JCF JEWISH COMMUNITY FEDERATION & ENDOWMENT FUND

2024

BENEFITS ENROLLMENT GUIDE

BENEFIT PROGRAM INFORMATION

BENEFITS OVERVIEW

Jewish Community Federation and Endowment Fund offers a comprehensive benefits package to promote health and wellness along with financial security for both you and your family. The complete benefit package is briefly summarized in this enrollment guide. Please be sure to review it carefully so that you are able to elect the coverage that is most appropriate for your personal situation. If there is any discrepancy between the insurance carrier's certificate of coverage and this guide, the insurance carrier's certificate of coverage is the prevailing document.

For information about...	Go to..
Your Benefits	Radhika Warrier, She/Her/Hers Senior Director Of People Ph: (513) 288-8748 radhikaw@sfjcf.org Virginia Tran, She/Her/Hers HR Generalist Ph: (415) 512-6421 virginiat@sfjcf.org
NFP Customer Service Support	Lynda Van Epps, Account Executive Ph: (510) 250-8410 lynda.vanepps@nfp.com Marie Montany, Account Manager Ph: (925) 444-9428 Marie.Montany@nfp.com
Medical Plan **Page 5**	Kaiser Permanente Member Services: (800) 464-4000 Group #603260 www.kp.org United Health Care Member Services HMO.: (800) 624-8822 Group #929738 www.myuhc.com To locate UHC providers use the appropriate URL: Harmony HMO https://www.whyuhc.com/svharmonynocal
Medical Plan **Page 5 HMO and 6 PPO**	United Health Care Member Services Select Plus/Choice Plus H.S.A.: (866) 314-0335 Group #929738 www.myuhc.com To locate UHC providers use the appropriate URL: Select Plus PPO https://www.whyuhc.com/selectpluswest Choice Plus PPO Outside California: Group #929738 https://welcometouhc.com/choiceplus
Dental Plan **Page 9**	MetLife Member Services: (800) 275-4638 Group #5996882 www.metlife.com
Vision Plan **Page 10**	VSP Member Services: (800) 877-7195 Group #12276936 www.vsp.com

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For information about...	Go to..
Health Savings Account **Page 8**	Navia Member Services: (866) 987-0031 hsa@naviabenefits.com https:app.naviabenefits.com/#/login
Flexible Spending Accounts **Page 11**	Navia Member Services: (800) 669-3539 customerservice@naviabenefits.com https:app.naviabenefits.com/#/login
Commuter Benefits **Page 11**	Go Navia Member Services (800) 669-3539 customerservice@naviabenefits.com https:app.naviabenefits.com/#/login
Life, LTD & VTL **Page 12 Life, LTD** **Page 13 VTL**	Mutual Of Omaha Group #G000CFJJ Member Claims Services – Life/AD&D & VTL: (888) 493-6902 Member Claims Services – LTD: (800) 775-1000 www.mutualofomaha.com
EAP **Page 14 - 16**	Mutual Of Omaha EAP Member Services: (800) 316-2796 mutualofomaha.com/eap
Travel Assistance **Page 17**	Mutual Of Omaha Travel Assistance Member Services: (800) 856-9947
Pet Insurance **Page 18**	PUMPKIN Member Services: (866)-ARF-MEOW or (866)-273-6369 https://www.pumpkin.care/teams ***CODE: JCFSF***
Working Advantage **Page 19**	Working Advantage Member Services: (800) 565-3712 https://www.WorkingAdvantage.com ***CODE: SFJCFPERKS***
Credit Union **Page 20-21**	Pacific Service Credit Union Member Services: (888) 858-6878 www.pacificservice.org

BENEFIT PROGRAM INFORMATION

ELIGIBILITY

Coverage begins for enrolled eligible employees Medical, Dental and Vision benefits begin 1st of the month following date of hire.

Life, AD&D & LTD benefits begin 1st of the month following 90 days.

To obtain benefits you must satisfy the following:

- You must be a full-time employee working 20 hours or more per week
- If eligible, you may enroll your spouse and dependent children on the offered benefit plans
- Dependent children are eligible if less than 26 years of age

ELIGIBLE DEPENDENTS

- Your Spouse, Domestic Partner, and/or Children are eligible dependents. Children until they turn 26 regardless of student, marital, or employment status. This includes natural children, stepchildren, adopted children (or those placed for adoption), children of your domestic partner and children for whom you are legal guardian.

OPEN ENROLLMENT

During open enrollment, you may enroll in or make changes to your benefit programs. Open enrollment is the only time that you may add or change benefits during the year unless you have a qualifying life event. Make sure that you understand the offerings and enroll yourself and your eligible dependents in the programs that you would like for the upcoming plan year.

All plans are from Jan. 1, 2024, through Dec. 31, 2024. The next open enrollment period will be held in November.

QUALIFYING CHANGES

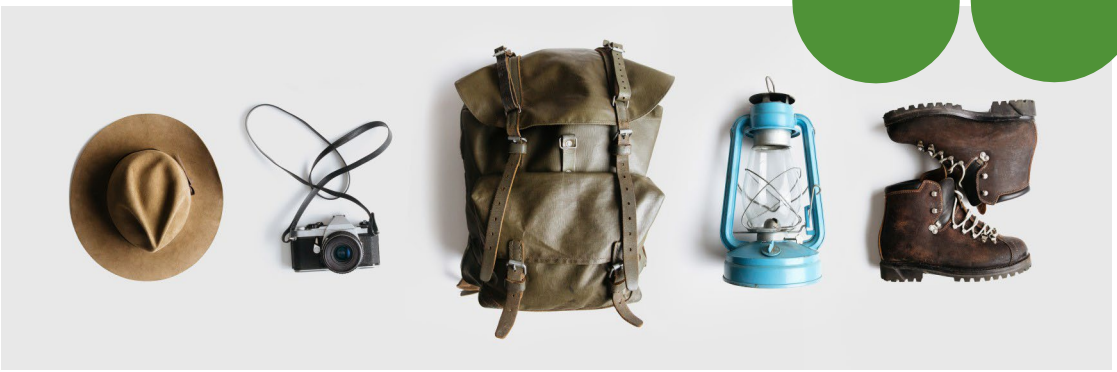
The following events allow you a **30-day** special enrollment period to complete and submit a change request to update your benefits outside of the open enrollment period:

- You get married, divorced or legally separated
- You add a child through birth, adoption or change in custody
- Your spouse or child dies
- Your spouse or child(ren) lose eligibility for coverage

The following events allow you a **60-day** special enrollment period to complete and submit a change request to update your benefits outside the open enrollment period:

- You, your spouse or child loses coverage under either a Medicaid plan under Title XIX or under a state child health plan (CHIP) under Title XXI of the Social Security Act due to a loss of eligibility for that program's coverage

- You, your spouse, or child becomes eligible for premium assistance with respect to the cost of coverage under our group health plan through either a Medicaid plan under Title XIX (such as Utah's Premium Partnership) or under a state child health plan (CHIP) under Title XXI of the Social Security Act (see enclosed disclosure)



NFP®

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

MEDICAL

	United HealthCare Signature Value HMO	Kaiser HMO $25	Kaiser HMO w/HSA
DEDUCTIBLE (calendar year)			
Individual	None	None	$2,500 Ind. / $3,200 Ind.+Family
Family	None	None	$5,000
OUT-OF-POCKET MAXIMUM (calendar year)			
Individual	$3,500	$1,500	$4,500
Family	$7,000	$3,000	$9,000
PROFESSIONAL SERVICES			
Office Visits	$30	$25	$30 (after ded.)
Preventive	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab	$25	$10	$10/encounter (after ded.)
Imaging (MRI, CT, PET)	$150	$50	$150/procedure (after ded.)
Chiropractic	$10 (30-visit max.)	$15 (20-visit max w/Acup)	Not Covered
FACILITY CHARGES			
In-Patient Hospital:	$750 per day up to 3 days	$500/admission	$250/admission (after ded.)
Outpatient Surgery:	$375	$100/procedure	$150/procedure (after ded.)
Urgent Care	$50	$25	$30 (after ded.)
Emergency Room:	$300 (waived if admitted)	$100 (waived if admitted)	$100 (after ded.) (waived if admitted)
PRESCRIPTION DRUGS[1]			
Retail Supply	31 Days	30 Days	30 Days
Generic	$10	$15	$10 (after ded.)
Brand	$35	$35	$30 (after ded.)
Non-Formulary	$70	$35	$30 (after ded.)
Specialty	$10/$35/$70	30% up to $250 max.	20% up to $250 max. (after ded)
Mail Order 90 Day Supply	2.5X Retail	2X Retail	2X Retail

MEDICAL

United HealthCare Comp Select H.S.A. PPO		
	In-Network	**Out-of-Network**
DEDUCTIBLE (calendar year)		
Individual	$3,200	$6,000
Family	$6,400	$12,000
OUT-OF-POCKET MAXIMUM (calendar year)		
Individual	$5,000	$10,000
Family	$10,000	$20,000
PROFESSIONAL SERVICES		
Office Visits	20%	50%
Preventive	No Charge	Not Covered
X-Ray & Lab	20%	50%
Imaging	20%	50%
Chiropractic	20%	50%
FACILITY CHARGES		
Inpatient Hospital	20%	50%
Outpatient Surgery	20%	50%
Emergency Room	20%	20%
PRESCRIPTION DRUGS		
Retail (31-Day Supply)	$10/$35/$70/Specialty $10/$150/$250	$10/$35/$70/Specialty $10/$150/$250
Mail Order (90 Day Supply)	2.5X Retail	Not Covered

MEDICAL

Plan	Employee (EE) Only	EE + Spouse	EE + Child(ren)	Family
Kaiser HMO 25	$0	$747.52	$747.52	$1,064.70
Kaiser HMO HSA	$0	$503.08	$503.08	$791.31
UHC HMO	$86.17	$1,085.50	$1,085.50	$1,649.40
UHC PPO HSA	$3.24	$818.44	$818.44	$1,241.80
MetLife Dental	$0.00	$63.16	$63.16	$149.34
VSP	$0.00	$6.46	1 Ch: $6.46 2Ch: $19.36	$19.36

HSA Employer Contribution:
JCF will contribute to each HSA account on a monthly basis as follows:
EE Only: Kaiser: $124.50 / UHC: $40.21
EE +1 Dep. or Family Kaiser or UHC: $45.00

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

HEALTH SAVINGS ACCOUNT

What is a Health Savings Account (HSA)?

A qualified high deductible health plan with a Health Savings Account is an alternative to traditional health insurance plans. The HSA is a savings product that offers a different way for consumers to pay for their health care costs. HSAs enable you to pay for current qualified expenses and save for future medical and retiree health expenses on a tax-free basis.

You must be covered by a Qualified High Deductible Health Plan (QHDHP) to be able to contribute to an HSA. You own and control the money in your HSA. As your account balances grow, you may also decide what types of investments to make with your HSA money.

You and/or your employer may contribute to your HSA, up to the legal maximum. **In 2024, the maximum annual contribution for single enrollee set by the IRS is $4,150, and the maximum family contribution is $8,300.** A catch-up contribution, up to an additional $1,000, is allowed for individuals who are 55 years or older. Please see the contribution chart below to determine the amount contributed to your HSA by your employer.

What you can do with your HSA

- Pay qualified health care expenses: Use the Navia H.S.A. online platform at www.naviabenefits.com to pay for qualified health care expenses. Depending on the HAS carrier, you may be able to use an online payment platform to pay for qualified health care expenses. You can use your debit card, request a check by phone or online, or transfer funds online.
- Save money for future medical expenses: You may not have significant health care expenses every year, but saving the maximum amount every year helps you build a sizeable savings for when you are faced with larger medical expenses
- Save for post-retirement expenses: Once you reach age 65, you can use your HSA funds to pay for anything you wish. Qualified medical expenses are still not taxed; any other expenses are subject to tax but not penalties

Your HSA is *your* money. Whatever you do not spend in a given year rolls over to the next. If you change jobs or retire, your HSA balance goes with you.

HSA/HDHP ANNUAL LIMITS

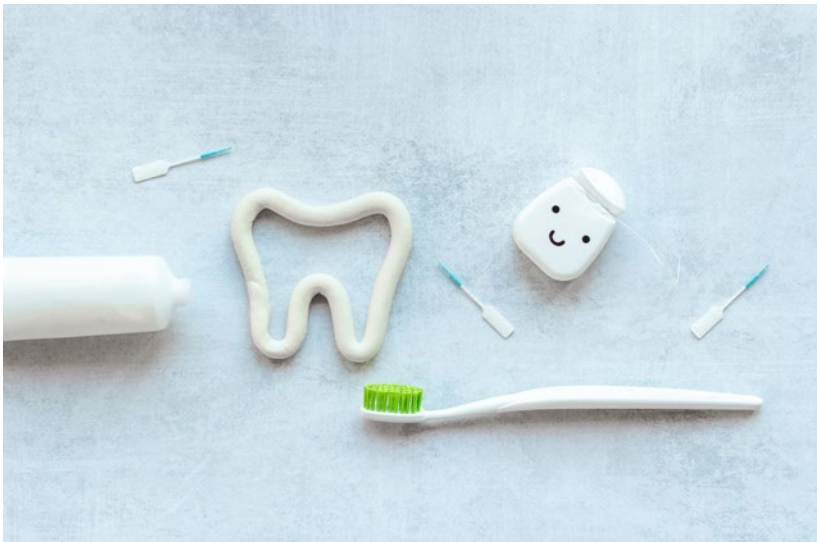
	Employee Only Coverage	Two-Party Coverage	Family Coverage
2024 Maximum Contribution to HSA	$4,150	$8,300	$8,300
Catch-up Contribution (age 55 & older)	$1,000	$1,000	$1,000

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

DENTAL

The dental PPO plan allows you to choose your provider. Using contracted providers will save you money because these dentists have reduced their regular fees. Non-contracted provider charges are covered at the 99th percentile of usual, customary & reasonable charges (UCR). Your portion of the cost depends upon the type of service performed and the amount charged by your dentist.

	MetLife Dental PPO	
	In-Network	**Out-of-Network**
Deductible (calendar year)	$50 individual / $100 2-party $150 Family (3+)	
Calendar Year Max.	$2,000 per person	
Preventive Services	100% (ded. waived)	100%
Basic Services	80%	80%
Major Services	50%	50%
Dental Cleanings	2 x per year	



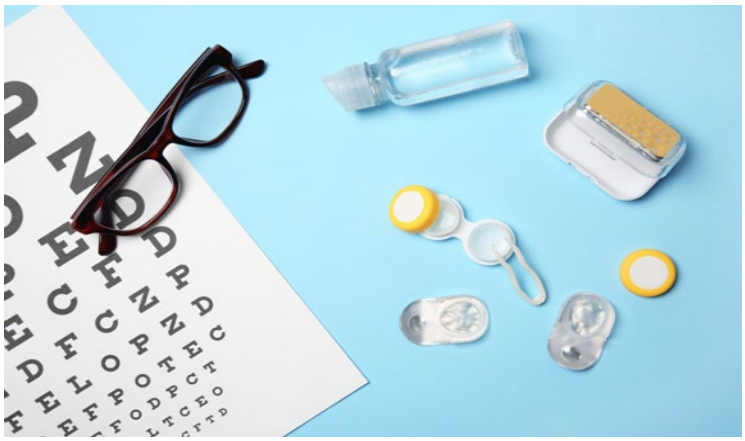
VISION

VSP Vision Benefits are based on service year, which is calculated based on the date you last received that service and/or bought frames or lenses.

You can purchase Contact Lenses in Lieu of Glasses.

	In-Network	Out-of-Network
Copay	$20	Up to $50 Reimbursement
Exam / Lenses **Frames**	Covered Every 12 Months Covered Every 24 Months	
Frame Allowance	$130	Up to $70 Reimbursement
Lenses: Single Vision	Covered in Full	Up to $50 Reimbursement
Lenses: Lined Bifocal	Covered in Full	Up to $75 Reimbursement
Lenses: Lined Trifocal	Covered in Full	Up to $210 Reimbursement
Elective Contacts	$130	Up to $105 Reimbursement
Medically Necessary Contacts	Covered in Full	Up to $210 Reimbursement

Even if you don’t wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health. With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor. Sunglasses or blue light filtering glasses may be just what you're looking for.



FLEXIBLE SPENDING ACCOUNT

You have the option to participate in an employee benefit that may increase your spendable income and lower your taxes. A Flexible Spending Account (FSA) allows you to pay for your portion of the group benefit premium, un-reimbursed health care expenses and dependent or childcare services with **pre-tax dollars**. With an FSA, contributions are deducted from your paycheck before state and federal taxes. By making these contributions with pre-tax dollars, you will reduce your taxable income **and take home a larger portion of your paycheck.**

Flexible Spending Account:

1. **Group Benefit Premiums:** An FSA allows your portion of group medical, dental, vision and most supplemental plan premiums to be deducted from your paycheck on a pre-tax basis.

2. **Flexible Spending Account (FSA)-Health Care Reimbursement (Including Dental and Vision):** Each year, you may set aside up to **$3,200 in** pre-tax dollars to pay for qualifying out-of-pocket medical, dental, vision, and some over the counter expenses.

3. **A Limited Purpose Flexible Spending plan, associated with HSA participation can only be used for dental and vision expenses.**

4. **Flexible Spending Account (FSA)-Dependent Care Reimbursement**: Each year, you may set aside up to **$5,000** pre-tax dollars (or $2,500 if you are married and filing individually) to pay for eligible dependent care expenses. This may include childcare, elder care or other eligible dependent care.
Funds are available for reimbursement only as they are deducted from your paycheck.

There are two types of Flexible Spending Accounts Available:

Flexible Spending Account–To be used without HSA Account Participation
Limited Purpose Flexible Spending Account–To be used with HSA Account Participation

Facts You Should Know:

- Participation is voluntary
- Participation in the plan simply allows you to pay for qualified expenses with pre-tax dollars

Flexible Spending Accounts are subject to the "use it or lose it" rule. Participants may forfeit any balance in the account(s) at the end of the plan year. Flexible Spending Accounts are subject to the "use it or lose it" rule, although you are allowed to **carry over up to $610** of unused funds into the next benefit plan year. Participants should carefully monitor their spending throughout the year to avoid any unused balance being forfeited.

- Over-the-counter medications and other items are eligible without a prescription

Go Navia Commuter Benefits:

www.navia.com

Transit Benefit:

The maximum amount you can set aside in 2024 on a tax-advantage basis for Transit and Parking services are:

Transit $315

Parking $315

EXAMPLE OF SAVINGS USING A FLEXIBLE SPENDING ACCOUNT

	Without Flexible Spending	With Flexible Spending
Gross Income	$40,000	$40,000
Pre-Tax Expenses for Health/Dependent Care	$0	$2,500
Taxable Income	$40,000	$37,500
Less Taxes	$10,279	$9,563
After-Tax Expenses for Health	$2,500	$0
Spendable Income	$27,221	$27,938
Your Savings With Flexible Spending		**$716**

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

LIFE & DISABILITY

Mutual of Omaha Life/AD&D	
Employee Life Benefit	2X Earnings up to $400,000
Employee AD&D	Matches Basic Life Benefit
Benefit Age Reduction	65% at age 65, 50% at age 70

AD&D: Accidental Death & Dismemberment

Mutual of Omaha Long Term Disability	
Elimination Period	90 days
Benefit Percentage	66.67%
Maximum Monthly Benefit	$15,000
Benefit Duration	Social Security Normal Retirement Age
Definition of Disability	2 years-own occupation
Mental Illness/Substance Abuse	24 months
Pre-Existing Condition Limitations*	3/12

Your employer pays the full cost for Mutual Of Omaha basic life, accidental death and dismemberment (AD&D) and long-term disability (LTD) benefits for all eligible employees.

EMPLOYEE COST
$0.00

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

VOLUNTARY LIFE

In addition to the basic life insurance provided by your employer, you have the option to buy Mutual Of Omaha supplemental life insurance. To purchase any of these plans talk to your HR director.

Employee:	
Benefit Amount	Up to $500,000, in $10,000 increments
Guarantee Issue Amount	5X salary up to $200,000
Benefit Age Reduction	65% at age 70, 50% at age 75
Late Entrants (other than at hire)	Subject to Evidence of Insurability (EOI)
Spouse:	
Benefit Amount	$25,000
Guarantee Issue Amount	100% of employee's benefit up to $25,000
Benefit Age Reduction	65% at age 70, 50% at age 75
Late Entrants	Subject to Evidence of Insurability (EOI)
Child(ren):	
Benefit Amount	$10,000

*Basic life benefits illustrated on previous page do not count toward the maximum benefit amounts for voluntary life.

Mutual of Omaha Voluntary Life Rates

Monthly Rates for Every $1,000 of Coverage

Employee	Spouse
0 - 24: 0.027	0 - 24: 0.059
25 - 29: 0.033	25 - 29: 0.066
30 - 34: 0.047	30 - 34: 0.078
35 - 39: 0.077	35 - 39: 0.106
40 - 44: 0.117	40 - 44: 0.149
45 - 49: 0.193	45 - 49: 0.233
50 -54: 0.308	50 -54: 0.369
55 - 59: 0.471	55 - 59: 0.573
60 - 64: 0.713	60 - 64: 1.00
65 - 69: 1.22	65 - 69: 1.76
70 +: 2.16	
Dependent: .035, no AD&D	
AD&D: 0.01	AD&D: None

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EMPLOYEE ASSISTANCE PROGRAM

Mutual Of Omaha EAP	
Eligibility	Services are offered to employees and spouses /dependent children.
Service Fees	Services provided by Mutual Of Omaha EAP are free, with no copayment or deductible required.
Services	**Individual counseling—3 Face to Face Sessions,** brief, solution-focused therapy model **Marital and relationship counseling—**relationship seminars and marital counseling **Family counseling—**supports parents' attempts to assist their children **Group counseling—**therapy and educational groups available **Financial counseling and referrals—**training in cash flow management skills. Referral to community resources, if necessary. **Elder Care support and referrals—**offers support in finding Elder Care for your parents and aging loved ones. Provides support in assessing your elder's overall situation, determining next steps to take, and identifying appropriate local services and resources. Offers support with the relationship issues that accompany this process. **Crisis intervention services—**assistance available 24 hours a day, seven days a week. **Educational seminars—**generally presented at worksite and designed to offer specific, helpful suggestions on a variety of topics, ranging from wellness to work-life issues.
EAP Referrals	Some types of problems will not respond to the short-term therapy offered by the EAP and are referred to community providers. The cost of referred services are not covered by the EAP.
Confidentiality	The EAP is a confidential service and no one will know that you used it. In addition to secure filing systems, disclosure of any information to third parties is performed only with your written consent in compliance with professional, federal and state confidentiality guidelines.

Your employer offers an Employee Assistance Program (EAP) through Mutual Of Omaha. This resource can be used to resolve distressing work or life related issues.

To schedule your appointment 24 hours a day, call 800-316-2796 or visit mutualofomaha.com/eap

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

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EMPLOYEE ASSISTANCE PROGRAM

Available Services When You Need Help the Most

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal

Continued on back.

*California Residents Knox-Keene Statue limits to no more than three face to face sessions in a six month period.

Mutual of Omaha

Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers for face-to-face counseling • National network of more than 30,000 licensed clinical providers for telehealth counseling • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources — legal libraries, tools and forms — available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals
Online Services	• An inclusive website with resources and links for additional assistance, including: ◦ Current events and resources ◦ Family and relationships ◦ Emotional well-being ◦ Financial wellness ◦ Substance abuse and addiction ◦ Legal assistance ◦ Physical well-being ◦ Work and career • Bilingual article library
Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

Insurance products and services are offered by Mutual Of Omaha Insurance company or one of its affiliates. Mutual Of Omaha Insurance Company is licensed nationwide. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Each underwriting company is solely responsible for its own contractual and financial obligations. Some exclusions or limitations may apply. Not all services available in New York.

Mutual Solutions

Worldwide Travel Assistance That Travels With You

Take comfort in knowing that Travel Assistance* travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

Enjoy Your Trip – We'll Be There If You Need Us – 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Pre-trip Assistance**

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements for foreign countries
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations

Emergency Travel Support Services

- Telephonic translation and interpreter services – 24/7 access to telephone translation services
- Locating legal services – referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- Baggage – assistance with lost, stolen or delayed baggage while traveling on a common carrier
- Emergency payment and cash – assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- Emergency messages – assistance with recording and retrieving messages between you, your family and/or business associates at any time
- Document replacement – coordination of credit card, airline ticket or other documentation replacement
- Vehicle return – if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

*Brought to you by Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Services provided by AXA Assistance USA (AXA)
**Available at any time, not subject to 100 mile travel radius

452632

Mutual of Omaha

WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free:
1-800-856-9947

Outside the U.S. call collect:
(312) 935-3658

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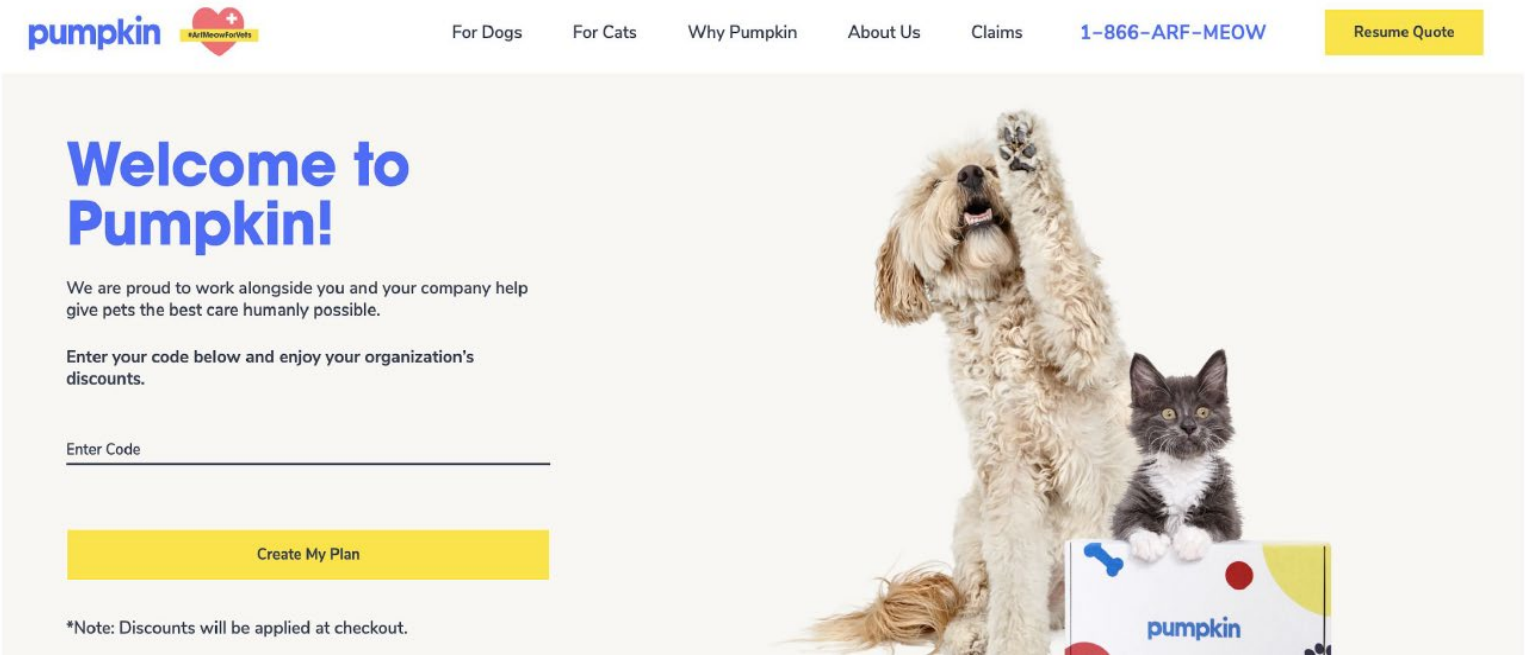
Outside the U.S. call collect:
(312) 935-3658

PUMPKIN PET INSURANCE

Easy online employee enrollment



Enter your Group Code: JCFSF

The discount can be used through http://www.pumpkin.care/teams, or on the phone: **1-866-ARF-MEOW** (1-866-273-6369)

Pumpkin provides best-in-class pet insurance and add-on, non-insurance optional preventive care packs to help keep dogs and cats healthy throughout their lives. If you'd like to insure your pet with Pumpkin, you can receive **10% off** the monthly insurance premium for your first pet and **20% off** for any additional pets you enroll after that!*

Claims can be submitted online or via email to claims@pumpkin.care.

pumpkin

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

pumpkin

WORKING ADVANTAGE

Access Your Employee Perks Program Today!

working ADVANTAGE

More perks. More savings. More of what makes you happy.

We're here to support your personal and financial well-being through exclusive deals and limited-time offers on the products, services and experiences you need and love.

START SAVING ON

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SFJCFPERKS

Member Services: (800) 565-3712

NEED HELP? EMAIL US: CUSTOMERSERVICE@WORKINGADVANTAGE.COM

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

PACIFIC SERVICE CREDIT UNION

Because your employer cares about your financial well-being, cost-free financial services are available to all employees through Pacific Service Credit Union.

We provide an alternative to big banks. As a not-for-profit organization, we're about people, not profits. In most cases, we pay higher yields on savings, charge lower rates for loans and charge fewer and lower fees.

Benefits to you as an employee

- Low-cost financial services
- Account opening incentives
- World-class service
- Save time and money

We Do the Little Things Better

At Pacific Service Credit Union, we make service and convenience our top priority. Whether you are local to the bay area or across the country, you can expect world-class service and exceptional convenience.

To open your account today, simply click here or contact your dedicated account managers:

Kristin Peterson	Jennifer Goldstein	Beatriz Lainez
(925) 609-5051	(925) 609-5101	(925) 609-5104

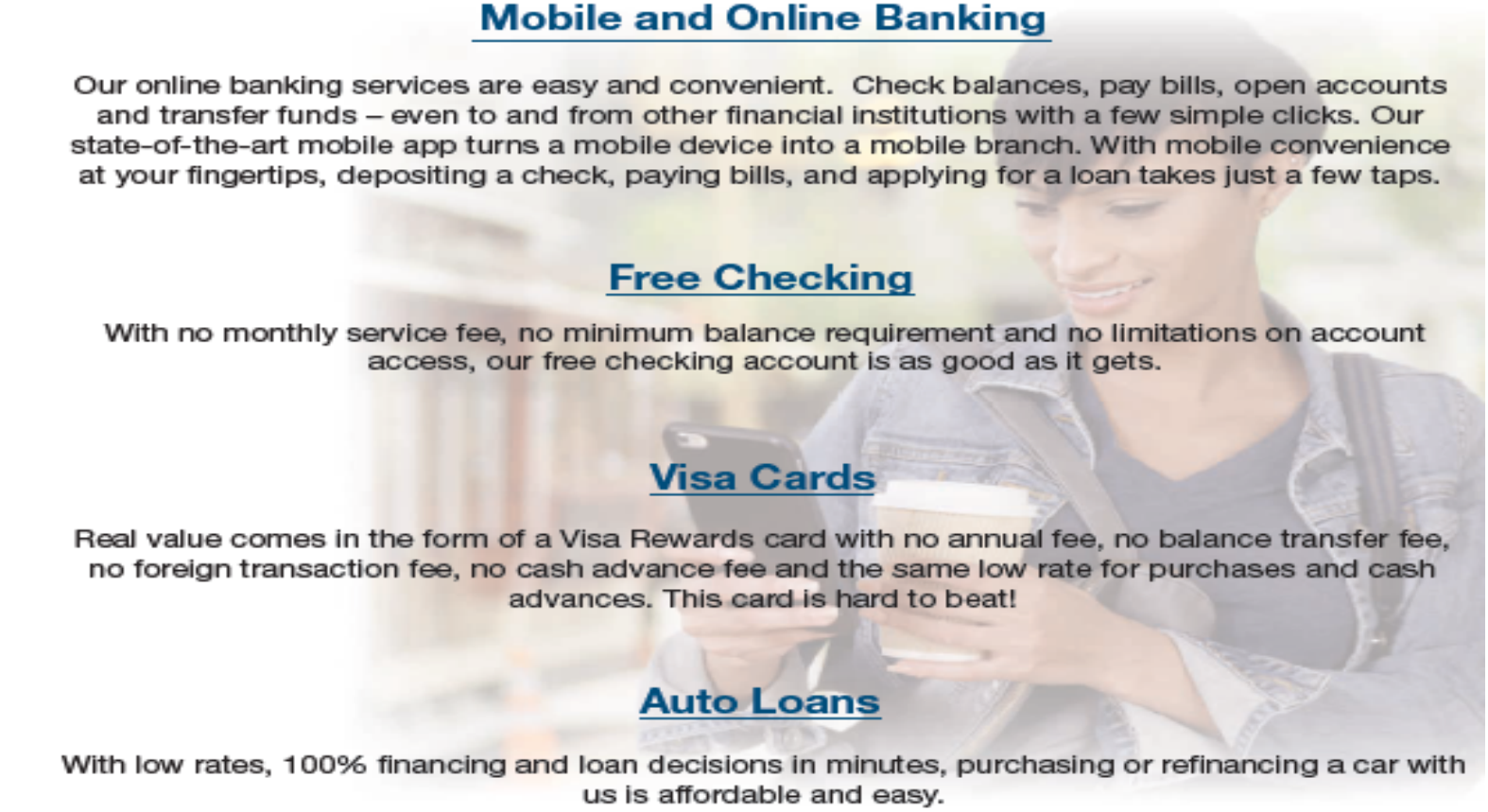
5,000 Shared Branch Locations and 30,000 Free ATMs

Through our partnership with the shared branch network, we offer free nationwide branch access, so there's always a convenient location nearby. Shared branching allows you to visit participating credit union locations and perform transactions as if you were at one of our branches. Our partnership with the CO-OP ATM Network provides free ATM access at nearly 30,000 locations…you're sure to find one near home or the office!

Fill out an application here or contact a dedicated account manager (listed in the flyer).

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

PACIFIC SERVICE CREDIT UNION



Mobile and Online Banking

Our online banking services are easy and convenient. Check balances, pay bills, open accounts and transfer funds – even to and from other financial institutions with a few simple clicks. Our state-of-the-art mobile app turns a mobile device into a mobile branch. With mobile convenience at your fingertips, depositing a check, paying bills, and applying for a loan takes just a few taps.

Free Checking

With no monthly service fee, no minimum balance requirement and no limitations on account access, our free checking account is as good as it gets.

Visa Cards

Real value comes in the form of a Visa Rewards card with no annual fee, no balance transfer fee, no foreign transaction fee, no cash advance fee and the same low rate for purchases and cash advances. This card is hard to beat!

Auto Loans

With low rates, 100% financing and loan decisions in minutes, purchasing or refinancing a car with us is affordable and easy.

Home Loans

Our in-house real estate department is available to assist with home purchases, refinances, and home equity loans. With dependable service and low rates, look no further for your real estate needs.

Local Branches

Concord
1355 Willow Way

Livermore
2800 Kitty Hawk Road

Pleasant Hill
1600 Contra Costa Boulevard
Suite E

San Ramon
2005 Crow Canyon Place
Suite 150

Fresno
102 East Nees
Avenue

Connect with us

Facebook | LinkedIn | Yelp | Twitter

Website: www.pacificservice.org
Phone: (888) 858-6878

Federally insured by NCUA

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

ADDITIONAL EMLOYEE PERKS

- Gym discounts at the ***Embarcadero YMCA & JCCSF***
- Free Entrance to the ***Contemporary Jewish Museum (CJM)***
- Partnership with ***Hebrew Free Loan*** for our employees
- **Working Advantage** – discounts on Entertainment & more
- Pacific Service Credit Union

TIME OFF BENEFITS

Time Off Benefits – The Federation offers generous time off benefits for our employees. Here are some of those perks:

- Holidays (Refer to Holiday Calendar 2024 provided by the Federation Intranet)
- 1 Floating Holiday
- Paid Parental Leave Maternity/Paternity = 12 weeks
- Bereavement Leave – 5 days
- Jury Duty/Witness – 5 days
- Sabbatical Leave – Completion of 7 vested years = 4 weeks of paid sabbatical. May be extended by 2 weeks, if spending time in Israel.

- For additional time off benefits, refer to the 2023 Federation Employee Handbook.

Vacation and Sick Time

Years of Completed Service	Annual Rate of Vacation Accrual	Maximum Vacation Accrual Cap
0-5 years	150 hours (4 weeks)	225 hours (6 weeks)
5+ years	187.50 hours (5 weeks)	225 hours (6 weeks)

Vacation Time
The Federation encourages regular, full-time, and part-time employees to use their vacation to take time away from work to rest and recharge. Vacation time accrues on the following schedule:

Vacation time accrues up to a maximum cap. Once this cap is reached, no further vacation time will accrue until vacation time is taken. Employees are not eligible to take vacation time more than what has accrued (“dip into negative balance”). Exempt employees must take vacation time in full days, not in increments (i.e. half days).

Sick Time
Regular, full-time employees accrue 1 day of paid sick leave per month, beginning at hiring. All regular and temporary part-time employees will accrue 1 day of paid sick leave every two months.

Paid sick leave is accrued up to a maximum of 225 hours (6 weeks or 30 days). Employees are not paid for unused sick leave upon termination of employment.

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details.

403B Plan

We provide employees with a vehicle to save for ***Retirement*** through our ***403b*** plan, which is administered by Primark. Employees scheduled to work at least 20 hours per week are eligible to participate in the retirement plan on date of hire. We make non-discretionary employer contributions of 3% based on your quarterly earnings. You are 100% vested after completion of 3 full years of employment (subject to change).

Call (650) 692-2043, ext. 20
Email: pbretire@primarkbenefits.com
www.primarkbenefits.com

PRIMARK BENEFITS

SF Healthcare Security Ordinance

SF Healthcare Security Ordinance (SFHCSO)

The San Francisco Health Care Security Ordinance (SF HCSO) requires employers to make a minimum health care expenditure on behalf of their covered employees. The Federation-sponsored medical plan exceeds the required expenditure and is available in lieu of the HCSO.

An employee is eligible to participate in HCSO if s/he:

- Is entitled to be paid minimum wage,
- Has been employed here for at least 90 calendar days,
- Works at least 8 hours/week within the geographic boundaries of San Francisco, and
- Does not meet one of the five exemption criteria discussed below.

Employees exempted or excluded from eligibility under the HCSO are those who:

- Voluntarily waive their right to have the Federation make expenditure for their benefit
- Are managers, supervisors, or confidential employees and earn more than the salary exemption amount
- Are covered by Medicare or TRICARE
- Are employed by the Federation for up to one year as trainees in federally recognized training program
- Receive health care benefits under the San Francisco Health Care Accountability Ordinance (HCAO)

If you choose not to enroll in one of the Federation medical plans, you may be eligible to participate in the HCSO if you certify that you are receiving health care services through a spouse, partner, or your parent's employer. If you meet the criteria above, you may elect to participate in or voluntarily waive participation in HCSO (and may revoke your election at any time by submitting a written request to HR).

If voluntary waiver is chosen, you must complete the HCSO waiver form, certify the other medical plan under which you're covered, sign and submit the form to HR. The Federation will then make quarterly payments in HCSO for your use. Once a payment is made, you will receive information and instructions from the city of SF in a welcome letter.

Required Notices and Federal Mandates

NFP®

Required Notices

Federal regulations require employers to provide certain notifications and disclosures to all eligible employees. This section of your benefit guide is dedicated to those disclosures for 11.01.21 – 10.31.22. If you have any questions or concerns please contact your Human Resources

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) of 1993 was designed to provide eligible employees with up to 12 workweeks per year of job-protected leave, to address critical personal and family matters. It is the policy of your employer and its U.S. subsidiaries to provide eligible employees with a leave of absence in accordance with the provisions of FMLA.

You are eligible for an FMLA leave of absence under this policy, if you meet the following requirements:

- You have completed at least 12 months of employment (need not be consecutive, but employment prior to a continuous break in service of seven or more years may not be counted).
- You have worked at least 1,250 hours during the 12-month period immediately preceding the commencement of the requested leave.
- You are employed at a work site where 50 or more employees are employed by the Company within 75 miles of that work site ("eligible employees").

To the extent permitted by law, leave taken pursuant to FMLA will run concurrently with Workers' Compensation, Short Term Disability, and all other Company leave policies.

The "break in service cap" doesn't apply if it:

- is attributable to fulfillment of National Guard or Reserve military service obligations; or
- is addressed in a written agreement, including a collective bargaining agreement, that expresses the employer's intent to rehire the employee after the break in service, such as a break to pursue education or raise children.

Procedure for Applying for FMLA Leave

If you desire and require an FMLA leave of absence under this policy, you must notify your manager and your Human Resources Department, and call your FMLA Administrator at least 30 calendar days in advance to the start of the leave, when the need for such leave is reasonably foreseeable (such as in the case of a birth, the placement of a child for adoption, or a planned medical treatment for a serious health condition). However, if the date of the birth, placement, or planned medical treatment requires leave to begin in less than 30 calendar days, you must provide such notice to the aforementioned parties as soon as it is both possible and practicable. Failure to provide timely notice may result in a delay or denial of FMLA leave.

IRS CODE SECTION 125

Premiums for medical, dental, vision insurance, and/or certain supplemental plans and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC), and are pre-tax to the extent permitted. Under Section 125, changes to an employee's pre-tax benefits can be made ONLY during the Open Enrollment period, unless the employee or qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employees may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse, or dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of the qualifying event.

Examples Of Qualifying Events:

- Legal marital status (for example, marriage, divorce, legal separation, annulment);
- Number of eligible dependents (for example, birth, death, adoption, placement for adoption);
- Employment status (for example, strike or lockout, termination, commencement, leave of absence, including those protected under the FMLA);
- Work schedule (for example, full-time, part-time);
- Death of a spouse or child;
- Change in your child's eligibility for benefits (reaching the age limit);
- Change in your address or location that may affect the coverage for which you are eligible;
- Significant change in coverage or cost in your, your spouse's or child's benefit plans;
- A covered dependent's status (that is, a family member becomes eligible or ineligible for benefits under the Plan);
- Becoming eligible for Medicare or Medicaid; or
- Your coverage or the coverage of your Spouse or other eligible dependent under a Medicaid plan or state Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- You, your spouse or other eligible dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance.

Qualifying Events, which ARE NOT available for a Health Care FSA program, if applicable:

- Coverage by your spouse or other covered dependent permitted under the spouse's or covered dependent's employer's benefit plan due to a Change Event;
- The availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO is added to or deleted from the Medical Program);
- An election made by your spouse or other covered dependent during an open enrollment period under your spouse's or other covered dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your spouse's open enrollment period is in July and your spouse changes coverage); or
- The cost of coverage during the Plan Year, but only if it is a significant increase or decrease.

Available for Dependent Care FSA Only, If applicable:

- Your dependent care provider or cost of dependent care (a significant increase or decrease).

Additional Change Events For Health Care Options:

In addition to the above Change Events, you may also change elections for the Medical, Dental, Vision and Health Care FSA Programs if:

- You, your spouse, or other covered dependent become eligible for continuation coverage under COBRA or USERRA;
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child;
- You, your spouse, or other covered dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- You, your spouse, or other covered dependent become eligible for a Special Enrollment Period.

Required Notices

HEALTH COVERAGE REMINDER

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage or pay a penalty. You may obtain coverage through your employer or through the Marketplace.

- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.

Visit www.healthcare.gov for Marketplace information.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

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

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

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact Human Resource Department

MICHELLE'S LAW NOTICE

The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact your Human Resource Department as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

THE GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

Genetic Information Non-Discrimination Act (GINA) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

NOTICE OF ELIGIBILITY FOR HEALTH PLANS RELATED TO MILITARY LEAVE

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service; or
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed within the time period specified by USERRA, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect Continuation Coverage Under USERRA.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Required Notices

GRANDFATHERED HEALTH PLAN

Your health insurance issuer believes this Kaiser Permanente is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Kaiser $5, $15, $20 or $30 copay plans may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the plan administrator. See page two for contact information. For ERISA plans: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For individual market policies and nonfederal governmental plans ALSO add: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov

Required Notices | Medicare

MEDICARE PART D CREDITABLE COVERAGE NOTICE
Your Prescription Drug Coverage and Medicare

Important Notice from The Entrust Group 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 Kaiser Permanente and United Health Care plans 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 Kaiser Permanente coverage will not be affected, please review your plan docu- ments for more information.

If you do decide to join a Medicare drug plan and drop your current Kaiser Permanente or Blue Shield Plan coverage, be aware that you and your dependents will 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 the Human Resources Department.

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.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Required Notices | COBRA

COBRA Coverage

Federal law requires your employer to offer participants and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

To Qualify For COBRA Coverage:

Participants – As an Employee Participant of your employer covered by our health plans, you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Spouses – As the spouse of an Employee Participant covered by our health plans, you have the right to choose continuation coverage for yourself if you lose group health coverage under our health plans, for any of the following reasons:

- The death of your spouse who was a participant;
- A termination of your spouse's employment (for reasons other than gross misconduct);
- A reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

Dependent Children - Dependent children of the Employee Participant covered by our health plans, have the right to continuation coverage if group health coverage under our plans, is lost for any of the following reasons:

- The death of a parent who was a participant;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;
- Parents' divorce or legal separation;
- A parent who is a participant becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the terms of the our health plans.

Please note that it is the Employee Participant's responsibility to notify the Human Resources/Benefits Department of any communication regarding loss of coverage and communication regarding such between the participant and the insurance carrier. Please note that employees must also provide notice of other events (e.g., divorce) to the Human Resources Department.

Continuation of Coverage Rights Under COBRA

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 Participant, 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 participant, 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.

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 Plans 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.

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:

Required Notices | COBRA

COBRA Coverage Continued..

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 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 Administrator 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.

Required Notices | CHIP

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 October 15, 2021. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research:

Attention: PRA Clearance Officer
200 Constitution Avenue N.W.
Room N-5718
Washington, DC 20210

or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

Required Notices | CHIP

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

For more information use this link

STATE	WEBSITE	PHONE
Alabama	http://myalhipp.com/	1-855-692-5447
Alaska	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861
Arkansas	http://myarhipp.com/	1-855-692-7447
California	https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx	1-916-445-8322
Colorado	Health First Colorado Website: http://www.healthfirstcolorado.com CHIP: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus	1-800-221-3943 / State Relay 711 CHIP: 1-800-359-1991 / State Relay 711
Florida	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	1-678-564-1162 Ext. 2131
Indiana	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ All other Medicaid: http://www.indianamedicaid.com	1-800-438-4479 1-800-457-4584
Iowa	Medicaid Website: https://dhs.iowa.gov/ime/members Hawki Website: http://dhs.iowa.gov/Hawki	Medicaid: 1-800-338-8366 Hawki: 1-800-257-8563
Kansas	https://www.kancare.ks.gov/	1-800-792-4884
Kentucky	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov	1-855-459-6328
Louisiana	www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid: 1-888-342-6207 LaHIPP: 1-855-618-5488
Maine	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-442-6003
Massachusetts	https://www.mass.gov/topics/masshealth	1-800-862-4840
Minnesota	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	1-800-657-3739
Missouri	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	1-573-751-2005
Montana	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
Nevada	http://dhcfp.nv.gov/	1-800-992-0900
New Hampshire	https://www.dhhs.nh.gov/oii/hipp.htm	1-603-271-5218 Toll free number for the HIPP Program: 1-800-852-3345, Ext. 5218
New Jersey	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP Website: http://www.njfamilycare.org/index.html	Medicaid: 1-609-631-2392 CHIP: 1-800-701-0710
New York	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	https://medicaid.ncdhhs.gov/	1-919-855-4100
North Dakota	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma	http://www.insureoklahoma.org	1-888-365-3742
Oregon	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania	https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	1-800-692-7462
Rhode Island	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
South Carolina	http://www.scdhhs.gov	1-888-549-0820
South Dakota	http://dss.sd.gov	1-888-828-0059
Texas	http://gethipptexas.com/	1-800-440-0493
Utah	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip	1-877-543-7669
Vermont	http://www.greenmountaincare.org/	1-800-250-8427
Virginia	https://www.coverva.org/hipp/	Medicaid: 1-800-432-5924 CHIP: 1-855-242-8282
Washington	https://www.hca.wa.gov/	1-800-562-3022
West Virginia	http://mywvhipp.com	1-855-699-8447
Wisconsin	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

Required Notices | HIPAA

NOTICE OF HIPAA PRIVACY PRACTICES

The privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) became effective April 14,2003. These federal regulations require covered entities, such as health plans, to provide plan participants with a notice of privacy practices describing the health-related information that is collected, how it is used, and the ways in which the regulations permit it to be disclosed. These privacy notices also provide information on a participant's right to access, review and, if necessary, to have this information amended.

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.

"**We**," "**us**", and "**Plan**" refer to all the health benefit plans and programs presented herein. "Plan Sponsor" refers to **your employer**. ''You" or "yours" refers to individual participants in the Plans. PHI is information that may identify you and that relates to past, present, or future health care services provided to you, payment for health care services provided to you, or your physical or mental health or condition.

Your employer Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);
2. Your privacy rights with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to:

1. Maintain the privacy of your PHI;
2. Provide you with certain rights with respect to your PHI;
3. Provide you with this Notice of our legal duties and privacy practices regarding your PHI; and
4. Abide by the terms of this Notice as it may be updated from time to time.

We protect your PHI from inappropriate use or disclosure. Our employees and those of our Business Associates are required to protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to determine coordination of benefits or services. We will not disclose your PHI to anyone for marketing purposes.

USES AND DISCLOSURES OF PHI

Primary Uses and Disclosures of PHI: The main reasons for which we may use and may disclose your PHI are in order to administer our health benefit programs effectively and to evaluate and process requests for coverage and claims for benefits.

The following describe these, and other uses and disclosures, together with some examples:

Treatment*: Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. We may disclose your PHI to health care providers to provide you with treatment. For example, we might respond to an inquiry from a hospital about your eligibility for a particular surgical procedure.

Payment*: Payment refers to our activities in collecting premiums and paying claims for health care services you receive. We may use your PHI or disclose it to others for these purposes. For example, if you had insurance coverage from a spouse's employer, we might disclose your PHI to the other insurer to determine coordination of benefits or services. Payment also refers to the activities of a health care provider in obtaining reimbursement for services. We may disclose your PHI to a provider for this purpose.

Health Care Operations Purposes*

1. We may use your PHI or disclose it to others for quality assessment and improvement activities.

2. We may use your PHI or disclose it to others for activities relating to improving health or reducing health care costs, development of health care procedures, case management, and care coordination.

3. We may use your PHI or disclose it to others for the purpose of informing you or a health care provider about treatment alternatives.

4. We may use your PHI or disclose it to others for the purpose of reviewing the competence, qualifications, or performance of health care providers, or conducting training programs.

5. We may use your PHI or disclose it to others for accreditation, certification, licensing, or credentialing activities.

6. We may use your PHI or disclose it to others in the process of contracting for health benefits or insurance covering health care costs.

7. We may use your PHI or disclose it to others for purposes of reviewing your medical treatment, obtaining legal services, performing audits or obtaining auditing services, and detecting fraud and abuse.

8. We may use your PHI or disclose it to others in our business management, planning, and administrative activities. As an example, we might use your PHI in the process of analyzing data about treatment of certain conditions to develop a list of preferred medications.

Business Associates: We contract with various individuals and entities (Business Associates) to perform functions on behalf of the Plans or to provide certain services. To perform these functions, our Business Associates may receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to safeguard your PHI.

Plan Sponsor: We and our Business Associates may also disclose PHI to the Plan Sponsor without your written authorization in connection with payment, treatment, or health care operations purposes or pursuant to a written request signed by you. Such disclosures may only be made to the individuals authorized to receive such information. If PHI is disclosed to the Plan Sponsor for these purposes, the Plan Sponsor agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Other Covered Entities: your employer (including the insured plans) together are called an "organized health care arrangement. "The Plans may share PHI with each other for the health care operations purposes of the organized health care arrangement.

*The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purpose, as defined under the HIPAA rules.

OTHER POSSIBLE USES AND DISCLOSURES OF PHI

In addition to using and disclosing your PHI for treatment, payment, and health care operations purposes, we may (and are permitted) to use or disclose it in the following circumstances:

To Persons Involved in Care and for Notification Purposes:

We may disclose PHI to a family member, relative, close personal friend, or any other person identified by you, provided that the PHI is directly relevant to that person's involvement with your care or payment related to your care. In addition, we may use or disclose PHI to notify a member of your family, your personal representative, or another person responsible for your care of your location, your general condition, or your death.

Required Notices | HIPAA

In Regard to Abuse, Neglect, or Domestic Violence: In certain circumstances, we may disclose your PHI to a government authority that is authorized to receive reports of cases of abuse, neglect, or domestic violence.

To Coroners, Medical Examiners, and Funeral Directors: We may disclose PHI to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other purposes authorized by law. We may disclose PHI to funeral directors to enable them to carry out their duties.

For Public Health Activities: We may disclose PHI to public authorities for the purpose of preventing or controlling disease, injury, or disability. Under some circumstances, when authorized by law, we may disclose PHI to an individual who is at risk of contracting or spreading a contagious disease or condition. We also may disclose PHI to appropriate parties for the purpose of activities related to the quality, safety, or the effectiveness of products regulated by the U.S. Food and Drug Administration.

To Avert a Threat to Health or Safety: We may, under certain circumstances, disclose PHI to avert a serious threat to the health or safety of a person or the general public.

Organ and Tissue Donations: We may, under certain circumstances, disclose PHI for purposes of organ, eye, or other medical transplants or tissue donation purposes.

To Comply with Workers' Compensation Laws: We may disclose your PHI to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs.

For Law Enforcement and National Security Purposes: In certain circumstances, we may disclose PHI to appropriate officials for law enforcement purposes; for example, if it is required by law or legal process. In addition, we may disclose your PHI if you are or were armed forces personnel or to authorized federal officials for conducting national security and intelligence activities.

In Connection with Legal Proceedings: In certain cases, we may disclose PHI in connection with the legal proceedings of courts or governmental agencies. For example, we may disclose your PHI in response to a subpoena for such information but only after certain conditions required by HIPAA are met.

For Health Oversight Activities: We may disclose PHI to a governmental agency authorized by law to oversee the health care system, compliance with civil rights laws, or government benefit. Health oversight activities include audits, inspections, investigations, or legal proceedings.

Military Personnel: If you are in the armed forces, we may disclose your PHI for activities that military authorities consider necessary to the accomplishment of a mission.

Inmates: If you are incarcerated, we may disclose your PHI to appropriate authorities who tell us they need it for your health care, your safety, the health or safety of other persons, or general administrative purposes.

Research: Under certain circumstances, we may disclose PHI for research purposes.

Health Information: We may contact you with information about treatment alternatives and other health-related benefits and services.

As Required by Law: We may disclose your PHI when required to do so by federal, state, or local law.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures we are required by law to make:

Disclosures to the Secretary of the U.S. Department of Health & Human Services: We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with HIPAA.

Disclosure to You: We are required to disclose to you most of your PHI. We will also disclose your PHI to an individual whom you have designated as your personal representative. However, before we can disclose your PHI to such person, you must submit a written notice of his/her designation along with documents supporting his/her qualification (such as a power of attorney). In limited situations HIPAA permits us to elect not to treat the person as your personal representative if we have reasonable belief that it could endanger you.

OTHER USES AND DISCLOSURES OF YOUR PHI WITH AUTHORIZATION

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. You may revoke an authorization at any time by providing written notice to us. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in reliance on the authorization. To obtain an Authorization for Release of Information, call the **Human Resources Department.** You may revoke an authorization by contacting the Health Information Privacy Officer identified at the end of this Notice.

YOUR RIGHTS

Right to Request Restrictions on Uses and Disclosure

You may ask us to restrict uses and disclosures of your PHI for treatment, payment, or health care operations purposes, or to restrict disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care, or to restrict disclosures for notification purposes. However, we are not generally required to comply with your request for restrictions except in those situations where the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment), and the PHI pertains solely to a health care item or service that was paid out of pocket in full. You may exercise this right by contacting the Health Information Privacy Officer identified at the end of this Notice who will provide you with additional information including what information is required to make a restriction request.

Right to Inspect, Copy, and Amend Your PHI

As long as we maintain records containing your PHI, you have a right to inspect and copy such information. These rights are subject to certain limitations and exceptions. For example, if the requested information contains psychotherapy notes or may endanger someone, it may not be available. You may request a review of any denial to access. If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. If you believe your PHI held and created by us is incorrect or incomplete, you may request that we amend your PHI. You will be required to provide the reason the amendment is necessary. Requests for access to your PHI or amendment of your records should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to a List of Disclosures

You have a right to an accounting of certain disclosures of your PHI by us. The accounting will not include those items which are not required to be provided such as disclosures made at your request or disclosures made for treatment, payment, or health care operations. A request for a list of disclosures should be directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to Request Confidential Communications

We will accommodate a reasonable request by you to receive communications from us by alternative means or at an alternative location if you believe that disclosure of your PHI could pose a danger to you. For example, you may request that we only contact you by mail or at work. Requests for confidential communications should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Required Notices | HIPAA

Right to be Notified of a Breach

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to Receive Paper Copy

You have the right to receive a paper copy of this Notice from the Plan upon request even if you have previously agreed to receive copies of this Notice electronically. Requests for a paper copy should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI we maintain. If we change this Notice, you will receive a new Notice. Active employees will receive the Notice by distribution in the workplace; inactive employees (including retirees) will receive the Notice by mail.

Complaints: If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below under "Health Information Privacy Officer'' or with the office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Health Information Privacy Officer: You may exercise the rights described in this Notice by contacting the office identified below, which will provide you with additional information.

Glossary of Terms

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- Primary Beneficiary – A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- Contingent Beneficiary – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.
- Domestic partnership (if covered)

Proof of relationship documentation may be required in order to add dependents to your plan(s). Employees will receive request for documentation.

The definition of qualifying dependents may vary by carrier and plan type. If there is any discrepancy, the insurance carrier's certificate of coverage is the prevailing document.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care — That meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network — The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

About NFP

NFP is a leading property and casualty broker, benefits consultant, wealth manager, and retirement plan advisor that provides solutions enabling client success globally through employee expertise, investments in innovative technologies, and enduring relationships with highly rated insurers, vendors and financial institutions.

Our expansive reach gives us access to highly rated insurers, vendors and financial institutions in the industry, while our locally based employees tailor each solution to meet our clients' needs. We've become one of the largest insurance brokerage, consulting and wealth management firms by building enduring relationships with our clients and helping them realize their goals.

For more information, visit NFP.com.

Insurance services provided through NFP Corporate Services (UT), Inc. a subsidiary of NFP Corp. (NFP).