2024 JAN-CARE

BENEFITS GUIDE

January 1st, 2024 - December 31st, 2024

THOMPSON RISK
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Table of Contents

Welcome to Your Benefits Overview

We're proud to offer you and your family members valuable benefits from some of the world's leading carriers. Take the time to carefully read through this packet and choose the best fit for you and your family's needs.

- Jan-Care provides three traditional PPO and one HSA plan option for you and your family to choose from.
- Your plans have a great concierge feature: CALL THE NURSE
- New Dental and Vision plan options through MetLife
- If you are seeking medical care, it will be most beneficial to CALL THE NURSE. If you do not, your benefits will be Out-of-Network. **1-866-562-2466**
- To locate a primary care physician or provider within the network, go to **www.multiplan.com**, and click Find a Provider.

Benefits Eligibility

Important Information about Your Benefits

New Hire

A Full-Time employee is eligible for benefits once they meet the new hire waiting period. Your effective date is the 1st of the month following **30 days** from date of hire. You have **30 days** from your hire date to login to your portal to make elections.

Qualifying Life Event (QLE)

Certain life events may allow you to elect or change your coverage during the year. When this occurs, you have **30 days**, by law, from the date of the event to notify us of the change and provide Documentation. See below for communication channels.

Covering Your Family

Your Spouse

You may cover your legally married spouse of the same or opposite gender, on select benefit plans.

Your Children

Natural, adopted, and step-children qualify for select benefit plans through the end of the month in which they reach age 26.

Disabled Dependents: Children who become disabled before age 26 and rely on you for support may be eligible beyond the age of 26.

Documentation: The carrier will require the date of birth and Social Security Number for each covered dependent. Additional documentation may be required on a case-by-case basis.

How to Make Changes?

To make changes outside of the open enrollment period, you must experience a Qualifying Life Event. You MUST notify Human Resources within **30 days** of the event.

Benefits Eligibility

Important Information about Your Benefits

What is Open enrollment?

Open Enrollment is your opportunity to learn about benefits being offered as of 01/01/2024.

During Open Enrollment, you can:

✓Enroll in benefits for the first time or make changes to your benefits for you and your family

✓Terminate current elections – for yourself or dependents

✓Add eligible dependents – legal spouse and/or child(ren)

Deductions for medical are pre-tax, so the impact on your pay will not be as great as the contribution amount. However, due to IRS regulations, the elections you make now for all coverages for which the premium is deducted on a pre-tax basis will remain through **12/31/2024**, unless you have a family status change, such as:

- ❑ Marriage
- ❑ Divorce
- ❑ Birth or Adoption of a child
- ❑ Death
- ❑ Change in spouse's benefits or employment status

This is an IRS regulation. You MUST notify your administrator within 30 days of the event, or you will lose the right to modify your election until the next open enrollment.

PHCS Network Managed through SISCO

MEMBER PORTAL ACCESS INSTRUCTIONS

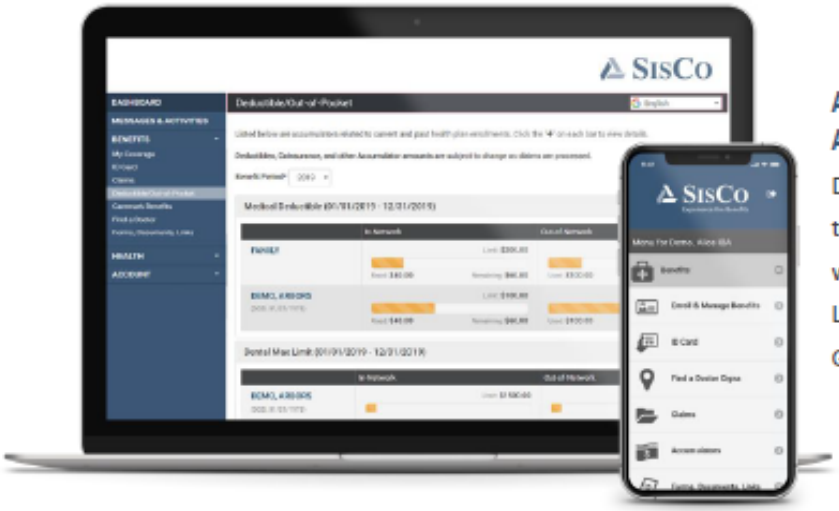
REGISTRATION

1. Visit your Member Portal at **https://siscoconnect.com**.
2. In the upper right corner of the Member Portal home screen, click **Register Now**.
3. Fill out the Registration Form and click Submit. Your **ID Number** is printed on your ID Card.

LOGGING IN

Once you've registered for the Member Portal, use your username and password to log in. The **Login** button is in the upper right corner of the Member Portal home screen.

For plan questions and technical support, contact a Wellness Navigator at **800.457.4726** or **sisco.service@siscobenefits.com**.



ACCESS ANYTIME, ANYWHERE

Download the Sisco Connect mobile app to access the same great health plan and wellness features as your Member Portal. Look for it in the Apple App Store and Google Play Store.

Medical and Rx

It is always most beneficial to stay in network.
What's even more beneficial? - **A Guided Provider. Call AIMM every time!**

	PPO- Option 1		***PPO – Option 2***	
Plan Name	**HSA Qualified- $2000**		**EMERALD- $0**	
PHCS	In-Network	Out-of-Network	In-network	Out-of-Network
	PHCS - GUIDED	PHCS - Non-GUIDED	PHCS - GUIDED	PHCS - Non-GUIDED
Calendar year Deductible Ind/Fam	$2,000 / $4,000	$5,000 / $10,000	$0	$5,000 / $10,000
Coinsurance	0%	50%	0%	50%
OOP Ind/Fam	$3,500 / $7,000	$10,000 / $20,000	$4,000 / $4,000	$10,000 / $20,000
Common Services				
Preventive Care	Covered in Full	CYD + 50%	Covered In Full	CYD + 50%
Telemedicine	Covered in Full	Covered in Full	Covered In Full	Covered In Full
PCP Copay	CYD	CYD + 50%	$30	CYD + 50%
Specialist Copay	CYD	CYD + 50%	$50	CYD + 50%
Lab	CYD	CYD + 50%	$30	CYD + 50%
X-Ray (Ind Facility)	CYD	CYD + 50%	$30	CYD + 50%
Imaging (CT/PET, MRI)	CYD	CYD + 50%	$80	CYD + 50%
Urgent Care	CYD	CYD + 50%	$40	CYD + 50%
Emergency Room	CYD	CYD + 50%	$200	CYD + 50%
Hospital Outpatient	CYD	CYD + 50%	$80	CYD + 50%
Hospital Inpatient	CYD	CYD + 50%	$1,500 Per Confinement	CYD + 50%
Pharmacy				
Tier 1	CYD, $0		$0	
US-Rx Care Tier 2	CYD, $20		$20	
Tier 3	CYD, $75		$75	
Tier 4	CYD, $150		$150	

IMPORTANT NOTE: This is only a partial listing of the in-network benefit provisions under the plans offered. Other copays and limitations may apply. See the Summary of Benefits and Coverage for each plan for specific information.

Medical and Rx

It is always most beneficial to stay in network.
What's even more beneficial? - **A Guided Provider. Call AIMM every time!**

	PPO – Option 3		***PPO – Option 4***	
Plan Name	**Ruby- $0**		**Diamond- $0**	
PHCS	In-Network	Out-of-Network	In-Network	Out-of-Network
	PHCS - GUIDED	PHCS - Non-GUIDED	PHCS - GUIDED	PHCS - Non-GUIDED
Calendar year Deductible Ind/Fam	$0 / $0	$5,000 / $10,000	$0 / $0	$3,000 / $6,000
Coinsurance	100% / 0%	70% / 30%	100% / 0%	80% / 20%
OOP Ind/Fam	$3,000 / $3,000	$10,000 / $20,000	$2,500 / $2,500	$6,000 / $12,000
Preventive Care	Covered in Full	CYD + 30%	Covered in Full	CYD + 20%
Telemedicine	Covered in Full	Covered in Full	Covered in Full	Covered in Full
PCP Copay	$20	CYD + 30%	$0	CYD + 20%
Specialist Copay	$40	CYD + 30%	$0	CYD + 20%
Lab	$20	CYD + 30%	$0	CYD + 20%
X-Ray (Ind Facility)	$20	CYD + 30%	$0	CYD + 20%
Imaging (CT/PET, MRI)	$60	CYD + 30%	$0	CYD + 20%
Urgent Care	$20	CYD + 30%	$0	CYD + 20%
Emergency Room	$200	CYD + 30%	$0	CYD + 20%
Hospital Outpatient	$60	CYD + 30%	$0	CYD + 20%
Hospital Inpatient	$500 Per Confinement	CYD + 30%	$0	CYD + 20%
Pharmacy				
Tier 1	$0		$0	
Tier 2	$20		$20	
US-Rx Care Tier 3	$75		$75	
Tier 4	$150		$150	

IMPORTANT NOTE: This is only a partial listing of the in-network benefit provisions under the plans offered. Other copays and limitations may apply. See the Summary of Benefits and Coverage for each plan for specific information.

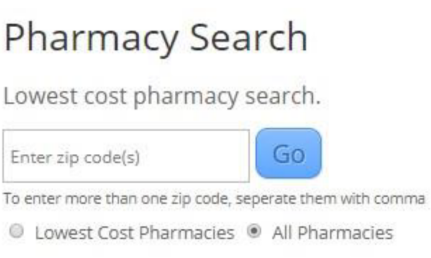
1-866-562-2466 CALL THE NURSE

- **AIMM is a team of nurses who are dedicated to you. If you want to get better Quality of Care and find the highest Quality providers, CALL THE NURSE!**
- **The AIMM team can help you make sure that the Doctor is the best choice by showing you which Doctor is the safest, smartest choice for your health! CALL THE NURSE!**
- **If you are seeking medical care, it will be most beneficial to CALL THE NURSE. If you do not CALL THE NURSE, your benefits will be Out-of-Network.**

US-Rx Care is our prescription provider: US-Rx Care helps you find the lowest cost, high quality prescriptions for you and your family!

US-Rx Care - Lowest Cost Pharmacy Search

Through your web browser access: https://usrxcare.com/members/
Click on the **'Pharmacy Search'** tab. Scroll down on the 'Pharmacy Search' tab to bottom right-**Pharmacy Search.**



- How does US-Rx Care work when I go to the pharmacy?
- Use your SmartPhone to focus the camera on the QR Code to the right and watch a **simple video explainer.** **> > >**
- You will find this is no different than how you've used other health insurance before!

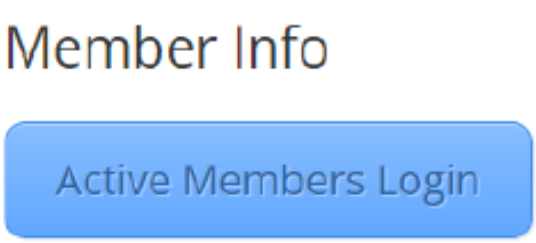
Prescription Drug Plan

To register for the on-line member portal, you will need the cardholder ID on your benefits card. You will also need your **Rx Group Number**. If you cannot locate your Rx Group Number on your ID card, you can obtain it by calling member services at 877-200-5533. *NOTE: Dependents over the age of 18 must register for their own accounts.*

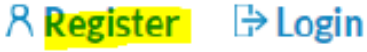
Below are instructions for registering in the US-Rx Care Member Portal:

1. Visit https://usrxcare.com/member/

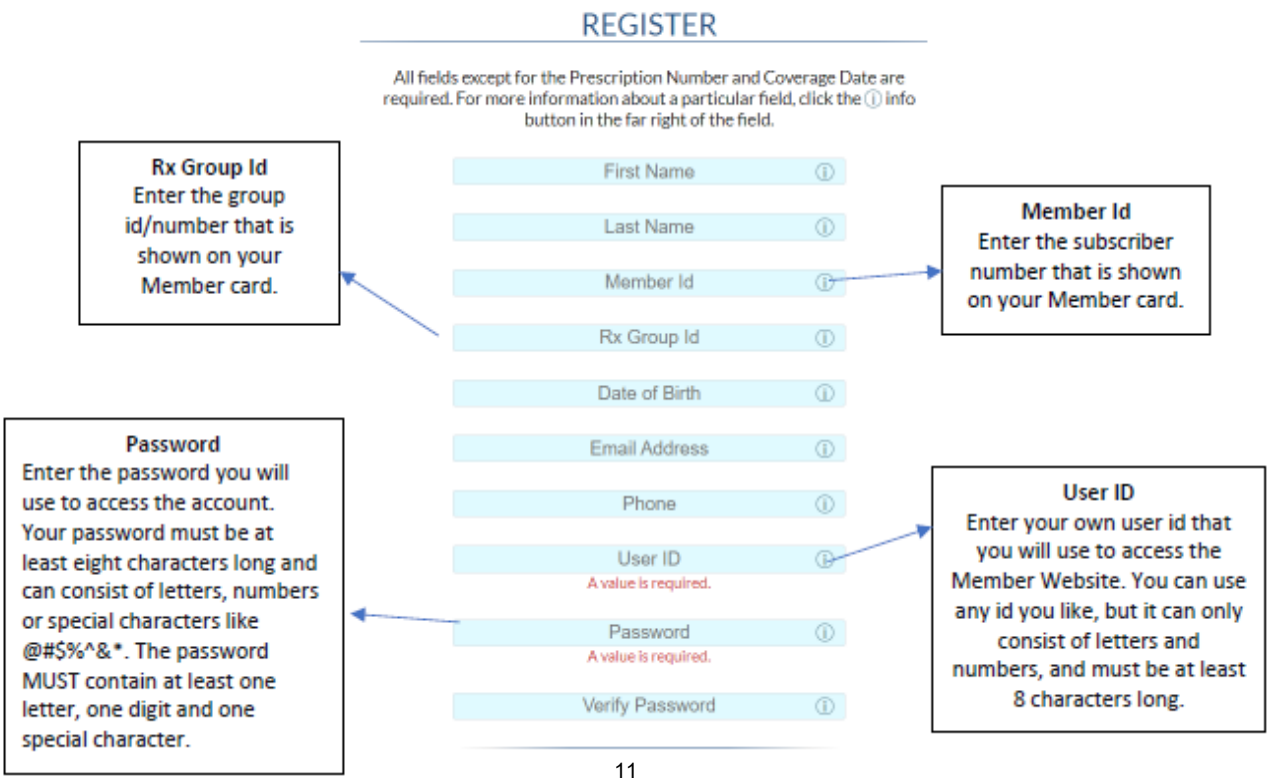
2. Click on Active Members Login under Member Info.



3. Click on Register at the top right of the screen:

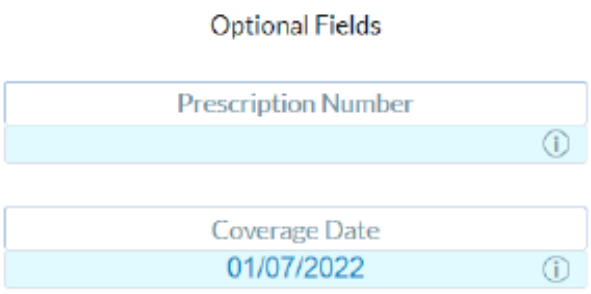


4. Complete all fields. Click on ⓘ for a definition of fields.



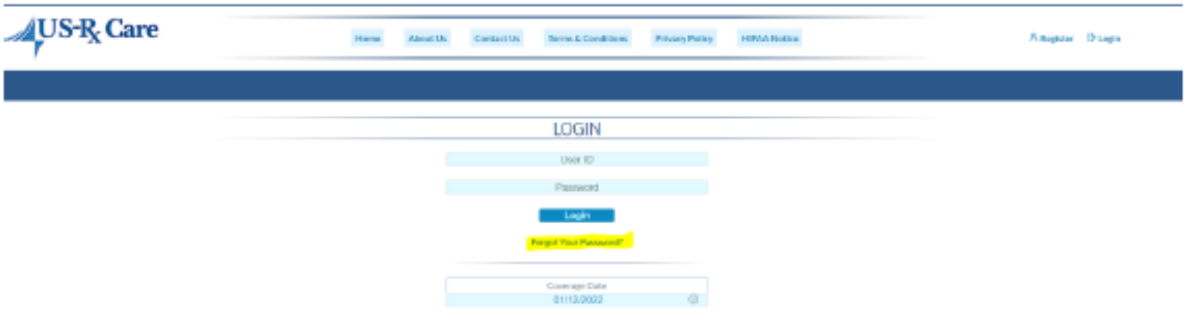
Prescription Drug Plan

5. Optional Fields are not required to register.



6. Click - 

7. If you forgot your password, on the LOGIN screen, press Forgot Your Password?



Enter your information under FORGOT PASSWORD and press Submit and a password will be sent to your email on file.

If you forget your User Id, you can **register again** and use a different user ID. Make sure you write it down so you can remember it. You can use the same email address you used originally.

US-Rx Care

ScriptSourcing Mandatory MAP Program

US Rx Care
Prior Auth
+
ScriptSourcing
Approval
=
FREE Rx

When you have a prior authorization through US RxCare for an approved specialty medication, **ScriptSourcing will begin contacting** you to walk through the approval process for the MAP Program. Meanwhile you will be allowed **two 30-day fills only**.

ONLY IF Prior Authorization is completed through US RxCare will your ScriptSourcing MAP Program approval be authorized to continue filling the script.

High-Cost Drug Management

scriptsourcing

$0 RX COPAY PROGRAM

Name-brand maintenance & specialty medications

Med-Finder

Scan here to search for your medication & schedule a call
or
Call 410-902-8811

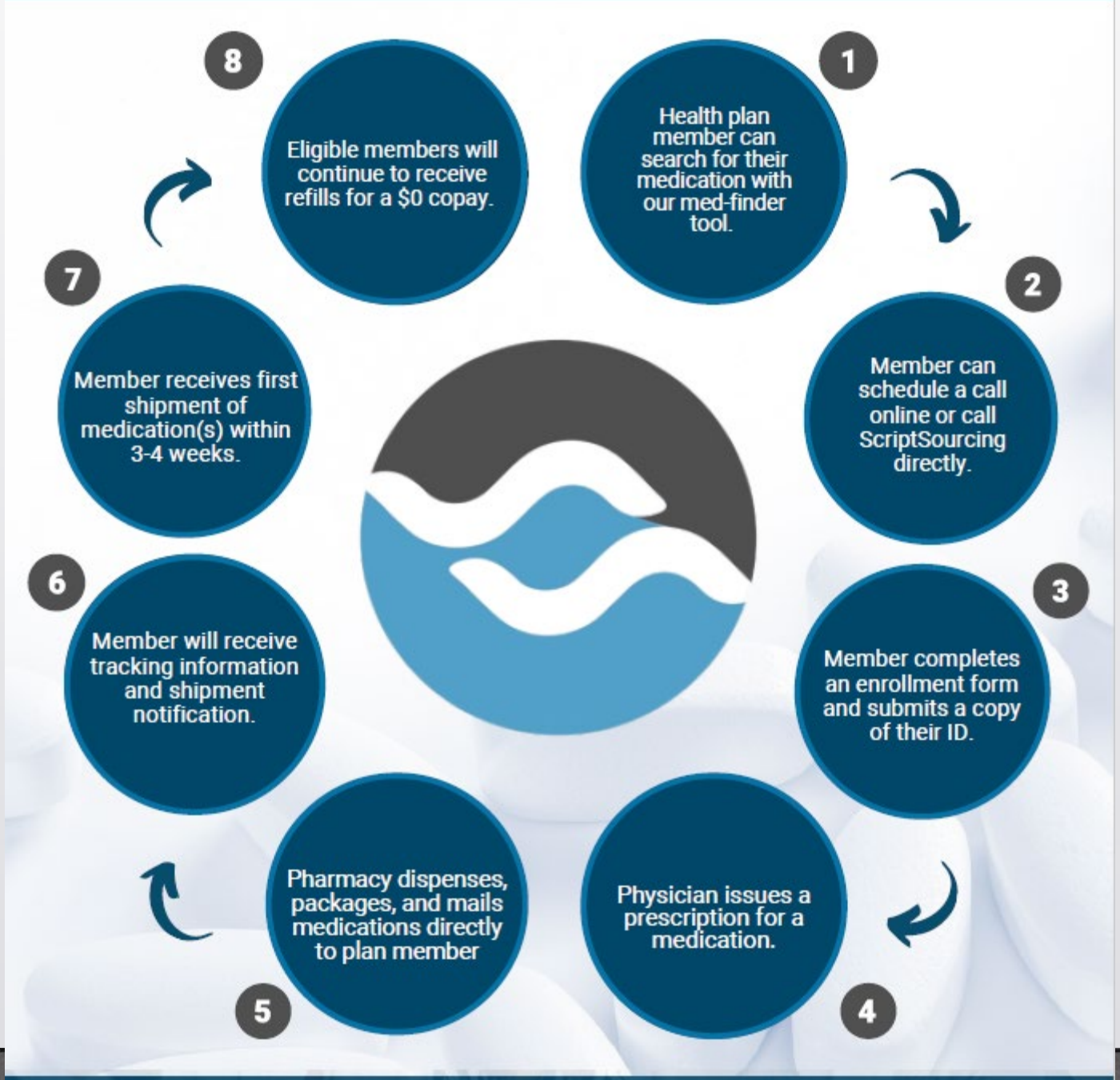
How to Enroll

1. **Search for Your Medication**
   Use the Med-Finder tool or call us directly and ask for a member advocate.
2. **Submit Your Enrollment Forms**
   A member advocate will walk you through the entire enrollment process.
3. **$0 COPAYS**
   Once enrolled you receive your medication(s) at no cost.

- Employees and their dependents pay a **$0 copay** for their medication(s).
- ScriptSourcing saves the health plan money and **lowers premiums** and **deductibles**.
- Prescriptions are **shipped directly** to the member.

WWW.SCRIPTSOURCING.COM/MED-FINDER

HOW DOES IT WORK?
INTERNATIONAL PHARMACY PROGRAM



2023 IPP FLOWCHART - SCRIPTSOURCING, LLC

Health Savings Accounts & Flexible Spending Accounts

The Relationship Between an HDHP and an HSA

When you enroll in a High Deductible Health Plan (HDHP), with a higher deductible than a traditional health plan, it also features a Health Savings Account (HSA) that enables you to pay for current, qualified health care expenses and/or save for future expenses on a tax-free basis. You can only use HSA funds as they are deposited into your account. You can always reimburse yourself later once you have accumulated the funds in your account by submitting a claim to your HSA.

An HSA account with Health Equity will automatically be created for you when you enroll in medical, IF you are enrolled in the employer sponsored SISCO health plan.

2024 IRS HSA Contribution Maximums

- **Individual: $4,150**
- **All other tiers: $8,300**

If you are age 55+ by December 31,2024, you may contribute an **additional $1,000.**

Accessing your HSA

Your Health Equity card will be mailed to your address and will need to be activated before use. You can easily manage your HSA account through healthequity.com and logging in as a member. Follow the steps below:

1. Select *My Coverage*
2. Select *Spending Accounts,* then click Go to your *Health Saving Account*
3. First-time visitors should select *Begin now* and follow the step-by-step verification process.

You cannot contribute to an HSA if the following applies to you:

- You are covered by a non-HSA eligible medical plan, healthcare FSA (including a healthcare FSA that your spouse may have enrolled in through his or her employer), or Health Reimbursement Arrangement.
- You are eligible to be claimed as a dependent on someone else's tax return.
- You are enrolled in Medicare or Medicaid.
- You have received Veterans Administration benefits in the last three months, unless the condition for which you received care was service related.
- Refer to IRS Publication 969 for details.

HSA OPTIONS

USE HSA DOLLARS TODAY

Use your HSA dollars today to pay for eligible expenses such as: deductibles, dental expenses, eye exams, menstrual products, over-the-counter medications, and prescriptions.

SAVE HSA DOLLARS FOR TOMORROW

Use your HSA to prepare for the unexpected. An HSA allows you to save and roll over money from year to year. The money in the account is always yours, even if you change health plans or jobs.

INVEST HSA DOLLARS FOR RETIREMENT

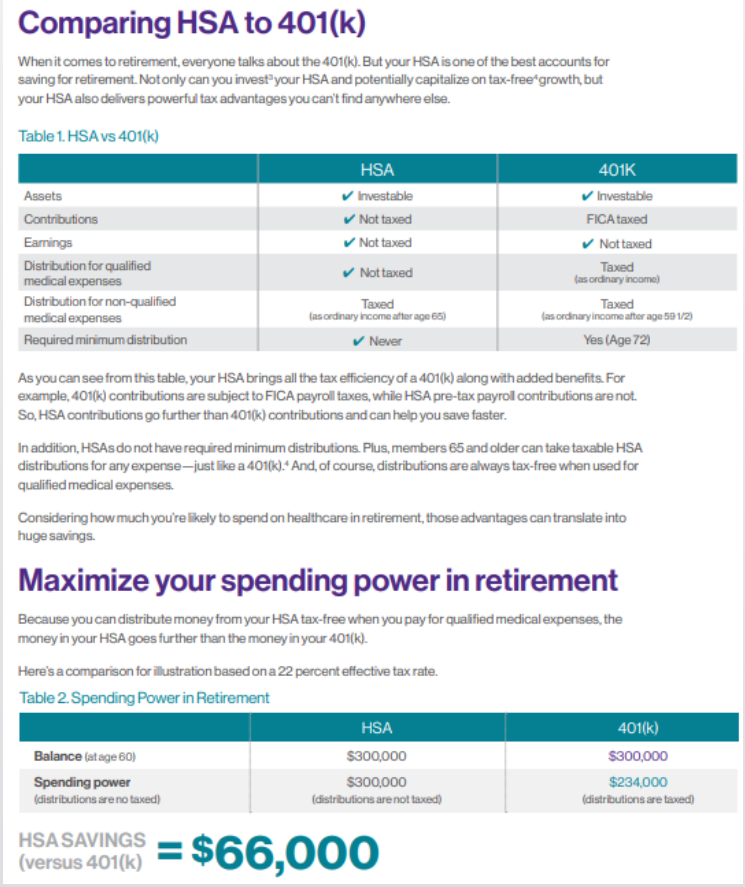
The money in your HSA can be invested and grown tax-free — including interest and investment earnings once your balance reaches $1000. After you reach age 65, your HSA dollars can be spent penalty free on any expense.

DOWNLOAD YOUR FREE HSA INVESTMENT GUIDE

CLICK HERE >>

Financial Wellness Tips

- Add a beneficiary to ensure your account savings benefit your loved ones in the event of your death.
- Elect to receive e-statements to save a monthly statement fee.



Comparing HSA to 401(k)

When it comes to retirement, everyone talks about the 401(k). But your HSA is one of the best accounts for saving for retirement. Not only can you invest[3] your HSA and potentially capitalize on tax-free[4] growth, but your HSA also delivers powerful tax advantages you can't find anywhere else.

Table 1. HSA vs 401(k)

	HSA	401K
Assets	✔ Investable	✔ Investable
Contributions	✔ Not taxed	FICA taxed
Earnings	✔ Not taxed	✔ Not taxed
Distribution for qualified medical expenses	✔ Not taxed	Taxed (as ordinary income)
Distribution for non-qualified medical expenses	Taxed (as ordinary income after age 65)	Taxed (as ordinary income after age 59 1/2)
Required minimum distribution	✔ Never	Yes (Age 72)

As you can see from this table, your HSA brings all the tax efficiency of a 401(k) along with added benefits. For example, 401(k) contributions are subject to FICA payroll taxes, while HSA pre-tax payroll contributions are not. So, HSA contributions go further than 401(k) contributions and can help you save faster.

In addition, HSAs do not have required minimum distributions. Plus, members 65 and older can take taxable HSA distributions for any expense—just like a 401(k).[4] And, of course, distributions are always tax-free when used for qualified medical expenses.

Considering how much you're likely to spend on healthcare in retirement, those advantages can translate into huge savings.

Maximize your spending power in retirement

Because you can distribute money from your HSA tax-free when you pay for qualified medical expenses, the money in your HSA goes further than the money in your 401(k).

Here's a comparison for illustration based on a 22 percent effective tax rate.

Table 2. Spending Power in Retirement

	HSA	401(k)
Balance (at age 60)	$300,000	$300,000
Spending power (distributions are no taxed)	$300,000 (distributions are not taxed)	$234,000 (distributions are taxed)

HSA SAVINGS (versus 401(k)) = $66,000

HealthEquity

Health Savings Account

HealthEquity®

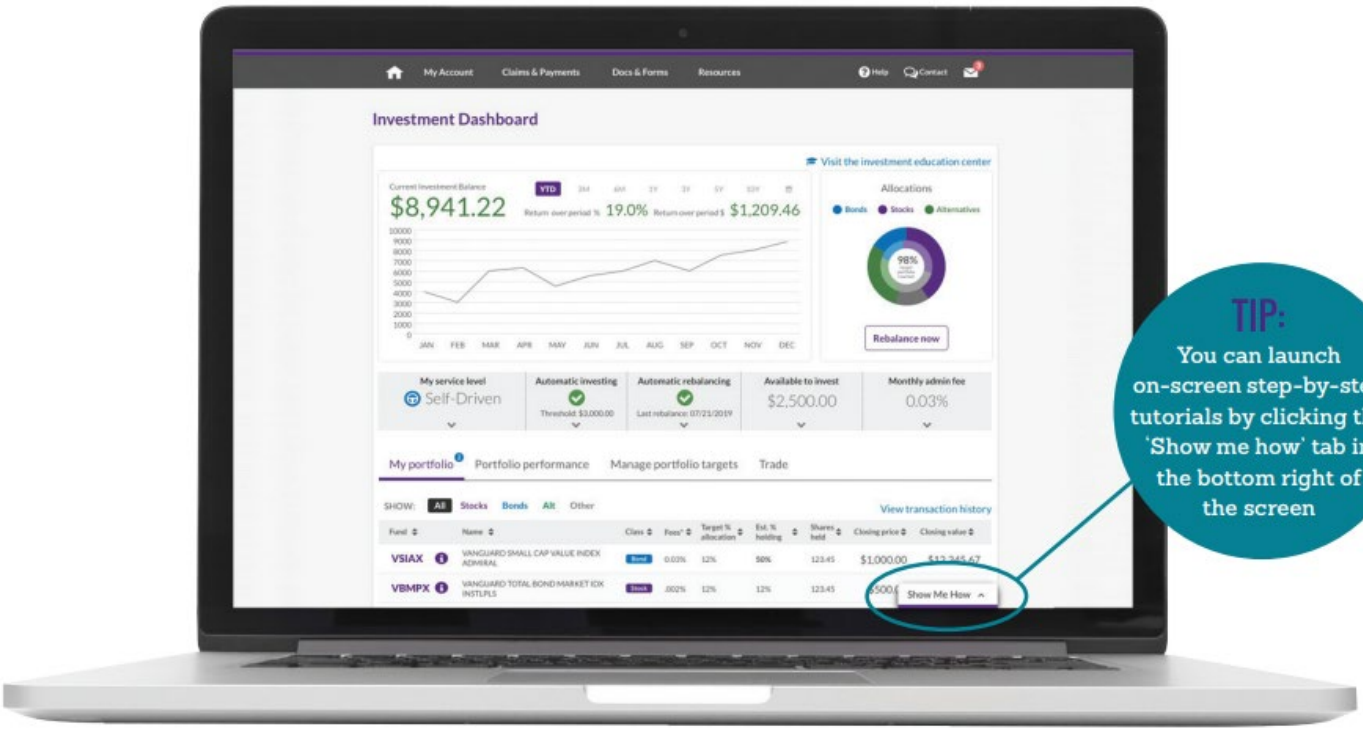
GETTING STARTED: HSA INVESTMENT DESKTOP

HealthEquity makes it easy to invest your HSA dollars. Here's how to access the HSA Investment Desktop:

1. Log into your HealthEquity member account
2. Hover over 'My Account' in the navigation bar
3. Select 'Investments' from the dropdown menu

Once inside, you have several options to choose and manage your investments.

- View portfolio performance and allocation
- Set portfolio targets
- Research fund options and historical performance
- Buy, sell and trade funds
- Automatically reinvest earnings and rebalance investments



Questions? We're here for you 24/7
866.735.8195 | HealthEquity.com/Learn

Healthcare Flexible Spending Account

This benefit allows you to set aside money on a pre-tax basis for qualified Medical expenses. Your election is binding for the plan year and cannot be adjusted unless you experience a Qualifying Life Event. This plan allows you to carry over up to **$640** of unused Healthcare FSA funds at the end of the plan year. However. Unused funds in excess of **$640** in the account will be forfeited at the end of the plan year.

How it Works

Annual Maximum FSA Election	Qualified Expenses	Ineligible Expenses
$3,200	• Health related costs (medical, dental, and vision copays) • Prescription medication	• Cosmetic surgery • Non-prescription medication • Life insurance premiums

Dependent Care Spending Account

This benefit allows you to set aside money on a pre-tax basis for qualified Dependent Care expenses for children under age 13 and adults IRS dependents incapable of self-care.

How it Works

Annual Maximum FSA Election	Qualified Expenses	Ineligible Expenses
$5,000 per Household **$2,500** if married filing jointly	• Work/ day childcare services • Cost of care at a licensed daycare • Before or after- school care	• Education expenses • Transportation expenses for childcare

Dental Benefits – NEW CARRIER

We're proud to offer you and your family members two dental benefit plan options this year through MetLife.

Voluntary Dental

Class Description	All Active Full Time Employees High (30 Hours)		All Active Full Time Employees Low (30 Hours)	
	In-Network	Out-of-Network*	In-Network	**Out-of-Network***
Reimbursement	Negotiated Fee Schedule	R&C 80th Percentile	Negotiated Fee Schedule	**R&C 80th Percentile**
Type A – Preventive	100%	100%	100%	**100%**
Type B – Basic	90%	90%	60%	**60%**
Type C – Major	60%	60%	30%	**30%**
Calendar Year Deductible applies to:	B & C	B & C	B & C	B & C
Individual	$50	$50	$50	$50
Family	$150 Aggregate	$150 Aggregate	$150 Aggregate	$150 Aggregate
Calendar Year Maximum (applies to A,B,C services)	**$5,000**	**$5,000**	**$1,000**	**$1,000**
Orthodontia	50%	50%	Not Covered	Not Covered
Orthodontia Lifetime Maximum	**$1,500**	**$1,500**	**Not Covered**	**Not Covered**

*** Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.**

MetLife

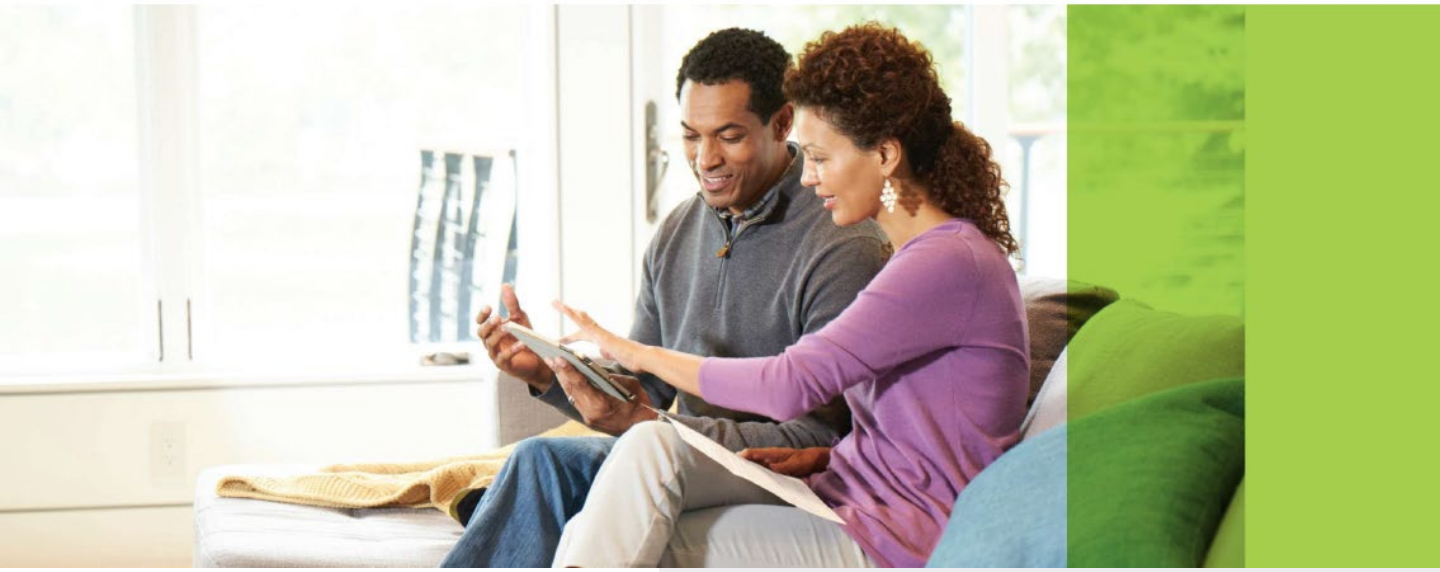
Vision Benefits– NEW CARRIER

We're excited to offer a new vision benefit plan option through MetLife with the VSP Network.

VSP Choice		
Class Description	All Active Full Time Employees (30 Hours)	
Plan Name	M200D-10/25	
Reimbursement	In-Network Coverage (Using a Network Provider)	Out-of-Network Reimbursement (Using a Non-Network Provider)
Eye Examination		
Comprehensive exam of visual functions and prescription of corrective eyewear.	$10 copay	$45 allowance
Retinal Imaging This screening is used to take pictures of the inside of the eye particularly the retina to look for possible changes.	Up to $39 copay	Applied to the exam allowance
Materials / Eyewear (Either Glasses or Contacts)		
Standard Corrective Lenses Single vision	$25 copay	$30 allowance
Lined bifocal	$25 copay	$50 allowance
Lined trifocal	$25 copay	$65 allowance
Lenticular	$25 copay	$100 allowance
Frame Allowance (You will receive an additional 20% off any amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.) Costco, Walmart and Sam's Club	$200 allowance $220 allowance on featured frames $110 allowance	$70 allowance
Contact Lenses		
Elective	$200 allowance	$105 allowance
Necessary	Covered in full after eyewear copay	$210 allowance
Contact Fitting and Evaluation	Standard or Premium fit: Copay not to exceed $60"	Applied to the contact lens allowance
Laser Vision correction[2]	Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Offer is only available at MetLife participating locations.	

MetLife | MyBenefits

Learn more about your MetLife benefits



The MetLife Mobile App is available on the iTunes® App Store and Google Play. Download the app, and use it to find a participating dentist, view your claims[1] and to see your ID card.[2]

metlife.com/mybenefits

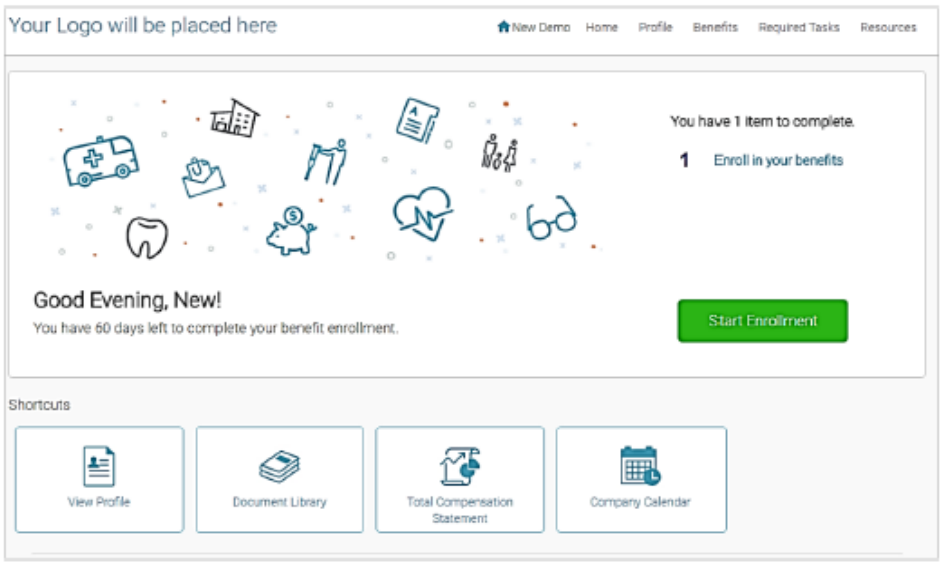
MetLife benefits information right from your desktop or handheld device.

- View Dental Plans
- Find a Participating Provider
- View and Print ID Cards
- Contact MetLife customer service and claims filing.

How to enroll

Visit to https://employeenavigator.com/

- Please create a username
- If you are a new user, click on Register as a new user
- Enter first name, last name, company identifier [Insert Identifer], pin (last 4 of SSN), and DOB
- Create username (recommended to use company email) and password (must include uppercase, lowercase, number and symbol-minimum of 6 characters)
- Sign in and accept the terms and conditions
- Once signed in, click on the green “Start Enrollment” button
- If you wish to shop spouse/dependent rates, they must be added on Step 3



For Questions about Your Benefits

SisCo
Phone Number: 800.457.4726
To verify eligibility, inquire about benefits or check claim status.

US-Rx Care for Prescriptions and Rx Approvals
Phone Number: 877.200.5533
Mail Order: 877.451.4994
usrxcare.com/member

ScriptSourcing for Specialty Drugs at a Low Cost
Phone Number: 410.902.8811
usrxcare.com/member

AIMM - CALL THE NURSE
Phone Number: 888.562.2466

PHCS Provider Search
www.multiplan.com/

MetLife for Dental and Vision
www.metlife.com/mybenefits

Health Equity HSA/FSA
Phone Number: 866.735.8195
www.multiplan.com/

THOMPSON RISK
Powered by Vensure

Employer Notices

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that addresses the privacy and security of certain individually identifiable health information, called protected health information (or PHI). You have certain rights with respect to your PHI, including a right to see or get a copy of your health and claims records and other health information maintained by a health plan or carrier. For a copy of the Notice of Privacy Practices, describing how your PHI may be used and disclosed and how you get access to the information, contact Human Resources.

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman'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:

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

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

Newborns' and Mothers' Health Protection Act Disclosure

Group health plans and health insurance issuers generally may not, under Feder l 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).

Patient Protection Notice

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your carrier 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 your 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.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself 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).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you 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. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources.

Employer Notices [Continued]

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 July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Employer Notices [Continued]

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – 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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Employer Notices [Continued]

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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 1/31/2026)

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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.

Employer Notices [Continued]

USERRA Notice
Your Rights Under USERRA

A. 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.

B. 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.

C. 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.

D. 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 do not 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.

E. 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 Web site 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, Veterans' Employment and Training Service, 1-866-487-2365.

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)
** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

Employer Notices [Continued]

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)
** Continuation Coverage Rights Under COBRA**

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to HR.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 addition months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred

Employer Notices [Continued]

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)
** Continuation Coverage Rights Under COBRA**

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Region or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/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.

https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

MEDICARE PART D
Important Notice About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Jan-Care has determined that the prescription drug coverage offered by Jan-Care 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 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage 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 will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Great Lakes Surgical Center, LLC 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.

Employer Notices [Continued]

MEDICARE PART D
Important Notice About Your Prescription Drug Coverage and Medicare

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Jan-Care changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 Jan-Care.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.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

Employer Notices [Continued]

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 Jan-Care Ambulance, Inc		4. Employer Identification Number (EIN) 55-0687929
5. Employer address 117 South Fayette St		6. Employer phone number 304-255-2931
7. City Beckly	8. State WV	9. ZIP code 25802
10. Who can we contact about employee health coverage at this job? Brent Osborne		
11. Phone number (if different from above)	12. Email address bosborne@jancare.comcom	

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:

Working the hours defined in the handbook as Full-Time. Full-time employees must work at least 30 hours per week however, additional hours may be required based on business needs. Benefits are effective first of the month following 30 days of continuous employment.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Natural, adopted, and/or step-child(ren), legal spouse

☐ 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.

If you decide to shop for coverage in the Marketplace, www.HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit www.HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.