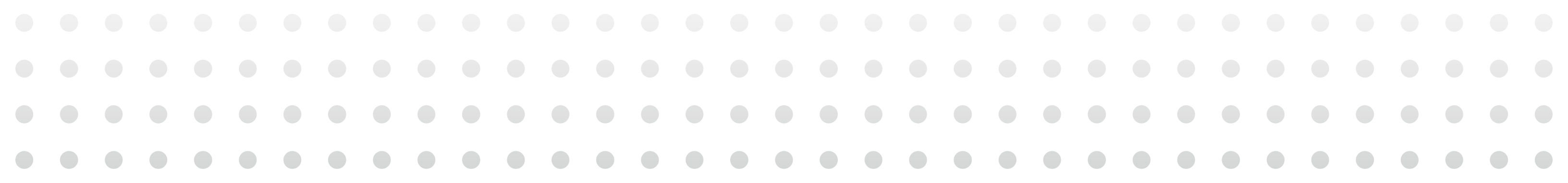
2024

Shelby City Schools
BENEFIT GUIDE



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Welcome Letter

Dear Employees,

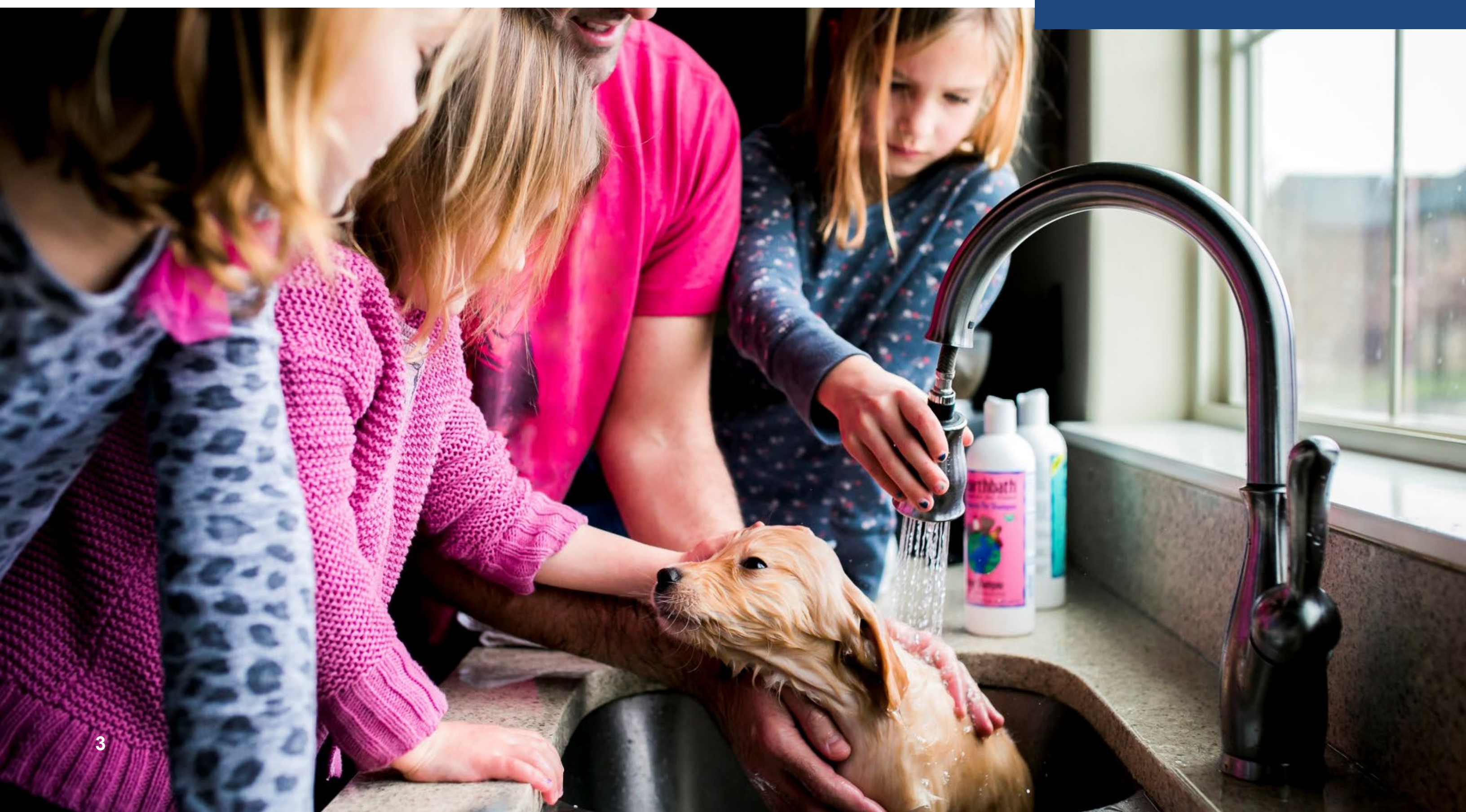
This “Employee Benefits Guidebook” is provided to you as a quick reference guide to address your benefits questions. We encourage you to share this guidebook with your family members and dependents to help you gain a better overall understanding of the benefits available to you.

Based on eligibility, you are only able to join or make changes to your benefit elections during either the annual Open Enrollment period or due to a qualifying life event, such as starting a new job, getting married, loss of other coverage, or for the birth/adoption of a child. In the case of a qualifying life event, you will have 30 days from the date of the event to join the plan, otherwise you may join the plan during the designated annual Open Enrollment period.

The Open Enrollment period generally occurs during the month of **November** with benefit elections becoming effective on **January 1.**

Please carefully review the information contained in this Guidebook. Should you have any questions or need further assistance please contact:

Jaclyn Arbogast
Risk Strategies Account Executive
jarbogast@risk-strategies.com
419-436-7631



Benefits Basics

Who is eligible?

If you're a full-time employee, you are eligible to enroll in the benefits outlined in this guide. In addition, the following family members are eligible for medical, dental, and vision coverage:

You may enroll your:

- Spouse to whom you are legally married.
- Natural, step or legally adopted child(ren)* up to the age of 26, who:
  - Do not need to be full-time students or an eligible dependent on your tax return;
  - Are not required to live with you; and
  - May be married or unmarried.
- Disabled (mentally impaired, physically handicapped or totally disabled) child(ren) age 26 and older. You must periodically provide medical documentation of such disability.

** Coverage terminates the last day of the month in which your child(ren) turns 26 years old. The spouse and/or child(ren) of your dependent child(ren) are not eligible for coverage.*

How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify your personal information and make any necessary changes.

Once your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully. See the next page for more information.

When to Enroll

Open enrollment begins in November and runs through the end of the month. The benefits you choose during open enrollment will become effective on January 1. Remember, after your Open Enrollment you cannot make changes unless you experience a ***Qualifying Event*** (see 'How to Make Changes' below).

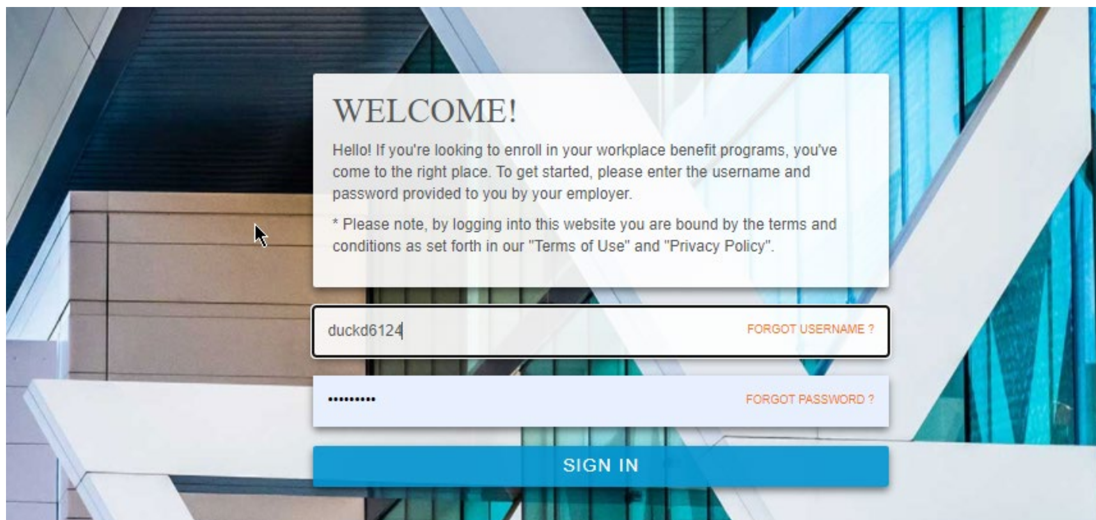
How to Make Changes

Unless you experience a life-changing ***qualifying event***, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

How to Enroll

You can enroll in benefits through the online enrollment system, Benefits Connect. Go to www.enroll.benefitsconnect.net and log in and complete each screen of the enrollment as well as an electronically signing the application.



Online Benefits Team
1-833-510-4430
FIG-OnlineBenefits@risk-strategies.com

Medical Plan Medical Mutual of Ohio

Coverage	Plan A	Plan C*
	In-Network	**In-Network**
Annual Deductible (Individual/Family)	$300 / $600	$3,200 / $6,400
Coinsurance Maximum	$1,700 / $3,400	None
Out-of-Pocket Maximum (Individual/Family)	$6,350 / $12,700	$3,850 / $7,700
Preventive Care	No Charge	No Charge
Office Visit (Primary/Specialist)	$20 Copay	Applies to Deductible
Urgent Care	$50 Copay	Applies to Deductible
Emergency Room	$100 Copay	Applies to Deductible
Hospital Care	10% Coinsurance	Applies to Deductible
X-rays, Labs & Imaging	10% Coinsurance	Applies to Deductible
Mental Health & Substance Abuse • Inpatient • Outpatient	10% Coinsurance	Applies to Deductible

Rx Coverage		
Generic	$5	$5 after deductible
Preferred Brand	$25	$25 after deductible
Non-Preferred Brand	$40	$40 after deductible

*If you enroll in the High Deductible Health Plan, the district will contribute $650 single and $1,300 family into your HSA.

Find a Provider Medical Mutual of Ohio

If you are looking for a specific provider, you can create a Medical Mutual account and search for the provider or you can go to www.providersearch.medmutual.com and click on group. From there you can click on the type of provider you are looking for within Medical Mutual. You currently utilize the SuperMed PPO and Cigna PPO network. If you seek services outside the state of Ohio the network will be Cigna. You will also need to provide your location. If you cannot find your provider by name you can search by facility as well.

Find a Provider

Whether you are a current or future member, we can help you find the right in-network provider.

Choose provider type:

Medical | Pharmacy | Dental | Vision

Hello,
What are you searching for today?

Doctors by name | Doctors by specialty | Places by name | Places by type

Search all | Advanced Search

DOCTORS BY SPECIALTY Primary Care Physician | PLACES BY TYPE Urgent Care

MMO Customer Service
1-800-332-0741

Other Medical Mutual Offerings

Medical Mutual offers program and discounts to their members at little to no cost to them. You can always find more information on the Medical Mutual MyHealthPlan site.

- WeightWatchers

  Medical Mutual members save almost 50% off the regular cost of WeightWatchers membership. For more information, call 1-800-251-2583 or visit MedMutual.com/WeightWatchers. You must sign up through Medical Mutual in order to receive the discount.

- Tobacco Cessation Program

  If you are looking to give up your tobacco habit for good. One-on-one coaching, a personalized plan and educational materials are available with no out-of-pocket costs. To learn more, call 1-866-845-7702.

- 24 Hour Nurse Line

  If you have a health question, minor injury or medical question, you can get answers 24/7 from a clinical expert. Staffed by fully qualified registered nurses. Nurseline is available at no charge to members. Call 1-888-912-0636 and have your member ID number ready.

- Fitness Discounts

  Save money on gym memberships, home exercise equipment, nutrition programs and more. To learn more, check out MyHealthPlan and click on healthy living then fitness to see who they have partnered with.

- Other Discounts

  There are other vendors who Medical Mutual has partnered with to offer discounts on a variety of unique health product and services. You can find more information on the MyHealthPlan under the Healthy Living tab

Health Savings Account (HSA)

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 a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses; you may be able to lower your overall health care costs. HSA funds generally may not be used to pay premiums.

While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you have a High Deductible Health Plan (HDHP) — generally a health plan that only covers preventive services before the deductible.

- For 2024, if you have an HDHP, you can contribute up to $4,150 for self-only coverage and up to $8,300 for family coverage into an HSA.
- HSA funds roll over year to year if you don't spend them. An HSA may earn interest or other earnings, which are not taxable.

IRS Regulations

- Must be enrolled in an IRS-qualified High Deductible Health Plan
- You cannot be covered by any other medical plan, entitled to Medicare benefits or be eligible to be claimed as a dependent on another person's tax return.
- You cannot contribute to an HSA and a Health Care Flexible Spending Account (FSA) in the same plan year. You may enroll in a Limited Purpose FSA.
- See Publication 502 at www.IRS.gov for eligible expenses.
- For proof of expense eligibility, save receipts.

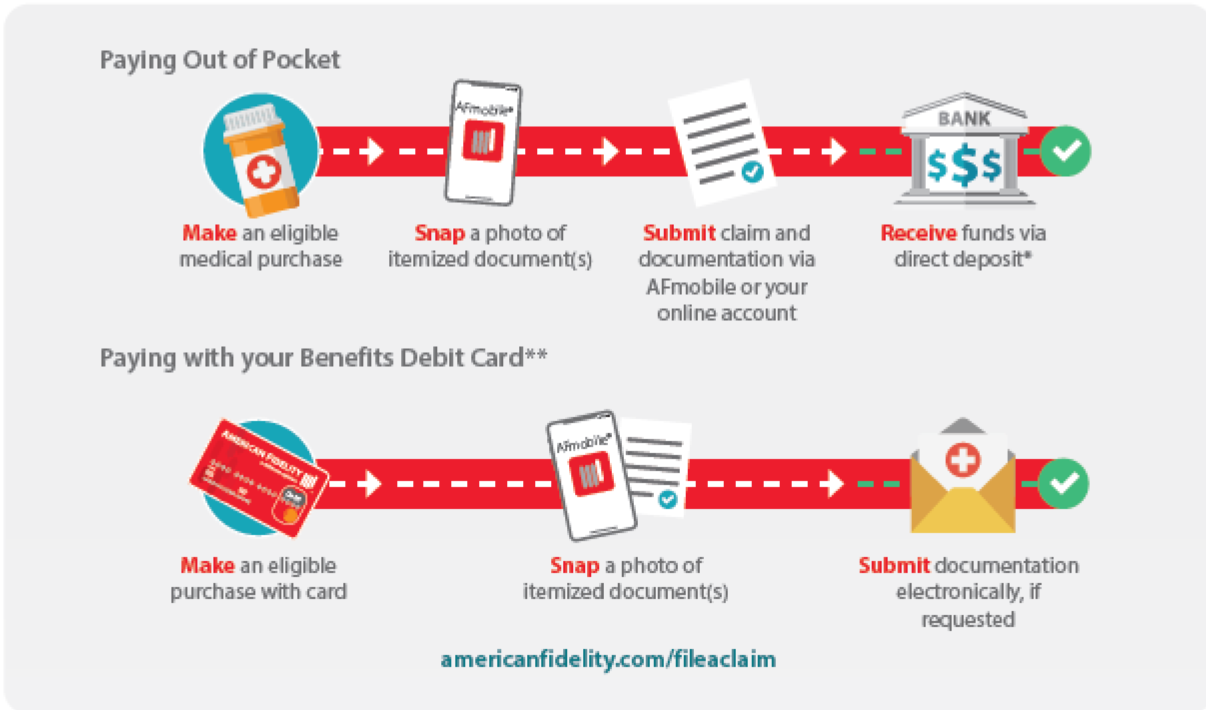
Flexible Spending Account (FSA) – American Fidelity

You have the option to participate in a Flexible Spending Account (FSA). An FSA allows you to select a pre-tax amount from your paycheck and use the money for eligible medical expenses throughout that year. For a list of eligible expenses, see Publications 502 and 503 at www.IRS.gov. or visit americanfidelity.com/eligible-expenses

Common Questions	Flexible Spending Accounts
In which medical plan must I enroll in to participate?	Plan A
Who owns the account?	Shelby City Schools
Will your company contribute?	$225 single $350 family
How much can I contribute?	$3.050
When are funds available?	At the beginning of the plan year
What can funds be used for?	IRS Eligible Expenses
How do I pay for expenses?	Use the associated debit card to pay for services or pay for expenses out of pocket and then submit the claim to American Fidelity to receive reimbursement via direct deposit
When do claims have to be filed?	Within 90 days of the end of the plan year

Flexible Spending Account (FSA) – American Fidelity

How It Works



*Funds deposit within 3-5 business days after claim approval.
** If your employer has elected to provide a Benefits Debit Card, you may use this card to pay for eligible medical expenses or pay out of pocket and file a claim for reimbursement.

Documentation Requirements

To verify HCFSA transactions, the Internal Revenue Code (IRC) requires documentation to prove expense eligibility. When filing your reimbursement claim, your documentation must include:

1. Provider Name
2. Recipient Name
3. Date of Service
4. Description of Service
5. Charges

These are not American Fidelity rules, these are IRC rules. As your plan provider, we are required to follow IRC rules.

Card Deactivated?

Your Benefits Debit Card could be deactivated if you fail to submit itemized documentation in a timely manner. Reactivate your card by:

- Submitting the required documentation
- Paying the transaction back for any ineligible expenses

Submit documentation at americanfidelity.com/submit-fsa

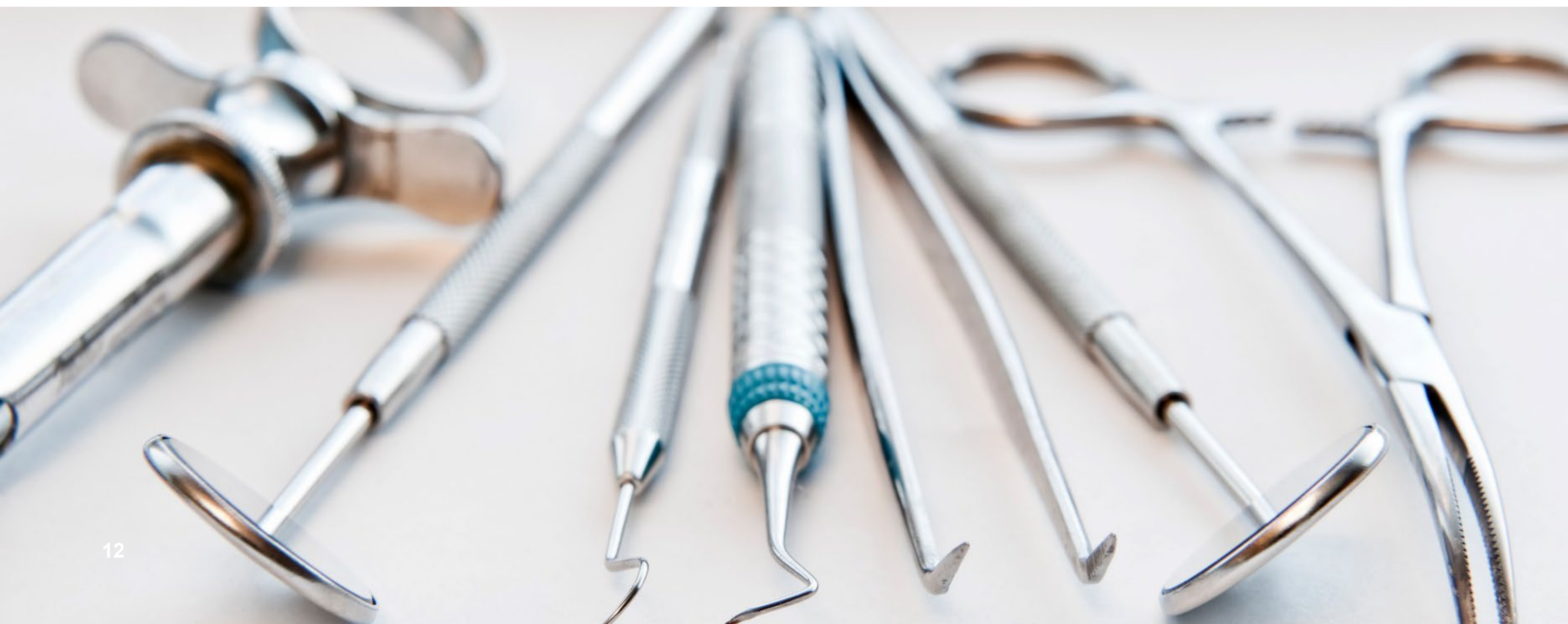
Spend Smart & Save on Eligible Medical Expenses

Copays/Co-Insurance	Prescription contacts	Chiropractic care	Deductibles
Physical exams	Asthma treatments	Eye exams/eyeglasses	Over-the-counter medicine
Prenatal care	Laser eye surgery	Physical therapy	Menstrual products

Discover more ways to spend at americanfidelity.com/eligible-expenses

Dental Plan Luminare Health

	Dental
Summary	**In-Network**
Annual Deductible (Individual/Family)	$25 / $50
Annual Benefit Maximum per Member (Excluding orthodontia, diagnostic and preventive care)	$2,000
Diagnostic & Preventive Care (Exams, cleanings, sealants, x-rays, space maintainers, fluoride, sealant)	100%
Basic Restorative Care (Fillings, extractions, root canals and pulp therapy, treatment of gum and mouth tissue disease, oral surgery, crown and denture repair, periodontics)	80%
Major Restorative Care (Inlays, onlays, fixed/ removable bridges, full or partial dentures)	60%
Orthodontia	60% $2,000 Lifetime Max



Find a Provider Luminare Health

If you are looking for a specific provider, you can create a myLuminare Health account. You can go to myLuminareHealth.com and click on create account under plan participant. You will need your ID card for the activation screen. After you provide your consent and enter your contact information you will be able to create your account. From there you will be able to search the directory for your provider.

luminare health
Experience. Solutions. Results.

log in
Username
Password
submit
Forgot your password?
Forgot your username?
Download our app today!

register
plan participant
Find a doctor, check claim status, manage your health and more.
create account
client/employer
Manage employee coverage and eligibility, view claims and view reports.
create account

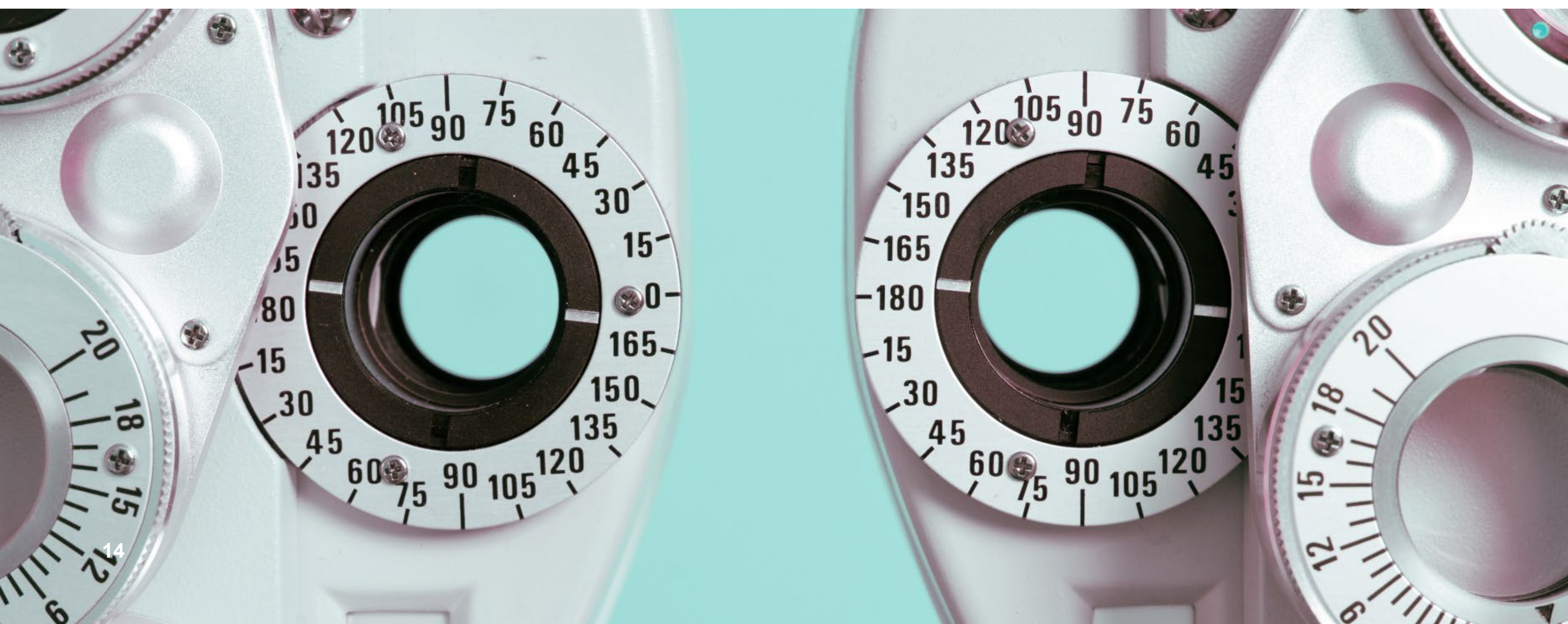
Activation
Let's get started!
To keep this simple, all of the fields below are required.
Your Member ID or SSN
012345678
Your Last Name
Sample
Your ZIP/Postal Code
12345
Your Date of Birth
01/01/1970
NEXT
SAMPLE

Personalization
Create your profile.
User Name
Password
At least 8 characters
Re-enter Password
Confirm password
Let's keep this secure — answer these 3 security questions.

Luminare Health
myLuminareHealth.com
800-832-3332

Vision Plan Vision Service Plan - VSP

Summary – In-Network	Plan A	Plan B	Plan C
Annual Exam	$10 Copay Every 12 months	$10 Copay Every 12 months	$10 Copay Every 12 months
Lenses • Single Vision, Bifocal, Trifocal, Lenticular • Standard Progressive • Premium Progressive • Custom Progressive	Every 24 Months $0 Copay $50 Copay $80-$90 Copay $120-$160 Copay	Every 12 Months $0 Copay $50 Copay $80-$90 Copay $120-$160 Copay	Every 12 Months $0 Copay $50 Copay $80-$90 Copay $120-$160 Copay
Frames • $130 Frame Allowance • 20% savings on the amount over your allowance	Every 24 Months $25 Copay	Every 24 Months $25 Copay	Every 12 Months $25 Copay
Contact Lenses* • $130 Allowance, copay does not apply	Every 24 Months Up to $60	Every 12 Months Up to $60	Every 12 Months Up to $60



Find a Provider Vision Service Plan

If you are looking for a provider for vision, please visit www.vsp.com and click on Find a Doctor. From there you can search by location, office or doctor. If you search by your zip code it will show you all providers in your area.

LOCATION OFFICE DOCTOR

1 ADVANCED SEARCH +

Zip OR Street Address (optional) City State

What is VSP Premier Edge™?

Your eyes will love the experience at a Premier Edge location. Available to all VSP members at no extra cost, your benefits go further when you visit a Premier Edge location – including private practice doctors and retail locations nationwide. You'll get exclusive rebates, advanced exam technology, a worry-free eyewear guarantee, and more!

Ready to schedule your appointment? Type in your ZIP code and look for the orange indicator!

Select Location (optional): ☐ **All Premier Edge Locations**

Select Location Type (check all that apply): ☐ **Premier Edge Private Practice** ☐ **Premier Edge Retail Chain Location**

Search

Vision Service Plan
1-800-877-7195
www.vsp.com

Life Insurance – One America

Basic Life Insurance

Life insurance can help provide for your loved ones if something where to happen to you. It provides full-time employees working 10 or more hours a week **with $40,000 in group life and accidental death and dismemberment (AD&D) insurance**.

Your company pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Your benefits end when your employment ends. Contact the treasurer office if you would like to update your beneficiary information.

Employee Assistance Program (EAP) – Carelon Behavioral Health

Employees and their families often face challenging daily demands, including issues at work, with family, finances and more, which is why your company provides an Employee Assistance Program (EAP). You receive 5 free face to face visits per year. These services that are available to you and your dependents, provide confidential support, resources, and information to get through
life's challenges.

Confidential Counseling

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service is staffed by experienced clinicians who are available by phone 24 hours a day, seven days a week. A consultant is available to listen to your concerns and refer you to a local provider for in-person counseling or to resources in your community for a variety of personal concerns, including:

- Depression;
- Stress and anxiety;
- Marital and family conflicts;
- Job pressure; and
- Grief and loss.

Legal and Financial Resources

Talk to a financial or legal expert for consultations and discounts on services provided for:

- Divorce
- Debt obligations;
- Real estate concern
- Budgeting

Other Services

Obtain professional resources and referral services related to child and eldercare, education, growing families, consumer resources, home maintenance and repair and daily living resources. You can find online resources to help improve your health, manage life events

Carelon Behavioral Health
877-233-0976
www.achievesolutions.net/jhp
Mention your school name when they ask who you are with.

Contact List

Benefit	Administrator	Website / Email	Phone
Medical	Medical Mutual of Ohio	www.medmutual.com	1-800-332-0741
Dental	Luminare Health	www.myLuminareHealth.com	800-832-3332
Vision	Vision Service Plan (VSP)	www.vsp.com	1-800-877-7195
Life	One America	www.oneamerica.com	800-553-3522
EAP	JHP – Carelon Behavioral Health	www.achievesolutions.net/jhp	877-233-0976
Risk Strategies Contact Info	Jaclyn Arbogast Account Executive	jarbogast@risk-strategies.com	419-436-7631

Terms to Know

Beneficiary: The person who receives the insurance proceeds at the death of the insured.

Coinsurance: A percentage of the medical costs you share with your health insurer after you have reached your plan deductible.

Consumer Driven Health Plan (CDHP): Another name for a High Deductible Health Plan (HDHP), which is a health insurance plan that is typically characterized by slightly higher out-of- pocket expenses and lower premiums. These plans are frequently paired with a Health Savings Account (HSA) to pay for eligible expenses, tax-free.

Copay: The flat fee you pay out of pocket each time you visit a provider.

Deductible: The amount you pay during the year for medical services, before your insurance starts to pay.

Disability: A physical or mental condition that makes an insured person incapable of performing one or more duties of his or her occupation.

Formulary: A list of generic and brand name prescribed medications covered by your health plan that treat the same conditions but cost less.

Health Savings Account (HSA): Available to you if you are enrolled in an HDHP. A Health Savings Account (HSA) is a bank account you own that can be used to pay for qualifying medical expenses, including those that apply to your annual deductible. You can even save the money for a future health need and into retirement. It's your choice. Any money deposited into your HSA is yours to keep, there is no "use it or lose it" rule, and you take your HSA with you even if you leave your company or change health insurance plans. You do not pay federal taxes on your HSA for any money you or your company deposits into your HSA, money you spend from your HSA on qualified expenses, or any interest earned on the HSA.

High Deductible Health Plan (HDHP): Another name for a Consumer Driven Health Plan (CDHP), which is a health insurance plan that is typically characterized by slightly higher out-of-pocket expenses and lower premiums.These plans are frequently paired with a Health Savings Account (HSA) to pay for eligible expenses, tax-free.

Network: A group of doctors, hospitals, and other health care providers that accept payments from your health insurance company. This group has also agreed to provide your care at special negotiated discounted rates, so staying within the network may save you money.

Out-Of-Pocket Maximum: The annual limit you must pay out-of-pocket for everything during your plan year, except your monthly premium, which does not count toward the out-of-pocket maximum.

Premium: The amount you pay every month for health insurance, usually taken out of your paycheck through payroll deductions.

Taxable Benefits: Employer-provided non-cash compensation that is subject to income tax.

COBRA RIGHTS

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Company 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 when you would Rev. August 2023 otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For 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 coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Care Flexible Spending Account (FSA) can also continue on an after-tax basis through the remainder of the plan year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries. If you make contributions to the Health Care FSA for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the plan year.
You may be offered to continue your coverage under the Health Care FSA if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the plan year; (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Care FSA during any annual enrollment for any plan year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate or proof of other insurance may be required as proof of a qualifying event. This general notice does not fully describe COBRA or the plan. More complete information is available from the Plan Administrator and in the summary plan document.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:
- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

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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.

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

COBRA RIGHTS (continued)

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:
• The month after your employment ends; or
• The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you

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

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

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

GINA protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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 this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number above.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your Plan Administrator.

For additional information about NMHPA provisions and how self-funded non-Federal governmental plans may opt- out of the NMHPA requirements, visit www.cms.gov/CCIIO/Programs-and-Initiatives/Other-InsuranceProtections/nmhpa_factsheet.html.

HIPAA SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, including: if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. 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) provided that you meet participation requirements. You must request enrollment, however, within 30 days or any longer period that applies under the plan, after you 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 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 or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator mentioned above.

If you have declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. You must, however, request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. You must, however, request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the Plan Administrator indicated in this notice.

MEDICARE PART D NOTICE (NOTICE OF CREDITABLE COVERAGE)

About Your Prescription Drug Coverage and Medicare
This notice has information about your current prescription drug coverage 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. Two important things to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- We have determined the prescription drug coverage offered by your provider is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the Plan Administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare-eligible individuals when you become eligible for Medicare Part D.
Visit www.cms.hhs.gov/CreditableCoverage which outlines the prescription drug plan provisions/options Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the Plan Administrator before making any decisions.
Note: In general, different guidelines exist for retirees regarding cancellation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the Plan Administrator for details.

MEDICARE PART D NOTICE (NOTICE OF CREDITABLE COVERAGE) (continued)

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know if you drop or lose your current 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 19 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 Plan Administrator for details. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period 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 or 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 800-MEDICARE (800-633-4227) (TTY: 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 800-772-1213 (TTY: 800- 325-0778).

Remember to 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).

Jaclyn Arbogast | 419-436-7631 | jarbogast@risk-strategies.com
risk-strategies.com