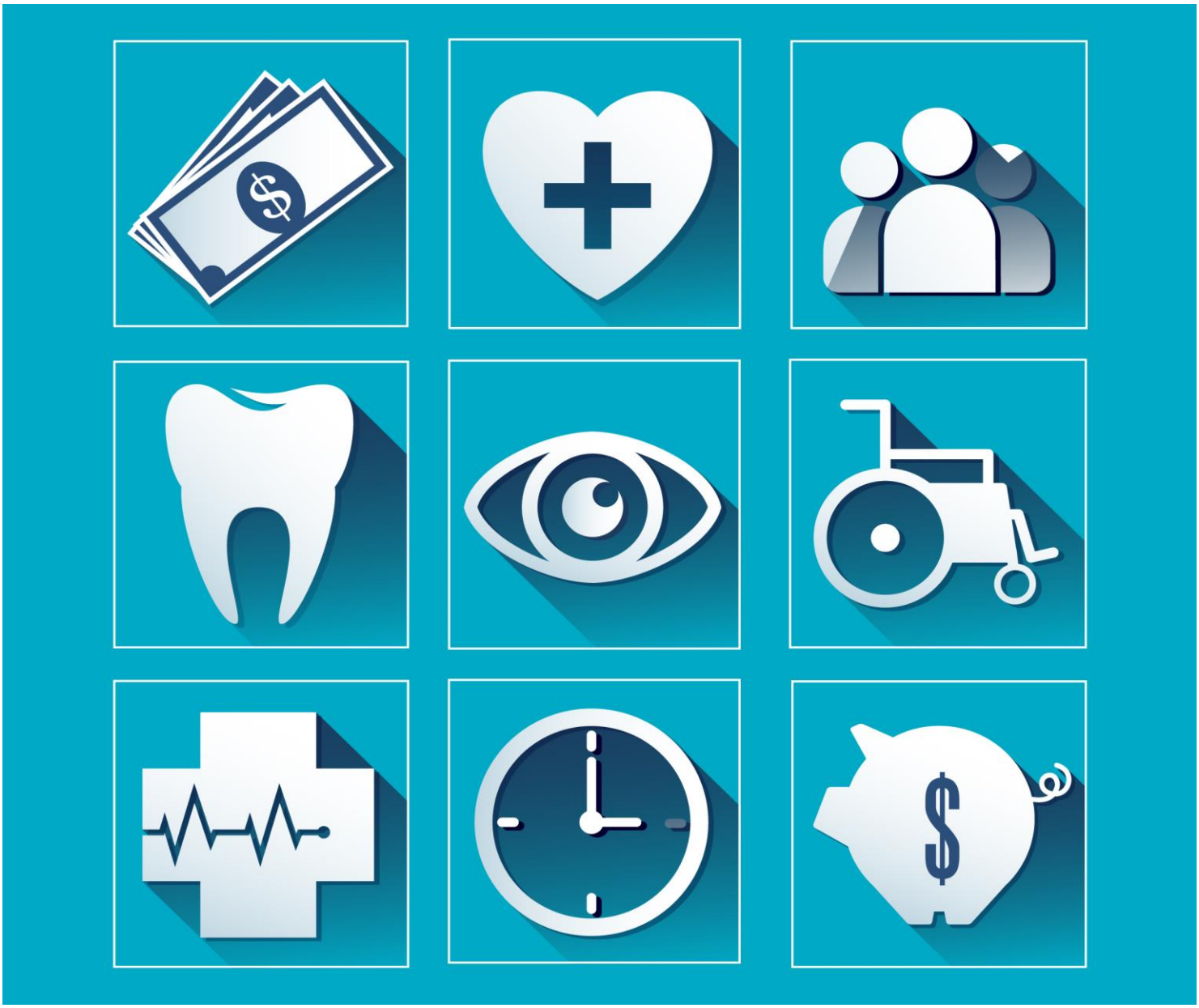
Diversified Services

Employee Benefits Enrollment Guide

Plan Year 2018 **Contract Employees**



Welcome to Open Enrollment for your Insurance Benefits for Plan year 2018/19

d. Diversified Services, Inc. offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This presentation is designed to provide you with an overview of the insurance coverages at d. Diversified Services, Inc. It is presented only as a general understanding of your insurance plans and should not be construed as a legal interpretation of the insurance policies that you will be covered under. Please refer to the specific insurance contracts for details on plan provisions, conditions, and exclusions.

Benefits for **2018/19:**

- ✓ Medical Insurance – McLaren POS – Two Plans
- ✓ Life Insurance – Guardian
- ✓ Voluntary Dental Insurance – Guardian – Two Plans
- ✓ Voluntary Vision Insurance – Guardian
- ✓ Voluntary Life Insurance -- Guardian

Who is Eligible?

If you are a full-time contract employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. Dependent spouses who do not have access to medical coverage at the workplace are eligible for medical coverage. Children are eligible for medical coverage through the end of the year they turn age 26.

How to Enroll

- **Medical Insurance:**

Employees currently enrolled don't have to do anything – you will remain enrolled. Employees wishing to switch to the optional medical plan should see Beth Piotrowski for enrollment information. If you are not enrolled in the medical plan, but wish to enroll, or if you wish to waive medical coverage, see Beth Piotrowski for the appropriate paperwork. Please complete all forms accurately and legibly. **Submit all forms to Beth Piotrowski by March 21, 2018**.

- **Life Insurance:**

All Full-time contract employees are automatically enrolled in the basic Life Insurance. If anybody requires a life insurance beneficiary change see Beth Piotrowski for the necessary paperwork.

- **Voluntary Dental & Voluntary Vision Insurance:**

Two dental plans and a vision plan are available on a voluntary basis. Anybody currently enrolled will continue to be enrolled. If you're not enrolled, wish to change your selection, or wish to enroll for the first time, please review the Guardian enrollment information and complete and submit the enrollment form to Beth Piotrowski by March 21st. New enrollee dental coverage will be effective May 1, 2018.

- **Voluntary Life Insurance:**

If you're already enrolled you don't have to do anything. If you wish to enroll please review the Guardian enrollment materials and submit your application to Beth Piotrowski. Please complete all forms accurately and legibly. Also, be sure to complete the Life Insurance "Beneficiary Form". Anyone enrolling after the initial offer will be required to answer medical questions.

When to Enroll

The open enrollment period is now through April 30, 2018.

- **If you wish to enroll in, or make any changes to, any of the d. Diversified Services, Inc. insurance coverages you need to submit the proper forms to Beth Piotrowski by March 21, 2018**

Making Benefit Election Changes

Unless you have a qualified change in status / Life Event, you can only make changes during the "Open Enrollment" period. **Additionally, any changes in your status need to be reported within 30-days of a change in status/Life Event.** Qualified changes in status include the following:

- Marriage
- Divorce
- Legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of spouse, child or other qualified dependent,
- Change in residence
- Commencement or termination of adoption proceedings
- Change in employment status
- Change in coverage under another employer-sponsored plan.

See Beth Piotrowski for the necessary change forms.

All forms need to be submitted to March 21, 2018.

Medical Insurance – Two Options*:

	Medical Insurance Options:	
Services	**Option 1: Base Plan Effective 4-1-18**	**Option 2: Buy-Up Plan Effective 4-1-18**
Insurance Carrier	McLaren	McLaren
Doctor Network	McLaren POS	McLaren POS
Deductible (Individual/Family)	$3,000/$6,000	$1,500/$3,000
Co-Insurance (You Pay) **-In Network** **-Out of Network**	0% After Deductible	0% After Deductible
Out-of-Pocket Max (Individual/Family) **Use of both In-Network & Out-Network services may increase Out-Of-Pocket Maximum charges**	$3,000+ // $6,000+	$1,500+ // /$3,000+
Physician Visit (You Pay)	$40	$40
Routine Wellness Exams	Covered at 100%	Covered at 100%
Emergency Room Copay (You Pay)	$250	$250
Urgent Care Copay (You Pay)	$50	$50
Prescription Drugs (You Pay) **Generic** **Formulary Brand** **Brand if Generic is available** **Non-Formulary Brand****	 $20 $50 $50+Difference $80	 $20 $50 $50+Difference $80
To Find A Network Doctor	Go to www.mclarenhealthplan.org	Go to www.mclarenhealthplan.org
Employee Cost: **Single** **2-Person** **Family**	**Weekly** $48.15 $112.29 $128.12	**Weekly** $51.40 $118.66 $137.21

***Dependent spouses who have access to medical insurance at his/her workplace are not eligible for d. Diversified Services medical benefits:**
****Prior Authorization or Step Therapy is required:**

Group Life and AD&D Insurance:
Carrier: Guardian
Eligibility: All Full-Time W-2 Contract Employees
Benefit: $10,000 Flat Benefit Per Employee

- d. Diversified Services pays the full cost of this benefit
- Scheduled Benefits for Dismemberment
- Benefits double if death is the result of an accident.

Voluntary Vision Insurance: (Employee pays the full cost of this coverage)
(Vision coverage available only when combined with Dental. Cost for vision is included in dental rates)

Carrier: Guardian/VSP
Network: VSP Network (Signature Plan)
Network Search: www.Guardiananytime.com

Co-Pays:	**In-Network Benefits:**
Exam:	$20 – One every 12 months
Materials – Lenses:	$20 – One every 12 Months
Materials – Frames:	$120 Allowance – One every 24 months
Contact Lens:	$120 Allowance – every 12 months

- Additional Discounts available on other services.
- Out-Network Benefits covered at Scheduled Amounts

Voluntary Life Insurance: (Employee pays the full cost of this coverage)
Carrier: Guardian (See Guardian enrollment information for rates)
Eligibility: All Full-Time W-2 Contract Employees
Benefit: Employee -- $10,000 increments to a Max of $500,000
Spouse – Up to 50% of employee coverage – Max of $250,000
Child – Up to 10% of employee coverage – Max $10,000

Voluntary Dental Plans: (Employee pays the full cost of this coverage)

(Dental available only when combined with Vision. Cost for dental includes vision costs)

	Dental Insurance Options:	
Services	**Option 1: Base Plan**	**Option 2: Enhanced Plan**
Insurance Carrier	Guardian DHMO	Guardian PPO
Doctor Network	First Commonwealth www.Guardiananytime.com	DentalGuard Preferred
Office Visit	$5	$0
In-Network Deductibles **Out-Network Deductibles**	NA NA	NA $25/$75
In-Network Co-Insurance: Preventive Basic Major	 Fee Schedule Fee Schedule Fee Schedule	 100% 90% 60%
Out-Network Co-Insurance: Preventive Basic Major	 Fee Schedule Fee Schedule Fee Schedule	 100% 80% 50%
Annual Maximum	Unlimited	$1,000 per person
Employee Cost: Single Emp+Spouse Emp+Child(ren) Family	**Weekly** $5.32 $11.07 $12.63 $15.99	**Weekly** $11.55 $23.60 $27.39 $37.38

Be a Wise Health Care Consumer

Participating Doctors and Surgeons may not necessarily use Participating Laboratories and Anesthesiologists. You should inquire BEFORE an event whenever possible. For example: if you are scheduled for surgery, ask if the surgeon and anesthesiologist participate with your specific plan type. Tell your providers to use a participating lab or anesthesiologist if they do not normally work with one.

If you would like to know if a specific service such as a surgery or a test your doctor has ordered is covered, ask your Doctor or provider for the diagnosis and procedure codes for the service to be performed. Customer Service Representatives can tell you how this will be covered under your plan if you provide this information in addition to your contract number and group number. You may also need to provide the name and location (city) of the provider. Ask if there are any limitations and what percentage will be paid under your plan.

Always show your ID card at time of service. Participating physicians will submit claims for you. If the provider will not bill for you, obtain an itemized receipt from the doctor and submit a claim form to your carrier. Always make copies of anything you send to your carrier. This way you have a copy for your files, and you can easily make another copy if you need to resubmit the claim.

Whenever a claim is submitted, the carrier sends you an "Explanation of Benefits" (EOB) form. This form shows whether charges are covered, why charges were not covered, and what amounts are applied to the deductible or co-insurance. Sometimes a Non-Participating Provider will require you to pay all or a portion of the bill at time of service. You should compare your payments to the provider with the information on the "Explanation of Benefits" form to make sure you do not pay for any charges you are not required to pay.

When you speak to someone in Customer Service, write down their first and last name and the date you spoke with them. Take notes on their replies to your questions. You may need to refer back to that person, or the information they gave you at a later date.

Glossary - Insurance Terms Defined

1. **Annual Cost** - The maximum amount you pay each year for approved benefits.
2. **Annual Maximum** - The maximum amount your plan will pay each year for approved benefits.
3. **Benefits** - The amount your insurance company will pay for a service.
4. **Carrier** -The company offering your insurance (Not The Reaume Company).
5. **Claim** - A bill submitted to your insurance company for payment
6. **Co-pay** - A fixed amount you must pay, for your portion of a covered service (e.g... $5, $10, etc..).
7. **Co-insurance** - A percentage amount you must pay for a covered service (e.g... 20%, 50%, etc...) until you reach your annual out-of-pocket maximum.
8. **Coordination of Benefits** - Your insurance company will combine your coverage with the coverage you have from another insurance company (e.g... your spouse's insurance) for approved benefits.
9. **Coverage** - The services and benefit level your insurance company will pay.
10. **Deductible** - The amount you pay first each year before your insurance company will pay for approved benefits.
11. **Effective Date** - The date your insurance becomes effective.
12. **EOB** - Explanation of Benefits, a statement from your insurance company explaining how your claim was processed, what they paid and what you owe.
13. **In-Network Services** - Services provided by a "participating" in-network doctor, hospital or lab.
14. **Mail Order Drugs** - A plan where you can receive prescription drugs through the mail at a discount.
15. **Maintenance Drugs** - Prescription drugs that need to be taken over a long period of time on a regular basis (e.g... blood pressure pills, insulin, etc...).
16. **Network** - A group of providers that have agreed to accept the payment offered by the insurance company.
17. **Out-of-Network Services** - Services provided by a "non-participating" doctor, hospital, or lab with generally reduced benefits.
18. **Out-of-Pocket Costs** - The amount you have to pay each year for approved benefits.
19. **Participating Provider** - A doctor, hospital or lab who has agreed to participate to accept an insurance company's payment schedule. When you use these providers, because they charge less, you will also end up paying less!
20. **POS** – “Point Of Service” Participants designate a In-Network “Primary Care Provider”, but like a PPO, patients may go outside the provider network for health care services – charges are likely to be higher than using In-Network providers.
21. **Provider** - A doctor, hospital or laboratory facility.
22. **Reimbursement** - The amount you will get paid back, after you have submitted a claim, for a bill you paid up front.
23. **Service** - The procedure performed at the doctor's office, lab or hospital.

Insurance Carriers & Advisors -- Contacts

Medical

McLaren Health Plan — **www.mclarenhealthplan.org**
G-3245 Beecher Road, Flint, MI 48532
Customer Service: 888-327-0671
McLaren Group # 102026

Insured HRA

Morgan White Administrators — **www.claims@morganwhite.com**
Customer Service: 888-888-2519

Dental, Life, & Vision Insurance

Guardian — **www.Guardiananytime.com**
Participant Contact Center: 800-627-4200
Guardian Group # G-466378

Agents/Advisors

Contacts:
Robert Reaume, REBC, RHU, CLU, CPFA (Agent)
Timothy J. Hite, RHU (Agent)
Eileen Dooley (Agent)

Address:
ARMADA Risk Partners
31000 Lahser Road - Suite 9
Beverly Hills, MI 48025
Email: Thite@armadarisk.us
Website: www.ArmadaRisk.us
Phone: 248-265-5443

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Guide, please contact Human Resources.

Important Employee Notices:

Newborns' and Mothers' Health Protection Act Model Language
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).

Notice of Opportunity to Enroll
in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the d. Diversified Services benefit offerings. Individuals may request enrollment for such children for 30 days from the date of notice. For more information contact McLaren Health Plan at 888-327-0671.

Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under the d. Diversified Services benefits plan through McLaren Health Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact McLaren Health Plan at 888-327-0671.

Patient Protection Model Disclosure

McLaren Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact McLaren Health Plan at 888-327-0671.

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

Genetic Information Non-Discrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("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.

Michelle's Law Notice
When a dependent child loses student status for purposes of d. Diversified Services group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the d. Diversified Services group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the d. Diversified Services group health plan, whichever is earlier.
In order to be eligible to continue coverage as a dependent during such leave of absence:

Women's Health and Cancer Rights Act 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? Call your plan administrator at McLaren Health Plan at 888-327-0671 for more information.

HIPAA Special Enrollment Notice
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 after the marriage, birth, adoption, or placement for adoption.
Special enrollment rights also may exist in the following circumstances:
- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within [insert "60 days" or any longer period that applies under the plan] after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.
To request special enrollment or obtain more information, contact Human Resources Department at 248-633-0033.
- The d. Diversified Services group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

To obtain additional information, please contact: Beth Piotrowski in the HR Department.

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 August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid FLORIDA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447 Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268
ALASKA – Medicaid GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507
ARKANSAS – Medicaid INDIANA – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447) Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711 Website:

http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900 Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid WASHINGTON – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059 Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493 Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669 Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002
VERMONT– Medicaid WYOMING – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427 Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
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

COBRA Continuation Coverage Rights

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.
If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent

child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Human Resources -- Beth Piotrowski
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1-248-633-0033