Randolph Health

2018 Employee Benefit Guide

Provided by: Marsh & McLennan Agency, LLC

Randolph Health

DEAR RANDOLPH HEALTH TEAM MEMBERS,

A core value of our organization is "Patient First." We believe it's important to take care of ourselves and our loved ones. As we work together to provide quality care and foster health and wellness in our communities, our commitment also includes the health and wellness of our own team. Randolph Health is committed to offering comprehensive benefit options that enable you and your family to have access to quality, affordable health care and many other critical benefits such as life insurance, dental care, vision coverage, disability coverage and matching contributions to your 403(b) retirement plan. With these goals in mind, I am excited to share with you our comprehensive employee options for this year!

Randolph Health will be holding open enrollment from November 7th to November 17th. Each year during open enrollment, you have the opportunity to re-evaluate your benefit needs and change your coverage elections. Remember, once you make your elections, you will not be able to change them during the year unless you experience a qualifying event. All changes made during open enrollment will be effective January 1, 2018. The information in this booklet is designed to provide you with the information needed to make the appropriate decision in electing your 2018 benefits.

As you know, due to a variety of factors, healthcare costs continue to rise. By bringing awareness to plan participants and providing programs that control chronic conditions, behaviors are starting to change. We are seeing positive results in our medical program utilization. In an effort to reduce our own health costs, we continue to focus on our wellness programs. Family Care and Corporate Wellness offers an on-site Wellness Nurse Coach to help you and any of your family members enrolled in the medical plan, who are living with chronic illnesses such as diabetes, asthma or hypertension. Our Wellness Coach provides health coaching, education, and other resources. She will also ensure that you are accessing services appropriately and timely so that you have the opportunity for the best possible outcome.

Additionally, the rising healthcare costs have made it necessary for us to adjust our medical plan premium contributions. For years, Randolph has held employee premium contributions for medical coverage steady. One of the benefits of our management services agreement with Cone Health, and their agreement with Carolinas Healthcare System, is the ability to benchmark ourselves in several areas against the other 46 hospitals in the system. Our employee premium contributions have consistently been the lowest of all 46 hospitals. Beginning this year, employee premiums will be increasing but will still be very competitive in the market. We hope that you understand the need to make this change.

In addition, we are committed to maintaining the value of our benefit program and making it easy for you to use. We are pleased to share that we have greatly simplified our medical plan this year moving from 5 tiers to just 2. You will also see vendor changes in other benefits that will greatly increase the network of providers available to you.

As a reminder, routine preventive services are covered at 100%. A preventive health visit can help identify any current or potential health issue(s) before they develop into something more serious. We encourage you to work with your physician to identify care options that may help maintain or improve your health. Again this year, a co-pay is not required when visiting either a Randolph Health physician or a physician who is participating in our high value network, Piedmont Integrated Health.

Thank you for your commitment to our health system. We ask that you continue to be engaged in your health and be aware of your available options as a healthcare consumer.

Sincerely,

Steve Eblin
Chief Executive Officer

CONTENTS

WELCOME TO YOUR 2018 BENEFITS!

Our 2018 Employee Benefit Guide will provide you with an overview of the comprehensive and rewarding benefits package offered by Randolph Health. We value your service as an employee and our competitive benefits are one way that we thank you for all that you bring to Randolph Health. We are proud to offer you a benefits program designed to protect the health and financial security of you and your family.

Get Help Making Your Benefit Elections

For the 2018 plan year open enrollment period, we will have enrollment counselors on site to meet with all of our employees individually. It is mandatory to schedule an appointment with a counselor to review your options and elect your benefits for the upcoming plan year. You can also contact the Human Resources Department or your EB Service Team for any further questions you may have

- **Employee Benefits Service Team**
  - **ebservices@senndunn.com**
  - **855-313-1075**

- Human Resources Department
  - Benefits Team
  - 336-629-8893

WHAT'S NEW FOR 2018

Randolph Health carefully evaluates our employee benefit offerings each year to ensure we are providing our employees a competitive program. We are pleased to announce the following changes for 2018:

- New medical administrator – UMR
- New two-tiered medical plan design
- New dental carrier – Lincoln Financial
- New vision carrier – Superior Vision
- New FSA Administrator – PlanSource

ELIGIBILITY

Benefits Eligibility

The following prefixes let you know which benefit you are eligible to choose after 30 days of work with Randolph Health:

- **(FT)** Full- Time employees working at least 36 hours or more per pay week.
- **(FT WEO)** Full-Time Weekend Option employees working at least 2 shifts each weekend.
- **(PT FLEX)** Part-Time Flex employees working between 20 and 36 hours per pay week, but agree to have his/her scheduled hours increased or decreased based on department need.
- **(PT FIXED)** Part-Time Fixed employees working less than 20 hours per pay week; works in same job for the same number of hours each pay period.
- **(PRN)** PRN Employees who agree to be available to work "as needed."

If you see your prefix next to a benefit choice, you are eligible for that benefit.

Dependents

Others in your family may be eligible for coverage under your benefit plans. Your eligible dependents include:

- Spouse as defined by federal law.
- Children under the age of 26, or who are disabled and incapable of self-support due to mental or physical disability.
    - Can be natural born child, stepchild, adopted child, child for whom you have been appointed legal guardianship by a court of law or a child for whom the Plan has received a Qualified Medical Child Support Order.
    - Children who are aging out of the medical plan will be removed from the insurance at the end of the month in which they turn age 26.

You must provide date of birth and Social Security number along with proper verification of dependent eligibility when requested by Randolph Health. Claims will be pending until verification of dependent eligibility is submitted.

ENROLLMENT

Open Enrollment

Randolph Health will be conducing annual open enrollment education sessions for all employees. You are required to meet with an enrollment counselor in order to enroll in, and/or maintain your benefits. No benefits will roll over this year. The enrollment counselors will help to educate you on the available benefit options, as well as assist with any questions that you may have concerning the benefits offered through Randolph Health. They will also complete your 2018 benefit election(s) online, via PlanSource.

The open enrollment period runs from November 7th through November 17th. The benefits you elect during open enrollment will be effective from January 1, 2018 – December 31, 2018. You will be able to schedule your appointment with a counselor the week of October 30th. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

Access to Benefits Online

Instructions for enrollment through the PlanSource portal:

1. **Login – Enrollment URL:** https://benefits.plansource.com
   Username: Your username is the following: the first initial of your first name, up to the first six characters of your last name, and the last four of your SSN. For example, if your name is Jane Anderson and the last four of your SSN is 1234, your username would be janders1234.
   Password: Your birthdate in YYYYMMDD format. For example, if your birthdate is August 14, 1962, your password would be 19620814. At initial login, you will be prompted to change your password.
2. **Launch Enrollment**
   Click on "**Make a Change to My Benefits**" to begin. If you are a new hire – this link will say "**New Hire – Enroll**" and during annual enrollment "**Enroll-Annual**".
3. **Enroll**
   Follow each step of the enrollment process from top to bottom. In making your elections, choose the plan option of choice or select the "Decline" option and then select "Continue" after each election has been made until you reach the confirm page.
4. **Confirm Enrollment Selections**
   Once you complete all coverage elections, you will land on the Confirmation Statement. Click the "Confirm Enrollment" button at the bottom of the page to complete your enrollment process.

How to Make Changes?

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include, for example: 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 or change in coverage under another employer-sponsored plan.

MEDICAL & PHARMACY COVERAGE

Several changes have been implemented to our medical and prescription drug benefits for the upcoming plan year. Our plan provides a high value network in two tiers. There are no out of network benefits available. The following chart shows the benefits of our medical plan for 2018.

Medical Plan

FT, FT WEO, PT FLEX

Network	Tier 1 Randolph Health & Piedmont Integrated Health	Tier 2 In-Network
Deductible		
Individual	$1,500	$2,000
Family	$3,000	$4,000
Out of Pocket Max		
Individual	$4,000	$5,000
Family	$8,000	$10,000
Preventive Care	No Charge	No Charge
Primary Care	$0 Copay	$25 Copay
Specialist	$0 Copay	$50 Copay
MD Live Video Visits	$0 Copay	No Coverage
Rehabilitation Services	$30 Copay	30% Coinsurance
Imaging	$150 Copay	$300 Copay, then 30% Coinsurance
Hospitalization		
Inpatient Facility	$500 Copay	$1,000 Copay, 30% after deductible
Outpatient Facility	$200 Copay	$400 Copay, 30% after deductible
Urgent Care	$25 Copay	$55 Copay, then 30% Coinsurance
Emergency Room	$250 Copay	$400 Copay, then 30% Coinsurance

Tips for Keeping Costs Down:

- Choose Randolph Health or Piedmont Integrated Health as your provider
- Take advantage of preventive care services
- Request generic prescriptions
- Use Urgent Care providers instead of the Emergency Room

Prescription Drug Coverage

FT, FT WEO, PT FLEX

The pharmacy benefits manager for the 2018 plan year will be OptumRx. The portion of the drug cost that you are responsible to pay is listed in the table below.

Tier 1 : Generic List	$ 10 Copay
Tier 2 : Preferred Generic	$20 + 20% coinsurance
Tier 3 : Preferred Brand	$35 + 20% coinsurance
Tier 4: Non-preferred Brand	$175 + 20% coinsurance

Please note that if you insist on a brand name medication when there is a generic available, and the doctor's prescription allows for a generic to be dispensed, a penalty will be added to your applicable copayment. This penalty is the difference in price between the brand name medication and its available generic.

The following medications are currently included on the Step Therapy Program:

- Oral and non-Insulin injectable Diabetes
- Cholesterol
- Anti-Hypertensive

Our pharmacy plan will require participants on maintenance medications to use OptumRx mail order system for a 90-day supply. The Pharmacy program is intended to promote better utilization management and employee convenience. As a local community hospital, we desire to support other local providers. You now have the **option** of filling maintenance medication scripts with a **select group** of local pharmacies. The local pharmacies included at this time are:

- Prevo Drug - Asheboro
- Carolina Pharmacy – Asheboro & Seagrove locations
- Ramseur Pharmacy – Ramseur
- Carter's Family Pharmacy – Asheboro

The OptumRx formulary will be slightly different from your previous carrier. It is important to review the new formulary to determine which drugs may be excluded and what tier they now fall under with OptumRx.

If you have additional questions about your pharmacy benefits and prescriptions you are taking today, please reach out to RxBenefits at 1-800-334-8134 or www.optumrx.com.

WELLNESS PROGRAM

As healthcare costs continue to rise, Randolph Health offers you the opportunity to join our Wellness Program and reduce the cost of your healthcare coverage. We have employees who have quit smoking, lost weight, and gained control of their health conditions. These results are occurring because of dedicated employees working closely with our Health Coaches and Case Management department. The goal of our program is to encourage you and your family to make healthier lifestyle choices.

Well Within Reach! Requirements:

WELLNESS

The employee (and/or covered spouse) must have an annual wellness physical performed by your physician prior to the end of the employee's birth month. The blood work from the annual physical should be faxed to the Wellness Manager at (336) 328-3593. Please find the form on RHINO under "Wellness".

The employee (and/or covered spouse) must complete the yearly Health and Wellness Survey prior to the end of the employee's birth month. The questionnaire can be found on your personal portal at www.managewell.com.

HEALTH COACHING

Based on the results of your Health and Wellness Survey and your annual physical, if you and/or your covered spouse are identified for health coaching, you will need to participate at the designated level.

TOBACCO (IF APPLICABLE)

Covered members identified as being a tobacco user will need to attend the Quit Smart counseling program that is available on and/or offsite free of charge. Or the employee and/or spouse must be tobacco free for at least 90 days and willing to sign a witnessed statement of confirmation.

Fitness Center Membership

A lifestyle of healthy living must include a regiment of consistent exercise!

In an effort to promote a culture of wellness and health improvement, we are pleased to offer reduced rate gym memberships at **Randolph Health Fitness Center - 600-A W. Salisbury Street, Asheboro**.

Our 7000 square foot, hospital-owned fitness center boasts machine and free weights, aerobic equipment, specialized equipment, a variety of group classes, and highly trained and certified personnel to guide you. Our goal is to assist you in achieving a lifestyle of comprehensive wellness.

DENTAL

FT, FT WEO, PT FLEX

Randolph Health will offer dental coverage administered by Lincoln Financial Group. You have two dental plans to choose from. Our plan allows you and your dependents to visit the dentist of your choice within network. Amount paid for dental services is made on the basis of usual and customary (UCR) fees. See an overview of the coverage below and view full details in your dental summary of benefits.

Find a Dentist

Visit www.lfg.com for a list of dentists near you

Services	Low	High
Deductible Applies to basic and major services	$75 Individual / $225 Family	$50 Individual / $150 Family
Benefit Maximum	$1,000	$1,500
Preventive Services Exams, cleanings, x-rays	20%	0%
Basic Services Fillings, simple extractions	20%	20%
Major Services Oral surgery, root canal, crowns	50%	50%
Orthodontia	Not Covered	50%, $1,500 lifetime maximum

VISION

FT, FT WEO, PT FLEX

Randolph Health offers the opportunity to enroll in a vision insurance plan through Superior Vision. Our vision plan covers eye exams and helps offset the cost of corrective eyewear. An overview of the plan is provided below; please see your summary of benefits for complete details.

Find an Eye Doctor

Visit www.SuperiorVision.com for a list of participating vision providers

Services	Benefit	Frequency
Vision Exam	$20 Copay	Once every 12 months
Lenses (single, bifocal, trifocal, lenticular)	$20 Copay	Once every 12 months
Frames	$125 allowance after copay	Once every 24 months
Contact Lenses (instead of lenses and frames)	$125 allowance after copay	Once every 12 months

EMPLOYEE CONTRIBUTIONS IN 2018

Below you will find your cost to enroll in the medical, dental or vision coverage depending on the tier in which you chose to enroll. These premiums will be deducted on a pre-tax basis from your paycheck.

Medical Coverage

Employee Biweekly Premium				
	FT – Wellness	**FT – Non-Wellness**	**PT – Wellness**	**PT – Non-Wellness**
Employee Only	$39.23	$62.31	$58.85	$81.92
Employee + Spouse	$124.62	$147.69	$186.92	$210.00
Employee + Children	$85.38	$108.46	$128.08	$151.15
Employee + Family	$170.77	$193.85	$256.15	$279.23

Dental Coverage

Employee Biweekly Premium			
	Employee Only	**Employee + 1**	**Employee & Family**
Low Plan	$10.32	$17.97	$31.53
High Plan	$12.63	$24.02	$42.58

Vision Coverage

Employee Biweekly Premium		
Employee Only	**Employee + 1**	**Employee & Family**
$2.93	$4.24	$7.61

Key Terms

- A **premium** is the amount you pay out of your paycheck for insurance coverage
- A **deductible** is the amount you pay before the plan contributes to the cost for services
- A **copay** is a fixed amount you pay for medical services or prescription drugs
- **Coinsurance** is the percent of charges you pay after you reach the deductible until you reach the plan's out-of-pocket maximum
- The **out-of-pocket maximum** is the most you will pay during the plan year for health care expenses, including your deductible, copays, and coinsurance

FLEXIBLE SPENDING ACCOUNTS

FT, FT WEO, PT FLEX

Randolph Health provides you the opportunity to pay for out-of-pocket medical, dental, vision, and dependent care expenses with pre-tax dollars through a Flexible Spending Account (FSA).

Contributions to your FSA are deducted from your paycheck before any taxes are taken out. You should contribute the amount of money you expect to spend on eligible expenses for the year. Any leftover money will not be refunded, per IRS regulations. Any funds from the 2017 plan year will need to be spent prior to the end of the grace period which is March 15, 2018.

Health Care FSA

The maximum you can contribute to a health care FSA for 2018 is $2,650. The full amount you elect is available at the beginning of the plan year.

Examples of qualified expenses include:

- Prescriptions
- Doctor visit co-pays
- Contact lenses
- Dental care
- Flu shots

Health Care Tax Savings Example	
Prescription drugs	$225
Doctor co-pays	$80
Orthodontia (braces)	$1,500
Suggested Plan Year Election	**$1,805**
Taxes (30%)	x 0.30
Estimated Annual Savings	**$541.50**

Dependent Care FSA

The maximum you can contribute to the dependent care FSA is $5,000 if you are a single employee or married filing jointly, or $2,500 if you are married and filing separately. Funds are available only after they are deducted from your paycheck.

Examples of qualified expenses include:

- Child care
- Before or after school program
- Elder care

Dependent Care Tax Savings Example	
Day care for child	$3,500
Summer child care	$1,500
Suggested Plan Year Election	**$5,000**
Taxes (30%)	x 0.30
Estimated Annual Savings	**$1,500**

Full List of Qualified Expenses

The IRS maintains a complete list of qualified medical and dental expenses eligible for FSA reimbursement. See the list at: https://www.irs.gov/publications/p502/index.html

*Tax savings examples are for illustrative purposes only and are not intended to reflect actual costs of care. 30% tax rate is used for illustration only and may be different than your rate.

DISABILITY INCOME BENEFITS

FT, FT WEO

Randolph Health is committed to providing a comprehensive benefits program. As part of your benefits package, long term disability income benefits are provided to you at no cost and employees may purchase short term disability insurance, as well. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits. Should you become unable to work due to a non-work related illness or injury, disability coverage acts as income replacement to protect you and your family from serious financial hardship.

Long-Term Disability Coverage

Administered by Lincoln Financial Group, long-term disability coverage pays 50% of your salary up to $5,000 per month, after a waiting period of 180 days. Randolph Health provides full time employees with this coverage, and pays the full cost of the plan.

Long-Term Disability	
Benefits Begin	After 180 day elimination period
Maximum Benefits Payable / Duration	Social Security Normal Retirement Age
Percentage of Income Replaced	50%
Maximum Benefit	$5,000 per month

Short-Term Disability Coverage

Administered by Lincoln Financial Group, short-term disability coverage pays 60% of your salary for up to 22 weeks, after a waiting period of 30 days.

Short-Term Disability	
Benefits Begin	31st consecutive day of disability
Benefits Payable / Duration	22 weeks
Percentage of Income Replaced	60%
Maximum Benefit	$800 per week

Short-Term Disability Rate Calculation Example:

_____ X $.01592 = _____

Weekly Earnings (Max earnings is $1,333)

Cost per pay period

When you enroll in Short Term Disability in the enrollment portal, your rate will be automatically calculated for you. The short term disability plan is a "post-tax" benefit.

LIFE INSURANCE

Basic Life and AD&D Insurance

FT, FT WEO

Randolph Health provides full-time employees with Basic Life and Accidental Death & Dismemberment (AD&D) Insurance at no cost. Employees are automatically covered at 1.5 times their annual base salary, up to $250,000. Randolph Health also provides life insurance for your spouse in the amount of $5,000 and child(ren) age 6 months—19 years in the amount of $5,000. You must provide your dependent's date of birth and SSN in order to obtain this dependent coverage. You may update your beneficiary within the enrollment portal.

Voluntary Life and AD&D Insurance

FT, FT WEO, PT FLEX

You are also eligible to elect Voluntary Life and AD&D Insurance for yourself and your dependents. You pay the full cost for this plan; premiums will be deducted from your paycheck.

This plan allows employees to elect $10,000 increments of coverage up to 5 times their annual salary, to a maximum of $300,000. During open enrollment employees can elect up to 2 increment increase without evidence of insurability. As a new hire, employees are able to obtain $200,000 on a guaranteed acceptance basis. Any amount over the guarantee issue will be subject to evidence of insurability. Employees who enroll in the supplemental plan can also elect coverage for their dependents in the following amounts:

Spousal Coverage

- $5,000 increments up to 50% of coverage elected for the employee

Child Coverage

- Dependent child coverage is available on a guaranteed issue basis in the amount of $10,000
- Children 14 days to 6 months are eligible for a benefit of $250

Key Terms

- The **guaranteed issue** amount is the minimum amount a policy will pay on an insured person's claim regardless of health status
- **Evidence of insurability** is an application process detailing your health condition that is required for certain types of insurance coverage
- An insurance plan that is **portable** gives the insured person the right to retain their coverage when switching employers
- A **wellness incentive** may be paid to the insured person for completing a preventive health care screening; this benefit is intended to help offset the cost of coverage

403(b) RETIREMENT SAVINGS PLAN

FT, FT WEO, PT FLEX

Saving for your future is important. Randolph Health offers you an easy way to save for retirement by supplying you with a Retirement Savings Plan through Branch Banking & Trust (BB&T). You are eligible to contribute money up to $18,500 per year on a before tax basis and an additional $6,000 if you are over the age of 50. Randolph Health makes matching contributions on the first 4% of your contributions to the retirement plan based on your years of service (see the chart below). Note: Matching contributions begin the first quarter following one year of service. While all employees are eligible to contribute to their retirement account regardless of status, only those employees who are considered Full-Time, Full-Time Weekend Option, and Part-Time Flex will receive the employer match once eligible.

Length of Service	Matching Contribution up to 4%
1-2 years	$0.25
3-4 years	$0.40
5-9 years	$0.50
10-14 years	$0.60
15-19 years	$0.70
20-24 years	$0.80
25+ years	$1.00

Vesting
You are 100% vested in your 403(b) contributions, as well as any matching employer contributions to the plan.

Employer Discretionary Contributions
To be eligible for the yearly contribution, you must have been working with us for one year, have worked 1,000 hours during the year, and be working on December 31st.

Who to Contact for More Information
You may contact BB&T directly at: 800-228-8076. You may also access your account information via the Internet by logging on to: www.bbt.com/planlink

Note: You will need your Social Security Number (SSN) and Personal Identification Number (PIN) to access your personal account information. If you have forgotten your PIN number simply follow the guidelines under Forgotten your Personal Identification Number (PIN) on the web.

OPTIONAL VOLUNTARY BENEFITS

FT, FT WEO, PT FLEX

Group Accident Insurance

Group Voluntary Accident Insurance, offered by Voya, can help cover the unexpected costs related to accident expenses. Employees, employee spouse, and employee dependent children are eligible for this coverage. This policy pays a specific benefit amount for:

- Initial care such as ambulance, emergency room, or initial doctor visit
- Follow-up care such as outpatient doctor's treatments and medical devices
- Injuries, including burns, dislocations, and fractures
- Catastrophic accidents
- Accidental death

Additional features include:

- Benefits paid for accidents that occur on and off the job
- Premiums are paid through payroll deductions
- The coverage is individually owned, so you may be able to take it with you if you leave your employer
- Annual Wellness Visit reimbursement up to $50 for employee and spouses, and $25 for children

Critical Illness Insurance

Employees are eligible for Group Critical Illness Insurance, offered by Voya. This benefit pays a lump sum benefit when you are diagnosed with a critical illness. You can use the benefits however you please, such as for medical bills, a wheelchair, your mortgage or other bills.

You choose the level of coverage with benefit amounts of $10,000 or $20,000. Up to $20,000 is guarantee issue during this open enrollment. Your spouse and children, if you elect family coverage, are covered at 50% of your benefit amount. During open enrollment, you may purchase coverage for you, your spouse, and your children with no medical examination or health questions asked.

Covered Diagnoses include:

- Heart Attack
- Stroke
- Organ Transplant
- By-Pass Surgery
- End Stage Renal Failure
- Coma
- Permanent Paralysis

Annual Wellness Visit reimbursement up to: $100 per year for the employee and spouse and $50 for children.

ADDITIONAL BENEFITS

FT, FT WEO, PT FLEX, PT FIXED, PRN

Employee Assistance Program (EAP)
Randolph Health offers an EAP through LifeCycles and Recovery and Lincoln Financial. When you find yourself with personal challenges, EAP has the resources to help sort things out. Help is available for you or any member of your immediate family living in your household. All employees and their eligible dependents are allowed 3 free professional, private therapy sessions per calendar year with a hospital designated provider through LifeCycles and Recovery, and up to 4 face to face visits and unlimited phone counseling through Compsych with Lincoln Financial.

Payroll Deductions
Payroll deductions can be arranged for the Cafeteria and Commons, Pharmacy and Gift Shop purchases, as well as other special purchases such as jewelry, uniform, and book sales.

Workers' Compensation
Randolph Health carries Workers' Compensation insurance for all employees. This coverage protects you in the event you suffer a work-related injury or illness.

Leave of Absence
Now and then you may need to spend time away from work for different reasons…personal, military, or educational.

Family & Medical Leave
Once you have completed 12 months of service and have worked 1,250 hours during the last 12 month period, you may be eligible for up to 12 weeks of job-protected leave under the Family and Medical Leave Act. Leave is available for the birth of a child, to care for a newborn, placement of adopted or foster child, and care for an immediate family member with a serious health issue or your own serious health issue.

Tuition Reimbursement
Randolph Health supplies many opportunities to help you meet your professional educational needs.

Birthday Recognition
During your birthday month, you will get a card as well as a coupon for a free birthday meal good in our Commons or Cafeteria.

Discounts
Discount tickets, memberships, and special offers available at many times throughout the year to:

-Area amusement parks
-Biltmore Estates
-NC Zoo Annual Membership discounts
-Uniform sale
-Summit Credit Union
-Art, jewelry, book sale
-Costco

CONTACT INFORMATION

Benefit	Provider	Phone	Website
Medical	UMR	800-826-9781	www.umr.com
Pharmacy	OptumRx/ RxBenefits	800-334-8134	www.optumrx.com
Dental	Lincoln Financial	800-423-2765	www.lfg.com
Vision	Superior	800-507-3800	www.superiorvision.com
Flexible Spending Account	PlanSource	888-266-1732	www.mywealthcareonline.com/PlanSource[mywealthcareonline.com]
Basic Life and AD&D Supplemental Life and AD&D Short-Term Disability Long-Term Disability	Lincoln Financial	800-423-2765	www.lfg.com
Employee Assistance Program	LifeCycles Recovery & Lincoln Financial	LifeCycles Recovery 336-318-4115	Compsych through Lincoln Financial 888-628-4824 www.GuidanceResources.com
403(b) Retirement Savings	Branch Banking & Trust (BB&T)	800-228-8076	www.bbt.com/planlink
Accident & Critical Illness	Voya	800-955-7736	www.claimscenter.voya.com
Employee Benefits Center	Marsh & McLennan Agency	855-313-1075	ebservices@senndunn.com

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 the 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 your Guide, contact Human Resources.

REQUIRED NOTICES

Your employer offers group health plans to some employees and as such is required to distribute certain notices annually to meet compliance guidelines.

Randolph Health will herein be referred to as “Employer”

Tier 1:$1500/$3000 Tier 2:$2000/$4000 will herein be referred to as “Deductible”

Tier 2: 30% will herein be referred to as “Coinsurance”

Randolph Health Medical Plan will herein be referred to as “Medical Plan(s)”

Randolph Health will herein be referred to as “Plan Administrator”

2018 will herein be referred to as “Plan Year”

You can contact your Plan Administrator at 336-629-8893 or 336-629-8898.

New rules published on May 17, 2016, under the Americans with Disabilities Act (ADA) require employers that offer wellness programs that collect employee health information to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. You are receiving this notice as your Employer offers a wellness program. Please contact your Plan Administrator with any questions.

Well Within Reach! will herein be referred to as “Wellness Program”
Medical Premium Discount will herein be referred to as “Wellness Incentive”

NOTICE REGARDING WELLNESS PROGRAM

Your Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a Wellness Incentive for completing your annual physical, health coaching, and being a non tobacco user]. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the Wellness Incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your Plan Administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as Health Coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your Employer may use aggregate information it collects to design a program based on identified health risks in the workplace, your Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) your physician, and health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your Plan Administrator.

Women's Health and Cancer Rights Act Enrollment Notice

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the Deductible and the Coinsurance applies.

If you would like more information on WHCRA benefits, call your Plan Administrator.

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 for more information.

Newborns' and Mothers Health Protection Act Enrollment Notice

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice from Your Employer About Your Prescription Drug Coverage and Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your Employer has determined that the prescription drug coverage offered by the Medical Plan(s) is/are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered

Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Employer coverage will be affected. *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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

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

You should also know that if you drop or lose your current coverage with your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact your Plan Administrator for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

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.
3. 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).

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.

Once it is determined that 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, 2014. Contact your State for more information on eligibility –

Medicaid and CHIP Contact Information			
Alabama (Medicaid)	Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Alaska (Medicaid)	Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
Arizona (CHIP)	Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Colorado (Medicaid)	Website: http://www.colorado.gov/ Phone (In state): 1-800-866-3513 Phone (Out of state): 1-800-221-3943
Florida (Medicaid)	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Georgia (Medicaid)	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
Idaho (Medicaid)	Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Phone: 1-800-926-2588	Indiana (Medicaid)	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
Iowa (Medicaid)	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Kansas (Medicaid)	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
Kentucky (Medicaid)	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Louisiana (Medicaid)	Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447
Maine (Medicaid)	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Massachusetts (Medicaid and CHIP)	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120

Minnesota (Medicaid)	Website: http://www.dhs.state.mn.us/ - Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Missouri (Medicaid)	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
Montana (Medicaid)	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084	Nebraska (Medicaid)	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
Nevada (Medicaid)	Website: http://dwss.nv.gov/ Phone: 1-800-992-0900	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: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
North Carolina (Medicaid)	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	North Dakota (Medicaid)	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
Oklahoma (Medicaid and CHIP)	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Oregon (Medicaid)	Website: http://www.oregonhealthykids.gov or http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
Pennsylvania (Medicaid)	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Rhode Island (Medicaid)	Website: www.ohhs.ri.gov Phone: 401-462-5300
South Carolina (Medicaid)	Website: http://www.scdhhs.gov Phone: 1-888-549-0820	South Dakota (Medicaid)	Website: http://dss.sd.gov Phone: 1-888-828-0059
Texas (Medicaid)	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Utah (Medicaid and CHIP)	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
Vermont (Medicaid)	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Virginia (Medicaid and CHIP)	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
Washington (Medicaid)	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473	West Virginia (Medicaid)	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
Wisconsin (Medicaid)	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002	Wyoming (Medicaid)	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Health Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Important Information About Your 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 must pay for COBRA continuation coverage.

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

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
You become divorced or legally separated from your spouse.

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

Sometimes, Filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer for retirees, or

- 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.

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.

Please contact the Plan Administrator for additional information.

Your Medical Plan(s) 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.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by your employer to its employees, its employee's dependents and, as applicable, retired employees. This Notice describes how your employer, collectively we, us, or our may use and disclose Protected Health Information to carry out payment and health care operations and for other purposes that are permitted or required by law.
We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting your Plan Administrator.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to our employees, employee dependents and, as applicable, retired employees.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization **–** Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care **–** If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates **–** At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services **–** We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures **–** We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI **–** You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from your Plan Administrator. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI **–** You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI **–** You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications **–** You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice **–** You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact you Employer's Privacy Office by writing to your Employer.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

HIPAA Special Enrollment Model 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 and 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 you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your Plan Administrator.

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to your Plan Administrator.

Lifetime Limits Disclosure Notice

The lifetime limit on the dollar value of benefits under your Medical Plan(s) 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 you Plan Administrator.

Summary of Benefits and Coverage

Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Coverage Examples

This summary of benefits and coverage will include a new, standardized health plan comparison tool for consumers called "coverage examples," much like the Nutrition Facts label required for packaged foods. The coverage examples would illustrate how a health insurance policy or plan would cover care for common benefits scenarios. Using clear standards and guidelines provided by the Center for Consumer Information and Insurance Oversight (CCIIO), plans and issuers will simulate claims processing for each scenario so consumers can see an illustration of the coverage they get for their premium dollar under a plan. The examples will help consumers see how valuable the health plan will be at times when they may need the coverage.

Uniform Glossary of Terms

Under the Affordable Care Act, consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "co-payment". To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor will also post the glossary on the new health care reform website, www.HealthCare.gov.

You can access the forms discussed here at **http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf**

The package of materials posted also includes an example of a completed summary of benefits and coverage, uniform glossary, as well as specific technical information for simulating coverage examples for two benefit scenarios: having a baby and managing type 2 diabetes.

Section 1557 Employer Nondiscrimination and Accessibility Requirements Statement

Your Employer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your Employer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your Employer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact your Plan Administrator.

If you believe that your Employer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with your Plan Administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Plan Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Your Employer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak any language besides English, language assistance services, free of charge, are available to you. Contact your Plan Administrator for additional information.