09/01/2021-08/31/2022 PLAN YEAR

BENEFIT BOOK

Sample

PRESENTED BY:

Awesome Agency

Broker Contact info

537 Houston Street, Dallas, TX 75019 / (214) 308-1440 / www.awesomeagency.com

Simply Connected

GUIDELINES FOR UNDERSTANDING YOUR EMPLOYEE HEALTH SERVICES BENEFITS

ELIGIBILITY:
Full-time employees working a minimum of 30 hours per week are eligible for benefits on the first day of the month following date of hire.

ELIGIBLE DEPENDENTS:
Your legal spouse or domestic partner are eligible for medical, vision and dental benefits. Children are eligible for medical and dental benefits up to age 26 regardless of their marital, financial, or student status (dependent upon contract).

WHEN CAN YOU ENROLL:
You can sign up for benefits at any of the following times:

- After completing the initial eligibility period (new-hire or transfer to benefit eligibility category).
- During the annual open enrollment period, August 2, 2021 - August 10, 2021, for a September 1, 2021 effective date.
- Within 30 days of a qualified family status change (birth, divorce, marriage, loss of coverage).
- If you do not enroll at the above times, you must wait for the next annual open enrollment period.

Employer Contribution:

The employer pays 85% of all plans offered.

Anthem Medical Plan

Anthem of CA | Anthem 500 | HMO | Group#: 1243

Anthem of CA Member Services | (800) 555-1212 | https://www.anthem.com/ca

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
In The Hospital		
Maternity Services	30% after deductible	30%
Impatient Services	30% after deductible	30%
In The Medical Office		
Outpatient Surgery	100000000	30% after deductible
Maternity Visits	$20 copay	$20 copay
Well baby care (through age 18)	No charge	No charge
Diagnostic lab	30% after deductible	30% after deductible
Preventative care (includes labs, preventative tests)	No charge (1 exam/yr)	No charge (1 exam/yr)
Physician/Specialist office visit	$20 copay	$20 copay
Annual Maximum		
Individual/Family	$2,385/$4,770	OOP Maximum satisfied in phase 1
Deductible (Deductible is included in OOP Max)		
Individual/Family	$600/$500	Deductible satisfied in phase 1
Emergency Services		
Emergency Room	30% after deductible	30%
Urgrent Care	30% after deductible	30%
Pharmacy		
Generic	$10	$10
Name Brand	$	$30
Non Formulary	0	$50
Day Supply	Up to 0 days	Up to 30 days

Notes

** Simply Connected does not promote the use of out of network providers but if an out-of-network provider is used, you will be responsible for higher out of pocket costs plus any balance over the maximum allowed amounts. Details can be found on your Medical Carrier schedule of benefits or by calling Carrier directly. Whenever possible, use only in-network providers.

Helpful Hints

- For Maintenance Medications, use mail order and get 3 months supply for a discount costs.
- Use in-network providers to keep out of pocket expenses down
- When possible, use generic drugs to keep costs low
- Use Urgent Care instead of ER when possible
- Visit carrier website or call member services for more information
- Pre-authorization may be necessary for some prescription drugs

In a effort to make your benefits more understandable, Awesome Agency has produced this brief summary of your benefits. This summary is a cursory description of your employee benefits and should be considered such.

Kaiser Medical Plan

Kaiser Permanente | Silver 70 HMO 1800/55 + Child Dental | HMO | Group#: 1234
Kaiser Permanente Member Services | (866) 555-1212 | https://www.kp.org/lookup

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
Deductible (Deductible is included in OOP Max)		
Individual/Family	$1,800 / $3,600	
Annual Maximum		
Individual/Family	$7,550 / $15,100	
Individual/Family - Child Dental	$350 Child/ $700 Children	
In The Medical Office		
Physician/Specialist office visit	$55/ $75 per visit, deductible n/a	Not covered
Preventative care (includes labs, preventative tests)	No charge, deductible does not apply	Not covered
Diagnostic lab	X-Ray $55/Lab Tests $50 per encounter	Not covered
Well baby care (through age 18)	No charge, deductible does not apply	Not covered
Maternity Visits	No charge, deductible n/a	Not covered
Outpatient Surgery	45% coinsurance, Physician fees included	Not covered
In The Hospital		
Inpatient Services	45% coinsurance, Physician fees included	Not covered
Maternity Services	45% coinsurance, Professional fees included	Not covered
Emergency Services		
Emergency Room	45% coinsurance, waived if admitted	45% coinsurance, waived if admitted
Urgent Care	$55/visit, deductible does not apply	$55/visit, deductible n/a
Pharmacy		
Generic	$30/prescriptio	Not covered
Name Brand	$75/prescriptio	Not covered
Non Formulary	2 coinsurance ter drug deductible	Not covered
Day Supply	30 Days	Not covered

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Dental Insurance

Anthem of CA | Prudent Buyer Anthem Dental Net 2000A - 2019 | Group#: 12478
Anthem of CA Member Services | (800) 555-1212 | https://www.anthem.com/ca

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
General		
Deductible	$0	No Coverage
Deductible Waived for Preventative	Yes	Yes
Class 1: Diagnostic/Preventative	$0 - $70 copay	No Coverage
Class 2: Basic	$0 - $175 copay	No Coverage
Class 3: Major	$0 - $425 copay	No Coverage
Orthodontia Coverage %	$1500 copay, no additional charges apply	No Coverage
Orthodontia Lifetime Benefit Maximum	N/A, copay applies	No Coverage
Orthodontia: Child Only (up to age 19) / Adult and Child / N/A	Adult and Child	No Coverage
Annual Benefit Maximum	N/A	No Coverage

Vision Insurance

Anthem of CA | Vision Plan for Simply Connected | PPO | Group#: 12347
Anthem of CA Member Services | (800) 555-1212 | https://www.anthem.com/ca

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
General		
Exam Co-pay	$5	Up to $42 reimbursement
Material Co-pay	$25	See plan summary
Exam Frequency	Once Every 12 Months	Once Every 12 Months
Lense Frequency	Once Every 24 Months	Once Every 24 Months
Frames Frequency	Once Every 24 Months	Once Every 24 Months
Contact Lenses Frequency	Once Every 24 Months	Once Every 24 Months
Plan Pays		
Examinations	Covered in Full after Copay	See plan summary
Single Vision	$0 copay	Up to $40 reimbursement
Bifocals	$0 copay	Up to $60 reimbursement
Trifocals	$0 copay	Up to $80 reimbursement
Lenticular	$0 copay	See plan summary
Frames	$120 allowance, then 20% off any remaining balance	Up to $45 reimbursement
Contact Lenses	$115 allowance, then 15% off any remaining balance	Up to $60 reimbursement

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Life Insurance

Met Life | 25,000 Employer Paid Life | Group#: 1234
Met Life Member Services | (888) 555-5555 |

PLAN FEATURES	
General	
Employer Paid	$25,000
Guaranteed Issue	$25,000

Short Term Disability

Met Life | Short Term Disability Plan for Simply Connected | Group#: 2345
Met Life Member Services | (888) 555-5555 |

PLAN FEATURES	
General	
Benefit Amount	66% of Earnings
Maximum Benefit Amount	$10,000/month
Benefit Duration	To age 65 or normal Social Security Age
Elimination Period	90 Calendar Days

Long Term Disability

Met Life | Long Term Disability | Group#: 2345
Met Life Member Services | (888) 555-5555 |

PLAN FEATURES	
General	
Benefit Amount	60% of Earnings
Maximum Benefit Amount	$5,000/Month
Benefit Duration	36 Months
Elimination Period	180 Days

In an effort to make your benefits more understandable, Awesome Agency has produced this brief summary of your benefits. This summary is a cursory description of your employee benefits and should be considered such.

YOUR TEAM

BROKER CONSULTANT

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- 2 HOUR - RESPONSE >> TIME << GUARANTEE

HEALTH PLAN SUMMARY PLAN DESCRIPTION

1. INTRODUCTION

Simply Connected (the Company) maintains this group health plan (the Plan) to provide benefits to you and your eligible dependents. Your benefits are provided under an insurance contract between the Company and one or more of the Carriers Listed below.

This document and the certificate of insurance booklet from the Insurer make up your summary plan description (SPD). Please read this document and the attached booklet to learn about your health plan benefits. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information. Please keep your health plan documents in a safe place for future reference.

Please note that this document does not provide any substantive rights to benefits that are not included in the certificate of insurance booklet. If you have any questions regarding the Plan, including whether you are eligible to participate in the Plan, please contact the Company. If you have questions regarding benefits payable under the Plan, please contact the Insurer or Plan Administrator.

2. PLAN INFORMATION CONTACTS

Name of Plan: Simply Connected Health and Welfare Plan

Plan Sponsor	Plan Administrator	Agent for Service of Legal Process
Simply Connected 233 N Michigan 200 Chicago, IL 60601 (720) 961-2235	Simply Connected 233 N Michigan 200 Chicago, IL 60601 (720) 961-2235	Dolores Smith 233 N Michigan 200 Chicago, IL 60601 (530) 888-1212

Welfare Benefit Plan Name	Coverage Effective Date
Anthem of CA Group/Policy #: 1234 Plan Type: Medical (800) 555-1212 https://www.anthem.com 1234 Bannister Way 343, Sacramento CA, 95621	Waiting Period: 30 Days Entry Period: 1st of the Month
Kaiser Permanente Group/Policy #: 1234 Plan Type: Medical (866) 555-1212 Https://www.kp.org 100 First Street, Sacramento AL, 95777	Waiting Period: 30 Days Entry Period: 1st of the Month
Met Life Group/Policy #: 2345 Plan Type: Long Term Disability (888) 555-5555 https://www.metlife.com 100 First St 150, Minneapolis MN, 98877	Waiting Period: 30 Days Entry Period: 1st of the Month
Met Life Group/Policy #: 2345 Plan Type: Short Term Disability (888) 555-5555 https://www.metlife.com 100 First St 150, Minneapolis MN, 98877	Waiting Period: 30 Days Entry Period: 1st of the Month

IDENTIFICATION NUMBERS

Plan Sponsor's Employer Identification Number (EIN): 20-2970355

Plan Number: 501

Plan Year Start Date: 01/01/2020

ERISA Effective Date of Plan: 01/01/2014

IMPORTANT DISCLAIMERS

Conflicting Terms

If the terms of this document conflict with the terms of the insurance contract between the Company and the Insurer, the insurance contract will control. This document may not confer additional rights that are not contained in the insurance contract.

No Contract of Employment

The Plan does not constitute a contract of employment between you and the Company or any other arrangement indicating that you will be employed for any specific period of time.

FUNDING

The Plan is fully insured. Plan benefits are payable pursuant to a contract with the Insurer. Claims for benefits are sent to the Insurer and the Insurer is responsible for paying benefits. The Company is not responsible for paying benefits under the Plan.

Premium contributions are paid in part by the Company out of its general assets and in part by employees through pre-tax contributions. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contract entered into between the Company and the Insurer will be allocated, if consistent with the fiduciary obligations imposed by ERISA and permitted by law, to reimburse the Company for premiums that it has paid.

TYPE OF ADMINISTRATION

Because the Plan's benefits are provided through an insurance contract, both the Insurer and the Company administer the Plan.

The Company, as plan administrator, has the discretionary authority to interpret and administer the Plan. This includes making determinations of an individual's eligibility to participate in the Plan. The Insurer has the authority to make benefit determinations under the Plan and is the Named Fiduciary responsible for following the Plan's claims procedures.

COMPLIANCE WITH STATE & FEDERAL LAWS

To the extent required by law, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, as amended, including the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998 (WHCRA), the Family and Medical Leave Act of 1993 (FMLA), the Families First Coronavirus Response Act (FFCRA or Act) of 2020, the Mental Health Parity Act (MHPA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Information Technology for Economic and Clinical Health Act (HITECH), Michelle's Law, the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act (PPACA).

AMMENDMENT OR TERMINATION

The Company may modify, amend or terminate the Plan at any time at its sole discretion. The right to modify, amend or terminate also applies to the insurance contract between the Company and the Insurer. Any modification, amendment, or termination will be communicated to participants under the Plan.

ELIGIBILITY & ENROLLMENT

To be eligible to participate in the Plan, you must meet certain requirements outlined in Offerings Section. If applicable, you must pay a certain amount of the premium for coverage.

Coverage will be extended to your non-custodial child if required by a Qualified Medical Child Support Order (QMCSO). Please contact HR at the Company for more information on the Plan's procedures for determining whether a medical child support order qualifies as a QMCSO.

Your coverage terminates on the end of the month you terminate employment with the Company. Coverage may also terminate in other circumstances, such as failure to pay required premiums, failing to meet eligibility requirements, submitting fraudulent claims and other reasons described in the attached certificate of insurance booklet. Coverage for your spouse and dependents terminates when your coverage ends and for other reasons described in the attached certificate of insurance booklet, such as divorce or reaching the Plan's limiting age for dependents.

SPECIAL ENROLLMENT RIGHTS

Notice of Special Enrollment Rights HIPAA applies to any employer that has two or more active employees. Under HIPAA group health plans are required to provide active employees, their dependents and COBRA qualified beneficiaries with special enrollment opportunities for certain situations. The following are just some events that may trigger a Special Enrollment Event:

- Loss of eligibility under other coverage;
- Due to divorce or legal separation;
- Dependent loss of eligibility due to age under a parents plan;
- Death of an employee's spouse which leaves the spouse with no coverage;
- Spouse's employment ends, as does insurance coverage; and
- Spouse no longer eligible due to hours being cut.
- Loss of eligibility under Medicaid/CHIP/state coverage;
- 18/36 month exhaustion under COBRA;
- Birth/ Adoption/Place for adoption of a child;
- Marriage of an employee; and
- Gain of eligibility for Medicaid/CHIP premium assistance.

You must notify your employer within 30 days of the Special Enrollment Event taking place. Coverage will not be provided if the request is made after the 30 day period. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Enrolling for the first time you must complete an enrollment form and provide the supporting documentation for your Special Enrollment Event. If you are currently enrolled and adding a dependent, then a written request is required along with the supporting documentation.

In certain special circumstances, you and/or your dependents may enroll in the Plan at times other than open enrollment. The certificate of insurance booklet and the Plan's Special Enrollment Notice contain more information about potential special enrollment rights.

CONTINUATION OF COVERAGE

If your coverage or the coverage of your spouse or dependents terminates because of certain reasons known as qualifying events (such as termination of employment, reduction in hours, divorce, death, or child ceasing to be a dependent under the plan), you, your spouse and your dependents may be entitled to continue health care coverage for a certain period of time under a federal law called COBRA. In addition, if you are absent from employment due to military service, you may be entitled to continuation of coverage or reinstatement in the Plan under a federal law called USERRA. You or your dependents may have to pay for such coverage. Contact HR at the Company for more information about your rights under COBRA and/or USERRA.

The Plan provides benefits to you and your eligible spouse and dependents while you are eligible for and covered by the Plan.

For a detailed description of benefits available under the Plan, please review the certificate of insurance booklet which includes cost-sharing information, out-of-pocket maximums, limitations, provider network provisions, when new drugs are covered, preventive care services, when medical tests/devices are covered, restrictions, excluded services, Procedures for obtaining prior authorization, approvals, or utilization review decisions, etc. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information.

Benefits are no longer payable if your coverage is terminated for any reason. The Plan reserves the right to recover overpayments of benefits or benefits paid in error through the rights of subrogation and reimbursement as described more fully in the attached certificate of insurance booklet.

EXCLUSIONS & LIMITATIONS

Please review the certificate of insurance booklet carefully for information on other situations that may affect your right to receive benefits under the Plan, such as applicable deadlines for submitting claims and any exclusions and limitations that may result in the denial of a claim or a loss or reduction of a benefit. Other situations may also lead to a reduction or limitation (e.g., timeline to file a claim), which are described in the certificate of insurance booklet.

PATIENT PROTECTION/NOTICE OF CHOICE OF PROVIDERS

Your carrier(s), plan administrator, or issuer generally allows/requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. In addition, your carrier could auto designate a primary care provider until you make your own selection. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact the carrier contact them directly. Contact information can be found under the “Offerings” section.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your Insurance Carrier(s), plan administrator, or issuer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, you may contact the carrier(s), plan administrator, or issuer directly. Contact information can be found under the “Offerings” section.

BENEFIT CLAIMS & APPEALS

The Insurer is responsible for reviewing and deciding all benefit claims in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. The attached certificate of insurance booklet provides more information about the Insurer's claims procedures, including information on how to file a claim.

CLAIM & APPEALS

The Insurer may deny claims in part or in full pursuant to the terms of the Plan. If your claim is denied, you will be notified of the denial. You may appeal any denial of a claim. The Insurer will review your denied claim and will decide your appeal in accordance with its reasonable claim's procedures, as required by ERISA and other applicable law.

If you do not appeal a denial by the applicable deadlines, you will lose certain rights, such as the right to file a lawsuit regarding the denial and you will not be deemed to have exhausted your internal administrative rights.

In some cases, you may have the right to an external review, which consists of review by an independent third party. The attached certificate of insurance booklet provides more information about external review.

7. STATEMENT OF ERISA RIGHTS

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if the plan administrator is required by law to file a Form 5500. The plan administrator may be required by law to furnish each participant with a copy of this summary annual report.

COBRA RIGHTS

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with

the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Use and Disclosure of Protected Health Information

(a) Any health plan under the Plan shall use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan shall use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

a. Health Care Treatment. Health care treatment means the provision, coordination or management of health care and related services by one or more health care providers. It also includes coordination or management of health care by a health provider and a third party and consultation or referrals between one health care provider and another.
b. Payment. Payment includes activities undertaken by any health plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits, or to obtain or provide reimbursement for the provision of health care, that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
   i. determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
   ii. coordination of benefits;
   iii. adjudication of health claims (including appeals and other payment disputes);
   iv. subrogation of health claims;
   v. establishing employee contributions;
   vi. risk adjusting amounts due based on enrollee health status and demographic characteristics;
   vii. billing, collection activities and related health care data processing;
   viii. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
   ix. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
   x. medical necessity reviews or reviews of appropriateness of care or justification of charges;
   xi. utilization review, including precertification, preauthorization, concurrent review and retrospective review;
   xii. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
   xiii. reimbursement to a health plan.
c. Health Care Operations
   i. quality assessment;
   ii. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;
   iii. rating provider and health plan performance, including accreditation, certification, licensing or credentialing activities;
   iv. underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
   v. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
   vi. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the health plan, including formulary development or

improvement of payment methods or coverage policies; and

vii. business management and general administrative activities of the health plan, including, but not limited to:

A. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

B. customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, provided that protected health information is not disclosed to such policyholder, plan sponsor, or customer;

C. resolution of internal grievances; and

D. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPAA or, following completion of the sale or transfer, will become a covered entity.

d. A health plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or other covered individual. With an authorization, a health plan shall disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers' compensation insurers, for purposes related to administration of the health plan.

e. A health plan shall disclose PHI to the Employer only upon receipt of a certification from the Employer that the health plan documents have been amended to incorporate the following provisions and that the Employer agrees to:

i. not use or further disclose PHI other than as permitted or required by the health plan document or as required by law;

ii. ensure that any agents, including subcontractors, to whom the Employer provides PHI received from a health plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

iii. not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

iv. not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual;

v. report to the health plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

vi. make PHI available to an individual in accordance with HIPAA's access requirements;

vii. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

viii. make available the information required to provide an accounting of disclosures;

ix. make the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining the health plan's compliance with HIPAA;

x. ensure that adequate separation between the health plan and the Employer is established as required by HIPAA; and

xi. if feasible, return or destroy all PHI received from the health plan that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible).

f. Only those employees or classes of employees identified in the Plan's privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Employer performs for the health plan. If such individuals do not comply with this health plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

g. Security. The Employer shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Employer shall:

i. implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan;

ii. ensure the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;
iii. ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (e.g., in the event the Employer provides information to the broker for renewal bids); and
iv. report to the Plan any security incident of which it becomes aware.

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 January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.ma[illegible].gov/dhh[illegible]/public assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http[illegible]://www.he[illegible]lth[illegible]ny.[illegible]/health_care/medicaid/ Phone: [illegible]-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: [illegible]
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MYWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Services	U.S. Department of Health and Human
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	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.

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date – April 2017

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Model Newborns' Act Disclosure

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).

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

▸ PAID LEAVE ENTITLEMENTS

Generally, employers covered under the Act must provide employees:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- ⅔ for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▸ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave or COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

▸ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

▸ ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

For additional information or to file a complaint:
1-866-487-9243
TTY: 1-877-889-5627
dol.gov/agencies/whd

WH1422 REV 03/20

CONTACT US

Awesome Agency

Broker Contact info

[redacted]

(214) [redacted]

(866) [redacted]

hello@awesomeagency.com

www.awesomeagency.com