduce Your Prescription Drug Costs

You can cut costs by up to 90 percent by becoming an informed consumer and using the same buying techniques that you use when shopping for other goods and services.

Prescription Tips

- Ask your doctor for samples
- Look for manufacturer coupons/programs
- Shop pharmacies
- Request generic medications
- Visit GoodRx – Use to price- shop. Cannot be combined with your health/Rx plan.

Price comparisons

Drug prices are not uniform; you can save a considerable amount of money by shopping around.

Drug substitution

When your doctor prescribes a drug, ask if a cheaper alternative is available.

Bulk buying

As you may know from your everyday shopping, it's cheaper to buy in bulk. The same is true for drugs. Buying larger quantities at a time generally reduces the per dose cost of drugs. This is especially true for generics purchased by mail.

Mail-Order Pharmacies

Mail-order and Internet pharmacies offer the best deals on prescription drugs, especially for patients with chronic conditions.

Pill-splitting

Many prescription drugs are available at increased dosages for similar costs as smaller dosages. Prescribing half as many higher-strength pills and having the patient split them to achieve the desired dosage can reduce the cost of some medications as much as 50 percent. However, pill splitting is not safe for all medications, so talk with your doctor.

Over-the-Counter Drugs (OTC)

Ask your doctor if an OTC drug will work just as well as a prescription drug. Today there are hundreds of OTC drugs that were previously only available by prescription.

Generic medications

Generic medications work as well as brand name drugs and can cost 20 to 80 percent less. This applies for both prescriptions and OTC drugs.

Pharmaceutical company assistance programs/state drug assistance

Many drug companies and states offer drug assistance programs for the elderly, low-income and/or people with disabilities.

Medicare drug plans

Seniors can combine smart shopping techniques with the Medicare drug plan. All the information you need is available at www.Medicare.gov.

Samples

Drug companies give thousands of samples to doctors every year. Your doctor may be able to provide you with weeks' worth of the medication at no charge.

Stay on your meds. If you take medication regularly, don't skip doses or go off your meds to save money. Sticking to your medication schedule will help you avoid health complications that will cost more money in the future.

Discount prescription cards

Look into a discount card, either through a drugstore chain or a national plan. They can provide additional discounts on your prescriptions for a small monthly or annual fee.

Pre-Tax Authorization (Premium Only Plan – POP)

How Does the Plan Work?

When insurance premiums are deducted from a paycheck, the deductions are normally made after FICA and federal income taxes are taken out. This means premiums are paid with "after tax dollars." With this plan, the eligible premiums are deducted before any tax or Social Security (FICA) deductions are made. The premiums are paid for with "pre-tax dollars." The income reported on your annual W-2 form is reduced by the amount of the insurance premiums and the taxable income is therefore lower. This is permitted under special sections of the Internal Revenue Code. Per IRS regulations, domestic partners are not recognized for tax benefit purposes. Therefore, the portion of deductions for the domestic partner is not eligible for tax favored status.

Commonly Asked Questions

If I Waive Coverage, Can I Enroll Later?

Not until the next annual POP enrollment period. Late enrollments are not permitted under IRS regulations.

When Can I Change my POP Enrollment?

Within 31 days after your family status has changed. This includes marriage, divorce, birth of a child, the death of your spouse or a dependent, your spouse's ending or beginning employment, when you or your spouse switch from part-time to full-time employment or full-time to part-time, or when you or your spouse take an unpaid leave of absence which impacts your medical, dental, and/or vision enrollment.

What if I Want to Change or Discontinue my Insurance Coverage During the Year and Have Not Had a Change in Family Status?

According to IRS guidelines, once you are enrolled in POP you may not change your deduction until the end of the POP plan year.

As I Participate in POP, Can I Use my Medical, Dental, and/or Vision Premiums as a Deduction on my Individual Income Taxes?

No. You will already have received your tax savings by participating in this plan.

Can I Have Just Part of my Premium Paid Through POP?

No. Only your full eligible premiums can be paid through this plan.

Pre-Tax Example

	Without POP	With POP
Gross Pay	$1,666/mo.	$1,666/mo.
Pre-Tax Benefits		
Premium	0	400
TOTAL	0	400
Wages subject to tax	1,666	1,266
Federal Tax	249	190
FICA Tax (Social Security)	127	97
Premiums	400	0
Spendable Income	$890	$979

Net Increase in Annual Take-Home Pay = $1,068

This is an illustration only and actual numbers may vary. Paying certain qualified expenses before tax increases your take-home pay.

Frequently Asked Benefit Questions

Why should I go to an In-Network provider?

Network doctors, mental health professionals, hospitals, clinics, and laboratories charge discounted rates, which saves you money. Network providers submit your claims for you, make sure it's an eligible expense under your plan, and ensure the service is paid at the discounted network rate.

What happens if I go Out-of-Network?

Even if your plan allows you to receive care outside of your network, it will typically cost you much more. When you go Out of Network, you do not receive discounted/negotiated rates. You can be billed for the difference between the total amount billed by the provider and the amounts allowed under your plan.

What Should I ask my doctor?

Amazingly, many patients do not ask their doctor basic questions. "How much will my treatment cost?" "Can I be treated another way that is equally effective but less costly?" "What are the risks?" "What are the side effects?" Having a dialogue with your physician can help you better understand how their care decisions affect your health plan costs. It will also help your physician get to know you better and consequently prescribe treatment that is more effective.

What is Preventive Care?

Preventive Care is proactive, comprehensive care which emphasizes prevention and early detection. This care includes physical exams, immunizations, well child, well woman and well man exams. Be sure your child gets routine checkups and vaccines as needed, both which can prevent medical problems (and bills) down the road. Adults should get preventive screenings recommended for their age to detect health conditions early.

Remember all preventive care benefits are covered 100% when you visit an In-Network provider.

What is the difference between Generic and Brand Name drugs?

The difference between Generic and Brand Name medications lies in the name of the drug and cost. Generic drugs cost much less than brand name drugs, save you and your employer money, and provide the same health benefits as brand name drugs.

What is a Summary of Benefits and Coverage (SBC)?

Summaries of benefits and coverage (SBC) are easy-to-read outlines that let you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits and other features that may be important to you. You'll get an SBC when you shop for coverage on your own or through your job, when you renew or change coverage or when you request an SBC from the health insurance company.

What is an Explanation of Benefits (EOB)?

An EOB is a description the insurance company sends to you explaining the healthcare charges you incurred and the services for which your doctor has requested payment. You should compare your EOB to the bill you receive from the physician. All data on your EOB should match the information that appears on the statements you receive from your physician. If it doesn't, contact the physician's office immediately.

Frequently Asked Benefit Questions Continued

What is a deductible?

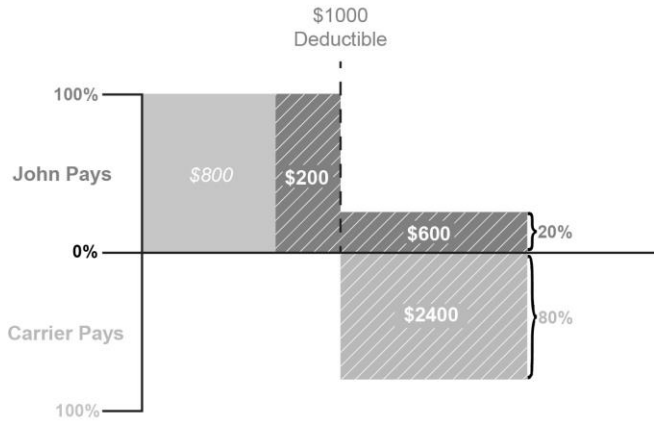
A deductible is the amount of money you or your dependents must pay toward a health claim before your organization's health plan makes any payments for health care services rendered. For example, a plan participant with a $1,000 deductible would be required to pay the first $1,000, in total, of any claims during a plan year.

Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and must have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.

What is Coinsurance?

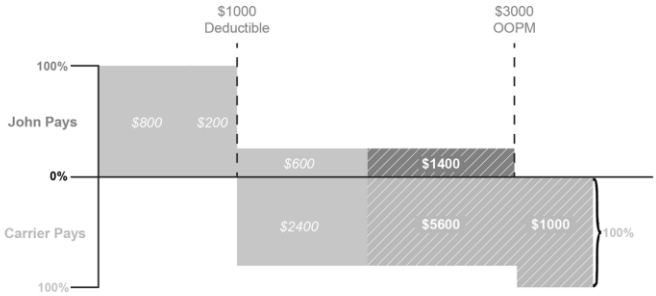
Coinsurance is the amount expressed as a percentage of covered health services that you must pay after you have satisfied your plan deductible.

Example: John's second surgery occurs in the same plan year as his first surgery and costs a total of $3,200. Because he has only paid $800 toward his $1,000 annual deductible, John will be responsible for the first $200 of the second surgery. After that, he has met his deductible and his carrier will cover 80 percent of the remaining cost, for a total of $2,400. John will still be responsible for 20 percent, or $600, of the remaining cost. The total John must pay for his second surgery is $800.



What is Out-Of-Pocket Maximum?

An out-of-pocket maximum is the most you should have to pay for your health care during a year, excluding the monthly premium. It protects you from very high medical expenses. After you reach the annual out-of-pocket maximum, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.



What is a copayment?

A copayment, or copay, is a fixed amount you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

Example: Sally takes her son to the pediatrician for a bad cough. She has a co-pay of $30 at the doctor's office.

Cost of Visit:	**$200**
Sally pays:	**$30**
Health plan pays:	**$170**

Summary of Benefits and Coverage (SBC)

The Affordable Care Act requires all health plan issuers and group health plans to provide eligible enrollees with a Summary of Benefits and Coverage (SBC). The SBC provides you information to better understand your plan and allows you to compare coverage options.

You are receiving this package due to one of the following plan coverage events that requires you to receive an SBC.

- Upon application for coverage,
- Prior to any material modification of your plan coverage,
- Prior to your plan renewal, or
- You are a special enrollee.

For more information regarding this document, please contact the Member Services number on the back of your ID card.

Disclosures & Notices

Patient Protection and Affordable Care Act Required Notifications Non - Grandfathered Plans

Annual Limits on Essential Health Benefits

Effective for plan years beginning on or after Jan. 1, 2014, health plans are prohibited from placing annual limits on essential health benefits. Effective for plan years beginning on or after Jan. 1, 2014, the ACA prohibits health plans from imposing pre-existing condition exclusions (PCEs) on any enrollees. PCEs for enrollees under 19 years of age were eliminated by the ACA for plan years beginning on or after Sept. 23, 2010.

Dependent Coverage to Age 26

Effective for plan years beginning on or after Sept. 23, 2010, the ACA requires health plans that provide dependent coverage of children to make coverage available for adult children up to age 26. However, for plan years beginning before Jan. 1, 2014, grandfathered plans were not required to cover adult children under age 26 if they were eligible for other employer-sponsored group health coverage.

Notice of Patient Protections

Under the ACA, non-grandfathered group health plans and issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Also, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

If a non-grandfathered plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant, such as open enrollment materials.

Over – the – Counter Drugs (For Tax Years beginning on or after December 31, 2010)

Payments for such drugs from a health savings account (an "HSA"), a health reimbursement arrangement (an "HRA"), a health flexible spending account (an "FSA") or an Archer medical savings account (an "Archer MSA") are no longer eligible for nontaxable treatment unless for insulin and over-the-counter drugs prescribed by a physician.

The model language used to produce these notifications can be found at the United States Department of Labor website, specifically http://www.dol.gov/ebsa/compliance_assistance.html#section2 .

Disclosures & Notices

Texas Notice of Mandatory Benefits

The State of Texas requires notices to be given to insureds and applicants regarding coverage for certain mandated benefits. These rules originally became effective on March 29, 1998, but were periodically revised as new mandates were added. The last revision was on January 19, 2006 with the addition of the human papillomavirus and cervical cancer screening mandate.

The following are notices to advise you of certain coverage and/or benefits provided by your contract with your carrier.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and
(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: we may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payment or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage of Test for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled on the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) all stages of the reconstruction of the breast on which mastectomy has been performed;
(b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
(c) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician. Deductible, copayments, and/or coinsurance is applicable to coverage and/or benefits, as shown in Schedule of Benefits. Prohibitions: we may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

Your Contract, as requires by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Examination for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) a physical examination for the detection of prostate cancer; and
(b) a prostate-specific antigen test for each covered male who is

(1) at least 50 years of age; or
(2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery; and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharges before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

If a decision is made to discharge the woman prior to the expiration of the minimum hours of coverage, in-home post-partum care provide by a Physician, registered nurse or other appropriate provider will be covered.

Post-partum care includes health care services in accordance with accepted maternal and new-natal physical assessments, including:
parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary clinical tests.

Prohibitions: we may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accepts a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother and/or newborn child.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
(b) a colonoscopy performed every 10 years.

Disclosures & Notices

New Genetic Nondiscrimination Law Applies to Employers and Health Insurers

The Genetic Information Nondiscrimination Act of 2008 (GINA), signed by President Bush on May 21, amends several statutes regarding employment and health insurance, including Title VII of the Civil Rights Act of 1964 (Title VII), the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986 (Code). GINA's stated intent is "to prohibit discrimination on the basis of genetic information with respect to health insurance and employment." Sections of the law related to health insurance will take effect for plan years beginning after May 2009 (January 1, 2010 for calendar year plans). Employment-related changes will take effect in November 2009.

According to GINA's supporters, many Americans have declined genetic testing and services for fear that information about genetic findings could affect their health insurance and employment. GINA is designed to relieve these fears by protecting the public from discrimination based on genetic information. GINA is, however, unique in the history of nondiscrimination law, in that it was written primarily to be proactive, rather than as a reaction to pervasive discrimination. Without such a history of past discrimination, it is particularly difficult to predict GINA's impact either on health insurance or employment.

Genetic Information
GINA broadly defines "genetic information" to include the results from or information about "genetic tests" or "genetic services" for an individual or "family member" and the manifestation of a disease or disorder in a "family member." Genetic information does not, however, include an individual's age or sex. "Genetic tests" generally include analysis of DNA and chromosomes to detect genotypes, mutations or chromosomal changes. (See "GINA Questions and Answers" for examples.) Covered "family members" include fourth-degree relatives, such as great-great-grandparents and their descendants. GINA also protects the genetic information of fetuses and embryos. For example, a health care plan must not discriminate against a pregnant woman's fetus that has been genetically tested for Down syndrome on the basis of the genetic test.

Amendments to Title VII
GINA amends Title VII to prohibit employers, among others, from discrimination in the terms and conditions of employment based on genetic information. The rights, procedures and remedies for GINA are the same as for Title VII. GINA does not allow a cause of action based on disparate impact, but GINA contemplates that such a cause of action could exist. The statute establishes a commission—beginning six years from enactment of GINA—to study developments in genetic technology and consider the application of the disparate impact theory to genetic information. Employers must not fail to hire, discharge or classify employees on the basis of genetic information, and must not request, require or purchase genetic information, unless an exception applies. (See "GINA Questions and Answers" for a discussion of exceptions.) Finally, employers must not retaliate against an individual based on the exercise of rights created by GINA.

Genetic information, whether lawfully or inadvertently collected by employers, must be kept in a separate file from the employee's personnel file. Employers must not disclose employees' genetic information, unless an exception applies. (See "GINA Questions and Answers" for a discussion of exceptions.)

Amendments to ERISA and Other Statutes
GINA amends ERISA and the Code to impose penalties and taxes for discrimination in health insurance on the basis of genetic information. Group health plans, among others, must not request or require genetic information for underwriting or enrollment purposes, unless an exception applies. (See "GINA Questions and Answers" for a discussion of exceptions.) GINA also prohibits health insurers from increasing premiums on a group basis based on genetic information. GINA required the U.S. Department of Health and Human Services to issue final regulations to include "genetic information" in the definition of "private health information." While GINA itself does not impose any notice obligations on health insurers or employers, future regulations may create such obligations.

Regulations
GINA requires that regulations be published by May 21, 2009. Many issues are left to be addressed in these regulations, including:

- Whether a disease or disorder of family members has to be a genetic disease or disorder—and specific examples of genetic tests;
- If the "bona fide occupational qualification" defense, which may be used by employers in defense of some other cases under Title VII, may be used by employers in cases of genetic discrimination;
- Whether there is any exception to GINA for employers requesting information for non-FMLA leaves such as paid leaves of absence or bereavement leaves, or for providing reasonable accommodations required under the Americans with Disabilities Act; and
- How the maximum penalty for health insurers will be calculated.

Regulations addressing those and many other issues will to a large extent determine GINA's ultimate impact. The agencies responsible for the GINA health insurance regulations have requested comments from the general public regarding health insurance issues under GINA. These comments are due by December 9, 2008.

Disclosures & Notices

Michelle's Law Coverage for Dependent College Students

Michelle's Law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law is named after a New Hampshire college student, Michelle Morse, who continued her studies while battling colon cancer in order to maintain health insurance coverage under her parents' plan. Michelle died of colon cancer in November 2005 at the age of 22.

The 2010 health care reform bill, or Affordable Care Act (ACA), further expanded coverage requirements for dependents. Under ACA, group health plans or insurers who provide dependent coverage for the children of a participant must continue to make coverage available until the participant's child attains age 26, regardless of student or marriage status.

Coverage Benefits

Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under Michelle's Law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

Notice Requirements

The law requires group health plans to provide notice of the requirements of Michelle's Law, in language understandable to the typical plan participant, along with any notice regarding a requirement for certifying student status for plan coverage.

Effective Date

This federal coverage mandate applies to health plans governed by the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC), and became effective for plan years beginning on or after Oct. 9, 2009. Calendar year plans were required to comply beginning Jan. 1, 2010.

Impact of Health Care Reform

ACA diminished the impact of Michelle's Law. ACA states that if a group health plan or insurer provides dependent coverage for the children of a participant, the plan must continue to make the coverage available until the child attains age 26, regardless of student status. However, the plan is not required to make dependent coverage available to dependents that are eligible to enroll in their own employer-sponsored health plan. Thus, the impact of Michelle's Law on group health plans will generally be limited to plans not yet subject to ACA's requirements, grandfathered plans before 2014 and other plans that provide coverage to dependent students who are age 26 or over.

Disclosures & Notices

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact your employer for more information.

WHCRA Enrollment Notice

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

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

These benefits will be provided subjected to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, contact your employer for more information.

Newborns' Act Disclosure Requirement

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).

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as 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 of the marriage, birth, adoption, or placement for adoption.

Disclosures & Notices

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102

INDIANA – Medicaid	MINNESOTA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	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
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://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: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – 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: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493

NORTH CAROLINA – Medicaid	UTAH – Medicaid and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Disclosures & Notices

Important Notice from Landscapes USA 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 Landscapes USA 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. Landscapes USA has determined that the prescription drug coverage offered by the Aetna Copay Plans 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 coverage will not be affected. Refer to your certificate of coverage or your benefit booklet with explanation regarding your prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back until open enrollment.

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 Landscapes USA 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 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 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).

Date:	January 1, 2023
Name of Entity/Sender:	Landscapes USA
Contact:	HR Department
Address:	11849 Rim Rock Trail Austin, TX 78737
Phone Number:	(512) 366-8500

Disclosures & Notices

Important Notice from Landscapes USA About Your Prescription Drug Coverage and Medicare – Non-Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Landscapes USA 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. **Landscapes USA has determined that the prescription drug coverage offered by the Aetna HSA medical plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Aetna HSA medical plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3. You can keep your current coverage from Landscapes USA. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

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 decide to drop your current coverage with Landscapes USA, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Cigna HSA medical plan.

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

Since the coverage AllSavers HP50003060 medical plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Landscapes USA coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Landscapes USA coverage, be aware that you and your dependents will not be able to get this coverage back until open enrollment.

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 Landscapes USA 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:

1. Visit www.medicare.gov
2. 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 Non-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).

Date:	January 1, 2023
Name of Entity/Sender:	Landscapes USA
Contact:	HR Department
Address:	11849 Rim Rock Trail Austin, TX 78737
Phone Number:	(512) 366-8500

Disclosures & Notices

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

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

Get a copy of your health and claims records.

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

Ask us to correct health and claims records.

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

Request confidential communications.

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

Ask us to limit what we use or share.

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

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

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

Get a copy of this privacy notice.

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

Choose someone to act for you.

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

File a complaint if you feel your rights are violated.

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

Your Choices

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

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

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help Manage the health care treatment you receive.

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

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

Run our organization.

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

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

Pay for your health services.

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

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

Administer your plan.

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

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

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We 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 of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

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

Presented by:

3834 Spicewood Springs Rd, Ste. 100
Austin, TX 78759
512-452-8877 / 800-460-5932
www.watkinsinsurancegroup.com

Watkins Insurance Group offers a full range of insurance programs:

- Home & Auto
- Property & Casualty
- Employee Benefits
- Individual Life & Long Term Care