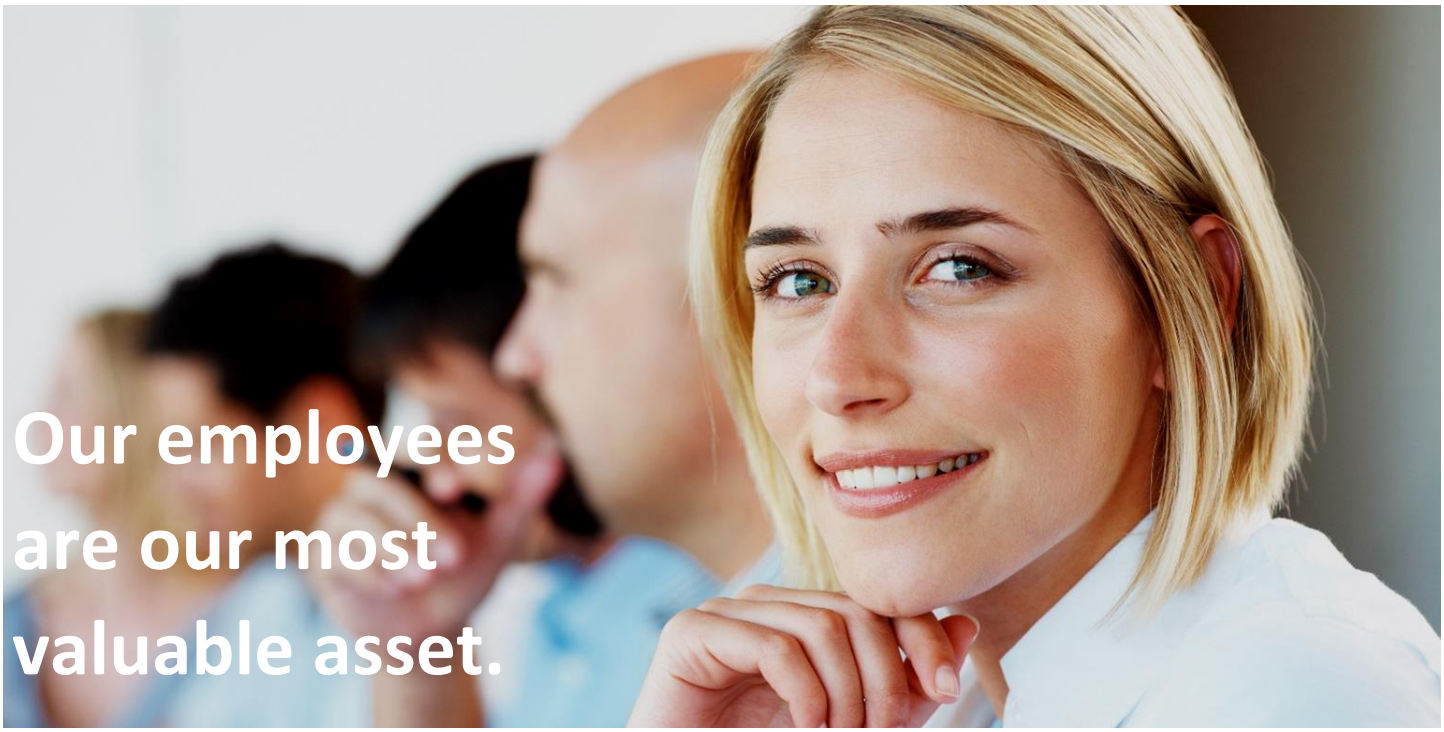
EMPLOYEE BENEFIT HIGHLIGHTS

PLAN YEAR 2022-2023

RAND EYE INSTITUTE
EXCELLENCE IN OPHTHALMOLOGY®

Disclaimer

The information in this Enrollment Guide is intended for illustrative purposes and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage and benefit information. Every effort was taken to accurately report your benefits however discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract nor are there any express or implied guarantees. In case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have any questions about this summary, please contact Human Resources.



Welcome to Open Enrollment for your 2022-2023 Plan Year Benefits

William J. Rand, M.D., P.A. offers you and your eligible family members a comprehensive employee benefit program that helps our employees stay healthy, feel secure and maintain a work/life balance. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Stay Healthy and Feel Secure

- Medical
- Gap
- Hospital Indemnity
- Dental
- Vision
- Voluntary Term Life and AD&D
- Critical Illness
- Accident

Contact Information

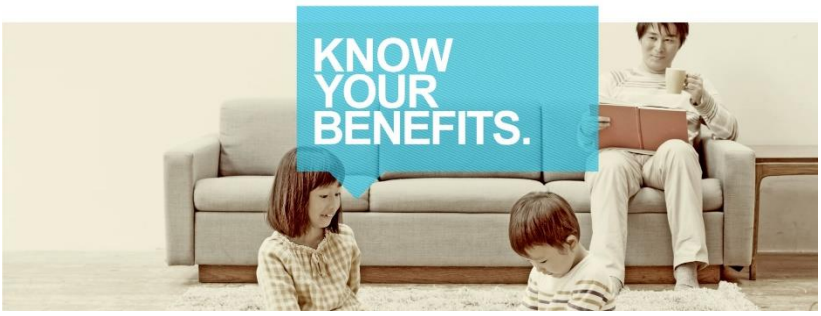
Company	Plan Type	Contact Information
RAND EYE INSTITUTE EXCELLENCE IN OPHTHALMOLOGY®	Company	Robin Rosmarin Phone: 954-782-1700
JDI	Broker	Phone: 800-832-1018 Claims@jdigroup.com
Florida Blue Your local Blue Cross Blue Shield	Medical Vision	Phone: 800-352-2583 www.floridablue.com
TRANSAMERICA	Gap	Phone: 866-224-3100 www.transamericaemployeebenefits.com
APL AMERICAN PUBLIC LIFE Expanding the Benefits Horizon™	Hospital Indemnity	Phone: 800-256-8606 www.ampublic.com
Principal®	Dental Voluntary Term Life and AD&D Critical Illness Accident	Phone: 800-986-3343 www.principal.com

Table of Contents

Disclaimer 2
Contact Information 4
Table of Contents 5
Glossary of Terms 6
Group Insurance Eligibility 7
Know Where To Go 8
Medical Insurance 9
Gap Insurance 14
Dental Insurance 16
Vision Insurance 18
Voluntary Term Life Insurance 19
Voluntary Term Life Deductions 20
Critical Illness Insurance 21
Critical Illness Deductions 22
Off-the-Job Accident Insurance 23
Discounts and Services 24
Notices and Disclosures 25
- Notice of Medicare Part D Creditable Coverage 25
- New Health Insurance Marketplace Coverage Options and Your Health Coverage 26
- General Notice of Cobra Continuation Coverage Rights 28
- Special Enrollment Notice 31
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) 32
- Newborns' and Mothers' Health Protection Act (NMHPA) 35
- WHCRA Notice 37
- Michelle's Law Notice 37
- Employee Rights Under the Family and Medical Leave Act 38

Glossary of Terms

Coinsurance – The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.



Copayment – A flat fee that you pay toward the cost of covered medical services.

Deductible – A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services. PAD is per admission deductible.

Dependent – Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity) – Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Member – You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

At open enrollment time, you have many decisions to make. Don't let confusing terms trip you up. Refer to this handy list of commonly used terms.

Out-of-pocket Expense – Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket Maximum (OOPM) – The highest out-of-pocket amount paid for covered services during a benefit period.

Premium – The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Usual, Customary and Reasonable (UCR) Allowance – The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.

Group Insurance Eligibility

Employee Eligibility

Employees are eligible to participate if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective following the 90-day waiting period from date of employment. For example, if the employee is hired on April 11, then the effective day of coverage will be July 10.

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child(ren) of the participant or spouse. The term "child" includes the employee's natural child, stepchild, legally adopted, foster child or child recognized under a medical child support order under age 26.

Termination

If an employee separates from employment, insurance will end on the termination date for all coverages, except the hospital indemnity, which will run through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

When to Enroll

Employees can enroll during the annual Open Enrollment period or after satisfying the 90-day waiting period for new hires.

How to Make Changes

Unless you have a qualified change in status, you **cannot** make changes to the benefits you elect until the next open enrollment period. See below for qualifying events.

Section 125

William J. Rand M.D., P.A. currently offers a Section 125 Plan (Cafeteria Plan) which provides a valuable tax benefit. It is authorized by Section 125 of the Internal Revenue Code, which allows employees to elect benefits on a pre-tax basis and restricts any changes except during open enrollment or if you experience a qualifying event. A qualifying event may allow you to add, change or drop coverage during the plan year due to the following reasons listed below (this list is not all inclusive):

- Marriage, Divorce or Legal Separation
- Birth or Adoption of a child
- Switching from FT to PT, vice versus
- Medicare eligibility
- Death of a spouse or dependent
- Change in Spouse's employment status

Not all qualifying events will allow the same election change for each benefit offered. These events must be reported to Human Resources **within 30 days** from the effective date of the qualifying event, or a missed enrollment opportunity will occur.

KNOW WHERE TO GO

If you are faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. In fact, Harvard University reported that 62 percent of personal bankruptcies are caused by medical expenses, making medical debt the leading cause of bankruptcy in America.

If you suddenly fall ill or become injured, how can you determine which facility is most appropriate for you condition.

CONVENIENCE CARE CLINIC

Convenience Care Clinics are equipped to treat minor medical concerns and provide a more affordable option for basic medical services than a visit to the emergency room or even urgent care center. These facilities are staffed by nurse practitioners and physician assistants and conveniently located in nearby pharmacies such as CVS or Walgreens. You can get quick access to medical attention and they are often open nights and weekends.

You should go to the nearest Convenience Care Clinic if you experience any of the following:

- ✓ Cold and flu
- ✓ Sinus infections
- ✓ Allergies
- ✓ Skin rashes
- ✓ Sore throats
- ✓ Pinkeye
- ✓ Headaches
- ✓ Head lice
- ✓ Minor cuts or burns
- ✓ Pregnancy testing
- ✓ Vaccines
- ✓ Ear infections
- ✓ Urinary tract infections

URGENT CARE CENTER

Urgent Care Centers have greater enhance capabilities than convenience care centers. They have doctors and nurses on staff and can provide you immediate medical attention where delaying treatment could cause serious problems or discomfort.

Unlike emergency rooms, they are not equipped to handle life-threatening situations. You can save hundreds of dollars by going to an urgent care center instead of a hospital emergency room.

You should go to the nearest Urgent Care Center if you experience any of the following:

- ✓ Skin rashes and infections
- ✓ Controlled bleeding or cuts that require stitches
- ✓ Sprains or strains
- ✓ Diagnostic services (X-rays, lab tests)
- ✓ High Fever or the flu
- ✓ Vomiting, diarrhea or dehydration
- ✓ Minor broken bones
- ✓ Sever sore throat or cough

EMERGENCY ROOM

Emergency Rooms are equipped to handle life-threatening injuries and illnesses and other serious medical conditions. Patients are seen accordingly to the seriousness of their condition in relation to the other patients.

You should go to the nearest Emergency Room if you experience any of the following:

- ✓ Sudden numbness, weakness
- ✓ Compound fractures
- ✓ Uncontrolled bleeding
- ✓ Seizure or loss of consciousness
- ✓ Poisoning or suspected poisoning
- ✓ Serious head, neck or back injuries
- ✓ Signs of a heart attack or stroke
- ✓ Severe cuts or burns
- ✓ Overdose

Finally, if your symptoms require immediate medical attention; such as, the loss of limb, heart attack or stroke, call 911 and have an ambulance or emergency vehicle come to you.

More than 10 percent of all emergency room visits could have been better addressed in either an urgent care facility or a convenience care clinic. Choosing the appropriate place of care will not only ensure prompt and adequate medical attention, but will also help reduce any unnecessary expenses. Although convenience care clinics and urgent care centers are usually more cost-effective, they are not a substitute for emergency care.

Medical Insurance

Florida Blue	BlueOptions 5302
IN-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$5,000 / $10,000
Coinsurance	30%
Out of Pocket Maximum (Ind/Fam)	$6,350 / $12,700
Lifetime Maximum	Unlimited
Office Services/Preventive Care	
Value Choice Provider/Primary	$0 / $30
Value Choice Specialist/Specialist	$20 / $55
Virtual Visit – Primary/Specialist	$0 / $55
Preventive	$0
Diagnostic Testing Facility	
Independent Clinical Lab/Value Choice Specialist	$0 / $20
Independent Diagnostic Testing Center	Deductible + 30%
Imaging Services (CT/PET Scans, MRIs)	Deductible + 30%
Prescription Drug Program	
Generic / Preferred / Non-preferred	$10 / $50 / $80
Emergency/Urgent Care	
Emergency Room Facility Services	$300
Value Choice/Urgent Care Centers	$0 for visits 1-2, then $60 / $60
Facility Services – Hospital/Surgical	
Inpatient	Deductible + 30%
Outpatient	Deductible + 30%
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$10,000 / $30,000
Coinsurance	50%
Out of Pocket Maximum (Ind/Fam)	$20,000 / $40,000
Per Pay Period Deductions (Bi-Weekly)	
Employee Only	$94.37
Employee + Spouse	$511.22
Employee + Child(ren)	$372.27
Employee + Family	$758.91

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Medical Insurance

Florida Blue	BlueOptions 5360
IN-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$1,500 / $4,500
Coinsurance	20%
Out of Pocket Maximum (Ind/Fam)	$5,000 / $10,000
Lifetime Maximum	Unlimited
Office Services/Preventive Care	
Value Choice Provider/Primary	$0 / $25
Value Choice Specialist/Specialist	$20 / $50
Virtual Visit – Primary/Specialist	$0 / $50
Preventive	$0
Diagnostic Testing Facility	
Independent Clinical Lab/Value Choice Specialist	$0 / $20
Independent Diagnostic Testing Center	$50
Imaging Services (CT/PET Scans, MRIs)	$450
Prescription Drug Program	
Generic / Preferred / Non-preferred	$10 / $50 / $80
Emergency/Urgent Care	
Emergency Room Facility Services	Deductible + 20%
Value Choice/Urgent Care Centers	$0 for visits 1-2, then $55 / $55
Facility Services – Hospital/Surgical	
Inpatient	Deductible + 20%
Outpatient	Deductible + 20%
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$3,000 / $9,000
Coinsurance	40%
Out of Pocket Maximum (Ind/Fam)	$8,000 / $16,000
Per Pay Period Deductions (Bi-Weekly)	
Employee Only	$137.08
Employee + Spouse	$612.87
Employee + Child(ren)	$454.27
Employee + Family	$895.58

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Medical Insurance

Florida Blue	BlueOptions 5182 HSA
IN-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$2,500 / NA
Coinsurance	10%
Out of Pocket Maximum (Ind/Fam)	$5,000 / NA
Lifetime Maximum	Unlimited
Office Services/Preventive Care	
Primary/Family Care Physician	Deductible + 10%
Specialist	Deductible + 10%
Virtual Visit	Deductible + 10%
Preventive	$0
Diagnostic Testing Facility	
Independent Clinical Lab	Deductible
Independent Diagnostic Testing Center	Deductible + 10%
Imaging Services (CT/PET Scans, MRIs)	Deductible + 10%
Prescription Drug Program	
Generic / Preferred / Non-preferred	Deductible + $10 / $50 / $80
Emergency/Urgent Care	
Emergency Room Facility Services	Deductible + 10%
Urgent Care Centers	Deductible + 10%
Facility Services – Hospital/Surgical	
Inpatient	Deductible + 10%
Outpatient	Deductible + 10%
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$5,000 / NA
Coinsurance	40%
Out of Pocket Maximum (Ind/Fam)	$10,000 / NA
Per Pay Period Deductions (Bi-Weekly)	
Employee Only	$82.44
Employee + Spouse	NA
Employee + Child(ren)	NA
Employee + Family	NA

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Medical Insurance

Florida Blue	BlueOptions 5183 HSA
IN-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$5,000 / $5,000
Coinsurance	10%
Out of Pocket Maximum (Ind/Fam)	$6,850 / $10,000
Lifetime Maximum	Unlimited
Office Services/Preventive Care	
Primary/Family Care Physician	Deductible + 10%
Specialist	Deductible + 10%
Virtual Visit	Deductible + 10%
Preventive	$0
Diagnostic Testing Facility	
Independent Clinical Lab	Deductible
Independent Diagnostic Testing Center	Deductible + 10%
Imaging Services (CT/PET Scans, MRIs)	Deductible + 10%
Prescription Drug Program	
Generic / Preferred / Non-preferred	Deductible + $10 / $50 / $80
Emergency/Urgent Care	
Emergency Room Facility Services	Deductible + 10%
Urgent Care Centers	Deductible + 10%
Facility Services – Hospital/Surgical	
Inpatient	Deductible + 10%
Outpatient	Deductible + 10%
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$10,000 / $10,000
Coinsurance	40%
Out of Pocket Maximum (Ind/Fam)	$20,000 / $20,000
Per Pay Period Deductions (Bi-Weekly)	
Employee Only	NA
Employee + Spouse	$482.82
Employee + Child(ren)	$349.36
Employee + Family	$720.72

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Medical Insurance

Florida Blue	BlueOptions 5908
IN-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$5,000 / $10,000
Coinsurance	20%
Out of Pocket Maximum (Ind/Fam)	$8,200 / $16,400
Lifetime Maximum	Unlimited
Office Services/Preventive Care	
Value Choice Provider/Primary	$0 / $30
Value Choice Specialist/Specialist	$20 / $60
Virtual Visit – Primary/Specialist	$0 / $60
Preventive	$0
Diagnostic Testing Facility	
Independent Clinical Lab/Value Choice Specialist	$0 / $20
Independent Diagnostic Testing Center	$60
Imaging Services (CT/PET Scans, MRIs)	Deductible + 20%
Prescription Drug Program	
Generic / Preferred / Non-preferred	$10 / $300 deductible +$60 copay/ Not covered
Emergency/Urgent Care	
Emergency Room Facility Services	$350
Value Choice/Urgent Care Centers	$0 for visits 1-2, then $100 / $100
Facility Services – Hospital/Surgical	
Inpatient	Deductible + 20%
Outpatient	Deductible + 20%
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (Ind/Fam)	$10,000 / $20,000
Coinsurance	50%
Out of Pocket Maximum (Ind/Fam)	$16,400 / $32,800
Per Pay Period Deductions (Bi-Weekly)	
Employee Only	$52.62
Employee + Spouse	$411.85
Employee + Child(ren)	$292.11
Employee + Family	$625.31

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Gap Insurance

***Eligible only to be paired with BlueOptions 5302 and BlueOptions 5360.**

Transamerica	Gap
Inpatient Hospital Benefits	
Your policy pays benefits for inpatient hospital stays, inpatient procedures, inpatient physician charges, and even routine nursery care for dependent children.	$3,000
Outpatient Hospital Benefits	
Your policy also pays benefits (separate from the inpatient hospital benefits) for: >> radiation therapy or chemotherapy authorized by a radiologist, chemotherapist, or an oncologist for outpatient cancer treatment >> outpatient surgery performed in a hospital facility, free-standing surgery center, or physician's office >> MRIs, CT scans, PET scans, diagnostic ultrasounds, electrocardiogram (EKG) tests performed in a physician's office >> cardiac cauterizations and stress tests >> accident injury or emergency condition treatment in a hospital ER or urgent care center >> laboratory tests performed on an outpatient basis in an independent laboratory (a lab that is independent of both an attending or consulting physician's office and of a hospital)	$3,000
Accident-Only Ambulance Benefit	
This benefit is payable when ambulance transportation (ground or air) is required to a hospital or emergency center for injuries sustained in an accident.	$1,000
Per Pay Period Deductions (Bi-Weekly)	
Employee Only	$21.11
Employee + Spouse	$45.83
Employee + Child(ren)	$36.79
Employee + Family	$66.30

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

GAP Insurance

***Eligible only to be paired with BlueOptions 5182/5183.**

APL	Gap
In-Hospital Benefit	
In-Hospital Benefit Maximum	$3,000 (Max of $9,000 for all covered persons combined.)
In-Hospital Deductible	$3,000 per covered person
Benefits include in-hospital confinement, ambulance and in-hospital treatment for mental or emotional disorder (subject to a maximum of 30 days of mental or emotional disorder treatment per covered person per calendar year). All benefits are subject to the in-hospital benefit maximum and in-hospital deductible.	
Outpatient Benefit	
Outpatient Benefit Maximum	$3,000 (Max of $9,000 for all covered persons combined.)
Outpatient Deductible	$3,000 per covered person
Covered outpatient benefits include: • Hospital emergency room • Urgent care facility • Surgery in a hospital outpatient facility or freestanding outpatient surgery center • Diagnostic testing in a hospital outpatient facility or MRI facility • Physical therapy facility • Ambulance • Outpatient treatment for a mental or emotional disorder in a hospital outpatient facility (subject to a maximum of 30 days of mental or emotional disorder treatment per covered person per year). All benefits are subject to the outpatient benefit maximum and outpatient deductible.	
Additional Riders	
Office Treatment, Cancer Outpatient Treatment, Independent Lab Facility, Durable Medical Equipment	

Per Pay Period Deductions (Bi-Weekly)	Ages 18-54	Ages 55+
Employee Only	$14.06	$21.09
Employee + Spouse	$28.14	$42.19
Employee + Child(ren)	$28.89	$35.92
Employee + Family	$42.95	$57.01

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Dental Insurance

Principal – Dental High Plan	In-Network	Non-Network
Deductible		
Per Person	$50	$50
Per Family	$150	$150
Calendar Year Benefit Maximum	$2,500	$2,500
Preventive		
Routine Exams – two per calendar year Routine Cleanings – four per calendar year Fluoride – Child under age 16 Sealants – Child under age 16 X-rays	Plan Pays: 100%, Deductible Waived	Plan Pays: 100%, Deductible Waived (Subject to Balance Billing, based on 90th percentile)
Basic		
Periodontal maintenance Emergency exams Fillings Simple and complex oral surgery General anesthesia/IV sedation Endodontics Periodontics	Plan Pays: 90% After Deductible	Plan Pays: 80%, After Deductible (Subject to Balance Billing, based on 90th percentile)
Major		
Crowns – each 60 months per tooth Core buildup – each 60 months per tooth Implants – each 60 months per tooth Bridges (initial/replacement) – 60 months old Dentures (initial/replacement) – 60 months old	Plan Pays: 60% After Deductible	Plan Pays: 50%, After Deductible (Subject to Balance Billing, based on 90th percentile)
Orthodontia		
Child and Adult	50%, $2,000 Lifetime Max	50%, $2,000 Lifetime Max
Additional Benefits		
Cosmetic and TMJ benefits	50%, $2,000 Lifetime Max	50%, $2,000 Lifetime Max
Per Pay Period Deductions (Bi-Weekly)		
Employee Only	$24.75	
Employee + Spouse	$49.50	
Employee + Child(ren)	$55.86	
Employee + Family	$84.26	

Dental Insurance

Principal – Dental Base Plan	In-Network	Non-Network
Deductible		
Per Person	$50	$50
Per Family	$150	$150
Calendar Year Benefit Maximum	$2,000	$2,000
Preventive		
Routine Exams – two per calendar year Routine Cleanings – four per calendar year Fluoride – Child under age 16 Sealants – Child under age 16 X-rays	Plan Pays: 100%, Deductible Waived	Plan Pays: 100%, Deductible Waived (Subject to Balance Billing, based on MAC)
Basic		
Periodontal maintenance Emergency exams Fillings Simple and complex oral surgery General anesthesia/IV sedation Endodontics Periodontics	Plan Pays: 80% After Deductible	Plan Pays: 80%, After Deductible (Subject to Balance Billing, based on MAC)
Major		
Crowns – each 60 months per tooth Core buildup – each 60 months per tooth Bridges (initial/replacement) – 60 months old Dentures (initial/replacement) – 60 months old	Plan Pays: 50% After Deductible	Plan Pays: 50%, After Deductible (Subject to Balance Billing, based on MAC)
Orthodontia		
Child and Adult	50%, $2,000 Lifetime Max	50%, $2,000 Lifetime Max
Additional Benefits		
Cosmetic and TMJ benefits	NA	NA
Per Pay Period Deductions (Bi-Weekly)		
Employee Only	$14.92	
Employee + Spouse	$29.84	
Employee + Child(ren)	$36.78	
Employee + Family	$54.61	

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Vision Insurance

Florida Blue	In-Network	Non-Network
Exams		
Exam Copay	$10	Up to $40
Exam Frequency	12 months	
Lenses		
Single	$25	Up to $40
Lined Bifocal	$25	Up to $60
Lined Trifocal	$25	Up to $80
Lenses Frequency	12 months	
Frames		
Frames Allowance	$100 allowance; 20% off amount over allowance	Up to $50
Frames Frequency	24 Months	
Contacts (in lieu of frames and lenses)		
Elective Contacts	15% discount for exam, $100 allowance for contacts	Up to $80
Medically Necessary	$25 Covered in full for members who have specific conditions	Up to $225
Elective Contacts Frequency	12 Months	
Per Pay Period Deductions (Bi-Weekly)		
Employee Only	$2.76	
Employee + Spouse	$4.97	
Employee + Child(ren)	$5.24	
Employee + Family	$8.27	

Voluntary Term Life Insurance

William J. Rand, M.D., P.A. provides employees with the opportunity to purchase voluntary life insurance. Below is a quick overview of benefits.

Principal	Voluntary Term Life
Employee Life Benefits	
Benefit Amount	Increments of $10,000
Maximum Benefit Amount	$300,000
Guarantee Issue Amount (During Initial Eligibility Period Only)	If under age 70: $100,000 If over age 70: $10,000
Age Reduction	35% benefit reduction at age 65, with an additional 15% reduction at age 70
Spouse Life Benefits	
Benefit Amount	Increments of $5,000
Maximum Benefit Amount	$100,000 Cannot exceed 100% of employee amount
Guarantee Issue Amount (During Initial Eligibility Period Only)	If under age 70: $30,000 If over age 70: $10,000
Age Reduction	35% benefit reduction at age 65, with an additional 15% reduction at age 70
Child Life Benefits	
Benefit Amount	You may choose to purchase $5,000 or $10,000

*High level benefit summary. Please see your plan summary for a more detailed benefit description

Estimated Bi-Weekly Premium Amounts provided on next page

Voluntary Term Life Deductions

Estimated Employee Bi-Weekly Premium Amounts up to the Guaranteed Issue Amount.

Employee	29 & Under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$10,000	$0.40	$0.43	$0.59	$0.90	$1.33	$2.10	$3.25	$4.47
$20,000	$0.79	$0.86	$1.19	$1.80	$2.66	$4.21	$6.50	$8.94
$30,000	$1.19	$1.28	$1.78	$2.70	$3.98	$6.31	$9.74	$13.41
$40,000	$1.59	$1.72	$2.39	$3.60	$5.32	$8.42	$13.00	$17.89
$50,000	$1.99	$2.15	$2.98	$4.50	$6.65	$10.53	$16.25	$22.36
$60,000	$2.38	$2.58	$3.57	$5.40	$7.98	$12.63	$19.50	$26.83
$70,000	$2.78	$3.00	$4.17	$6.30	$9.30	$14.73	$22.74	$31.31
$80,000	$3.17	$3.43	$4.76	$7.20	$10.63	$16.83	$25.99	$35.78
$90,000	$3.57	$3.86	$5.35	$8.10	$11.96	$18.94	$29.24	$40.25
$100,000	$3.97	$4.30	$5.96	$9.00	$13.30	$21.05	$32.50	$44.73

Estimated Spouse Bi-Weekly Premium Amounts up to the Guaranteed Issue Amount.

Spouse	29 & Under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$5,000	$0.20	$0.21	$0.30	$0.45	$0.66	$1.05	$1.62	$2.24
$10,000	$0.40	$0.43	$0.59	$0.90	$1.33	$2.10	$3.25	$4.47
$15,000	$0.59	$0.64	$0.89	$1.35	$1.99	$3.15	$4.87	$6.71
$20,000	$0.79	$0.86	$1.19	$1.80	$2.66	$4.21	$6.50	$8.94
$25,000	$0.99	$1.07	$1.48	$2.25	$3.32	$5.26	$8.12	$11.18
$30,000	$1.19	$1.28	$1.78	$2.70	$3.98	$6.31	$9.74	$13.41

Estimated Child Bi-Weekly Premium Amounts.

Child Deduction Schedule	
$5,000	$0.46
$10,000	$0.92

Critical Illness Insurance

William J. Rand, M.D., P.A. provides employees with the opportunity to purchase Critical Illness insurance. Below is a quick overview of benefits.

Principal	Critical Illness
Illness	% of Benefit
Invasive cancer	100%
Carcinoma in situ	25%
Coronary artery disease	25%
Heart attack	100%
Major organ failure	100%
Stroke	100%
Multiple Payouts	12 months required between critical illness occurrences and 12 months treatment free for recurring critical illness
Childhood Conditions	
Cerebral palsy	100%
Cleft lip/palate	100%
Cystic fibrosis	100%
Down syndrome	100%
Muscular dystrophy	100%
Spina bifida	100%
Benefit (During Initial Eligibility Period)	
Employee	$5,000 or $10,000
Spouse	$2,500 or $5,000 Up to 50% of your benefit
Children	Automatically covered for 25% of your benefit
Wellness	
Benefit Amount	$50
Limitation	
Preexisting Conditions	6 months prior / 12 months insured

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Estimated Bi-Weekly Premium Amounts provided on next page.

Critical Illness Deductions

Estimated Employee Bi-Weekly Premium Amounts.

Employee	24 & Under	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 & Over
$5,000	$1.19	$1.42	$1.70	$2.15	$2.97	$4.66	$6.90	$9.84	$15.18	$20.12	$27.23
$10,000	$2.39	$2.83	$3.41	$4.31	$5.94	$9.33	$13.80	$19.69	$30.35	$40.24	$54.46

Estimated Spouse Bi-Weekly Premium Amounts.

Spouse	24 & Under	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
$2,500	$0.60	$0.71	$0.85	$1.08	$1.49	$2.33	$3.45	$4.92	$7.59	$10.06
$5,000	$1.19	$1.42	$1.70	$2.15	$2.97	$4.66	$6.90	$9.84	$15.18	$20.12

Spouse coverage terminates at age 70.

Children are automatically covered for 25% of the employee's benefit at no additional cost.

Off-the-Job Accident Insurance

William J. Rand, M.D., P.A. provides employees with the opportunity to purchase Off-the-Job Accident insurance. Below is a quick overview of benefits.

Principal	Benefits Payable
Injury Benefits	
Fractures	Up to $10,000
Dislocations	Up to $7,500
Burns	Up to $5,000
Coma	$15,000
Concussion	$500
Dental Injury	$500
Eye Injury with Surgical Repair	$500
Injuries not specifically listed	$100
Internal Injury	$1,500
Knee cartilage injury with surgical repair	$1,500
Ruptured disc with surgical repair	$1,500
Tendon/ligament/rotator cuff injury with surgical repair	$1,500
AD&D	
Employee	$25,000
Spouse	$12,500
Children	$6,250 per child
Common Carrier	200% of AD&D Benefit
Wellness	
Benefit Amount	$50
Per Pay Period Deductions (Bi-Weekly)	
Employee Only	$7.12
Employee + Spouse	$10.72
Employee + Child(ren)	$12.66
Employee + Family	$19.25

*High level benefit summary. Please see your plan summary for a more detailed benefit description.

Discounts and Services

Laser Vision Correction	**Imagine your life free from glasses and contacts.** You, your spouse and dependent children receive 15% off standard pricing or 5% off promotional pricing on LASIK through the National Lasik Network, administered by LCA-Vision, Inc. principallasik.com I 888-647-3937
Hearing Aid Program/ AHB	**Consider how hearing loss affects the entire family.** That's why you, your spouse, children, parents and grandparents can receive free annual hearing consultations and a 60-day trial on hearing aids through American Hearing Benefits, Inc. (AHB). Plus, you all get discounts on hearing aids through their nationwide network of 3,000+ hearing professionals. principal.com/hearingbenefits/ahb I 877-890-4694
Hearing Aid Program/ EPIC	**Take care of your family's hearing.** You and your family have access to a large network of audiologists and ear, nose and throat (ENT) physicians through Ear Professionals International Corporation (EPIC). All of you get up to 60% off major brand hearing aids. Follow-up care and batteries for one year are included for hearing aids purchased through EPIC. principal.com/hearingbenefits/epic I 866-956-5400 and identify yourself as a Principal customer
Diabetic Living Magazine	**Live fully each and every day while managing diabetes.** You can purchase a one-year subscription for just $16 and get the second year free. Each issue of the magazine offers recipes, weight-loss strategies, a sense of community and more. principal.com/diabeticliving
Travel Assistance	**Ease some of the worries of traveling - whether in the U.S. or internationally.** You, your spouse and dependent children have access to a variety of benefits provided through AXA Assistance 1. These services include travel and medical assistance plus emergency medical evacuation benefits. Assistance is available for travel 100+ miles away from home for up to 120 consecutive days. Available with group term life insurance only. principal.com/travelassistance
Will & Legal Document Center	**Consider creating your simple legal documents online.** These online resources and tools, provided by ARAG®2, are easy-to-use. You and your spouse can create, print and store essential legal documents - such as a will, living will, healthcare power of attorney, durable power of attorney, and medical treatment authorization for minors. Plus, you can access estate planning tools and a personal information organizer. www.ARAGwills.com/Principal.
Identity Theft Kit	**Be proactive in protecting one of your most important assets -your identity.** If your identity is stolen, despite your best efforts, you'll get valuable tips on how to restore it. www.ARAGwills.com/Principal

Notices and Disclosures

Notice of Medicare Part D Creditable 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. **You Employer has determined that the prescription drug coverage offered by Florida Blue is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will (or will not) be affected.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Florida Blue **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 Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- 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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name William J. Rand, M.D., P.A.	4. Employer Identification Number (EIN) 59-2109417	
5. Employer Address 5 West Sample Road	6. Employer Phone Number 954-782-1700	
7. City Pompano Beach	8. State FL	9. Zip Code 33064
10. Who can we contact about employee health coverage at this job? Robin Rosmarin		
11. Phone Number (if different from above)	12. Email Address rrosmarin@randeye.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

Full-time individuals, working a minimum of 30 hours per week who have met the waiting period

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Employee's legal spouse, children, stepchildren, legally adopted children, foster child, or a child place in your custody by a court order up to age 26.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

General Notice of Cobra Continuation Coverage Rights
Continuation Coverage Rights Under Cobra

INTRODUCTION

You are receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

Read this notice carefully to help understand your COBRA rights. Keep in mind that when you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete 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 does not 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 known as 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 may be required to pay for COBRA continuation coverage.

Employee
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events happens:

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

Spouse
If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

Dependent Children
Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources: The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives timely 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. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of **36 months**.
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of **18 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability Extension
If you or anyone in your family covered under the Plan is determined by the Social Security Administration 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 total 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 continuation coverage.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second Qualifying Event Extension
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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. 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.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

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

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

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

Special Enrollment Notice

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

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 request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	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 and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ 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
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.OMB Control Number 1210-0137 (expires 12/31/2019)

Newborns' and Mothers' Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act (NMHPA) was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section.

In October 2008, final regulations relating to the NMHPA were jointly issued by the Internal Revenue Service (IRS), Department of Labor (DOL) and Department of Health and Human Services (HHS). The final regulations replace the interim final regulations that were issued in 1998 and are effective for plan years beginning on or after Jan. 1, 2009.

Coverage Requirements

The NMHPA sets limits on benefits that are provided for hospital stays after childbirth. However, nothing in the law or regulations requires a mother to give birth in a hospital or stay in the hospital for a specific period of time after giving birth. Also, group health plans may not be required to provide any benefits for hospital stays related to childbirth. However, if the plan provides these benefits, it must comply with the NMHPA's minimum requirements.

Hospital Length of Stay

The final regulations clarify when a hospital stay connected with childbirth begins.

- When a delivery occurs in the hospital, the stay begins at the time of delivery, not at the time of admission or beginning of labor.
- If there are multiple births, the stay begins at the time of the last delivery.
- For deliveries that occur outside of the hospital, the stay begins at the time the mother or newborn is admitted.

The decision of whether a hospital stay is connected with childbirth is a medical decision to be made by the attending provider.

Attending Provider Definition

The regulations provide an exception to the NMHPA's general rule regarding length of hospital stay for situations where the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than 48 or 96 hours, as applicable.

The attending provider is "an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child." The final regulations definitively state that the definition of attending provider does not include a plan, hospital, managed care organization or other issuer.

Prohibition on Incentives

The NMHPA contains a number of prohibitions designed to prevent benefits from being improperly limited. The regulations clarify that a group health plan may not deny a mother or her newborn coverage under the plan to avoid the NMHPA's requirements or provide payments or rebates to a mother to encourage her to accept lesser benefits than those provided for by the NMHPA.

Also, a group health plan may not penalize an attending provider for giving care in accordance with the NMHPA or provide incentives to induce an attending provider to discharge a mother or newborn before the end of the required time period. However, a group health plan may negotiate with an attending provider the compensation for care provided for hospital stays related to childbirth in general.

Authorization and Cost-sharing

The final regulations state that a plan may not require a physician or other health care provider to obtain authorization for prescribing a hospital stay in accordance with the NMHPA. In addition, a group health plan may not restrict benefits for a portion of a hospital length of stay provided for by the NMHPA in a way that is less favorable than benefits for a previous portion of the stay.

The regulations do not prohibit imposing cost sharing, such as deductibles or coinsurance, on hospital stays related to childbirth. However, the cost sharing must be consistent for the entire stay and cannot be higher for a later portion of the mandated length of stay.

Notice Requirements

The notice requirements with respect to the NMHPA differ depending on the type of plan or coverage involved. The regulations explain the differences as follows:

- **ERISA Plans.** ERISA's rules for summary plan descriptions (SPDs) require all group health plans to describe the federal or state law requirements applicable to the plan relating to hospital lengths of stay in connection with childbirth for the mother or newborn. Model language regarding the NMHPA is included in the SPD rules.

- **State and Local Government Plans.** Plans that are subject to the NMHPA must provide a notice with specific language describing the federal requirements. The final regulations clarify that the notice can either be included in the plan document that describes benefits or in the type of document the plan generally uses to inform participants and beneficiaries of plan benefit changes. Further, any time a plan distributes one or both of these documents after providing the initial notice, the applicable statement must be included in one or both documents.

- **Health Insurance Issuers in the Individual Marke**t. Health insurance issuers in the individual market must also provide notice in the insurance contract containing specific language regarding the federal rules.

State Insurance Mandates

The NMHPA and the final regulations do not apply to health insurance coverage (and group health plans that provide benefits only through health insurance coverage) in certain states that have adopted laws similar to the NMHPA. The final regulations clarify that a state law qualifies for this exception if it requires the health insurance coverage to do one of the following:

- Provide for at least a 48-hour hospital length of stay after childbirth (96 hours for a cesarean delivery);
- Provide for maternity and pediatric care in accordance with guidelines for care following childbirth established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics or any other established professional medical association; or
- Require, in connection with coverage for maternity care, that the hospital length of stay decision is made by the attending provider in connection with the mother or with the mother's consent.

WHCRA Notice

Women's Health and Cancer Rights Act of 1998

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

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

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

Michelle's Law Notice

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

Employee Rights Under the Family and Medical Leave Act

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

REQUESTING LEAVE

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with
equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave; * and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine
if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or
will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit
against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor Wage and Hour Division

Notes:

Provided by: