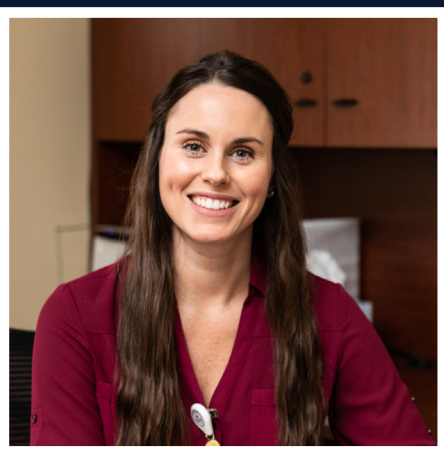
Your Health BEGINS HERE

START

END



2021 EMPLOYEE BENEFITS GUIDE

PARAGON REHABILITATION
A Synchrony Health Service

TRILOGY HEALTH SERVICES, LLC

PCA PHARMACY
A Synchrony Health Service

A WELCOME FROM THE PRESIDENT/CEO

Hello Trilogy Family!

At Trilogy, we have a tagline that perfectly sums up our philosophy: Where Family Comes to Live. We believe in serving you, our family, so that you can live your life to the fullest, both inside and outside of the workplace. This is why we're so passionate about offering you benefits that support you and your family financially, physically, emotionally, and socially. These benefits are conveniently outlined in this Benefits Guide, which we hope will serve as a valuable resource for you as you make decisions for yourself and those you love.

Of course, some of the most important decisions you'll make in your life concern your health. Our comprehensive wellness program, TrilogyFIT, is filled with perks, easy access to support, and rewards for living a healthy lifestyle. We even offer a wellness rate for employees who complete three easy (and free!) steps. This is just one of the ways we care for you as you care for others.

Our benefits have proven to be a life-changing asset to healthcare heroes – especially in times of turmoil. With the changes of 2020 having impacted us all in different ways, the value of benefits such as Purchasing Power, Marketplace Chaplains, and Will preparation cannot be overstated. By offering you these resources, we're making a promise that we'll always be here to provide you with the support you need, when you need it.

In addition to the resources available in this guide, you can also refer to our Virtual Benefits Fair - a new website where you can watch videos and read about all of the amazing benefits that we have to offer. If you have any questions during your selection process and beyond, your DirectPath Advocate is an invaluable resource. In addition to helping you choose what's best for your family, they can also advise you on everything from cost to finding doctors in your network.

Every benefit we offer our Trilogy family members is offered for a reason. As you review this guide and select your benefits, consider the reasons behind your choices. Do you want to improve your personal wellness? Take control of your finances? Grow your family? You can do it all, and we're here to help. I encourage you to read through this guide carefully, and to refer to it often. For your convenience, it is available via Red e App, on Trilogy University and in MyADP. Thank you for joining us in our mission of serving others!

Wishing you well,

Leigh Ann Barney

Leigh Ann Barney | President / CEO
Trilogy Health Services, LLC

"Benefits are not benefits unless we use them."

CONTENTS

This Benefits Guide is intended to be a brief summary. More detail is available in the Summary Plan Description of most benefits, as well as in the plan documents, contracts, and insurance policies governing each benefit. If any of those documents conflict with this summary, those other documents supersede this guide. Benefit plans are subject to change, amendment, or termination without notice or the agreement of any employee/participant.

WHAT'S NEW THIS YEAR

SYNCHRONY PHARMACY

New Pharmacy Option:
New April 1, 2021, you can refill your maintenance medicine through Synchrony Pharmacy, a subsidiary of PCA. Not only will it be cheaper, your prescription will be delivered to your home. ***See more information on pages 7 & 24.***

TRILOGY VIRTUAL BENEFITS FAIR

Visit **www.trilogybenefitsfair.com** to learn more about the benefits and resources available to you or contact DirectPath at 866-253-2273.

ELIGIBILITY

Effective February 7, 2021 employees are eligible for benefits on the first of the month following 60 days of employment.

What benefits am I eligible for?

- Full time employees: All benefits.
- Part time employees: All benefits except for Medical, Basic Life Insurance and Orthodontia.
- PRN employees: Trilogy Perks and BeWell EAP.
- Full time, part time and PRN employees are defined in the Trilogy Employee Handbook.

PLEASE NOTE: ALL EMPLOYEES HAVE 30 DAYS FROM THE DATE OF HIRE OR THE DATE OF THE STATUS CHANGE TO ENROLL.

SUMMARY OF PLANS

PLAN DETAILS

All three plans use the Anthem Blue Cross Blue Shield network which is a strong national network with quality providers in the areas where you live and work and cover the same services, specialty care, emergency services and 100% free preventive care. The plans limit your out-of-pocket costs but there are some important differences you should consider. Read the information below to help you make the right choice. ***See page 6 – 8 for a comparison of the plans offered.***

The Smart Choice Plan

A high deductible plan aligned with a special savings account called a Health Savings Account (HSA) with Fidelity. You pay the full cost for services and prescriptions when you stay in-network. You can pay-out-of-pocket or use money from your HSA *(Trilogy helps to fund your account and you may also contribute)*. Once you satisfy your deductible, more traditional coverage begins where you and Trilogy share costs through coinsurance *(You pay 10% if in-network until you reach out of pocket max)*.

The Traditional PPO Plan

A Preferred Provider Option with a lower deductible and copay for most services. This plan is aligned with an account called a Flexible Spending Account (FSA) with BMS. You pay the co-pay for services and prescriptions when you stay in-network. You can pay out-of-pocket or use money from your FSA. Once you reach the deductible, more traditional coverage begins where you and Trilogy share costs through coinsurance. *(You pay 20% if in-network until you reach your out of pocket max)*.

The Spouse / Family Plan

If you want to cover your spouse, this is the plan you choose. This plan includes the same services offered by the Smart Choice plan, with the only exception being you pay 20% in-network until you reach your out of pocket max. Spouses are only eligible if they do not have coverage available to them from their employer.

DirectPath®

SO. MANY. QUESTIONS.

You have questions. DirectPath has answers.

You have big decisions to make when electing benefits. Now and throughout the year you have questions about your benefits and health care options. Where should you begin? With one simple call to DirectPath.

Your DirectPath Advocate can:

- Answer questions about your benefit options to help you make the best choice for your situation
- Help you understand and use your benefits
- Compare costs for tests and procedures
- Resolve claims and billing issues
- Assist with prescription drug issues and find cost-saving options
- Help you find in-network providers and make appointments
- Explain expected out-of-pocket costs
- Assist with managing a chronic condition, and understanding diagnosis and treatment options

DirectPath is completely free and confidential and is available to you and your covered dependents as part of your benefits program. Call your Advocate with any benefits or health care question throughout the year!

866-253-2273
advocate@directpathhealth.com
Monday – Friday 7 a.m. – 8 p.m. CT and Saturday 8 a.m. – 1 p.m. CT

Join us at the Trilogy Virtual Benefits Fair!

www.trilogybenefitsfair.com

- Access need-to-know benefits information
- Learn how to make your benefits work for you
- Enter to win prizes!

HEALTH PLAN OPTIONS

Plan Name:	Traditional PPO	Smart Choice Plan	Spouse/Family
Annual Deductible*	SI: $2,000	SI: $3,000	SI:$4,000
	EC: $3,000	EC: $5,000	FA: $12,000
Out-Of-Pocket Max*	SI: $8,550 EC: $17,100	SI: $5,300 EC: $7,950	SI $6,750 / FA $13,500
Coinsurance	80% / 20%	90% / 10%	80% / 20%
PCP Office Visit	$10 Copay	Deductible then 10%	Deductible then 20%
Specialist Office Visit	$55 Copay	Deductible then 10%	Deductible then 20%
Preventive Services	100%	100%	100%
Immediate / Urgent Care	$55 Copay	Deductible then 10%	Deductible then 20%
Emergency Room Services	$250 Copay then 20%	Deductible then 10%	Deductible then 20%
Savings Plan	Health FSA Eligible	HSA Eligible	

WEEKLY PREMIUMS

	Wellness	Standard	Wellness	Standard	Wellness	Standard
Employee Only	$60.50	$88.00	$20.00	$33.50	N/A	
Employee + Child(ren)	$97.55	$125.05	$39.50	$67.00	N/A	
Employee + Spouse	N/A		N/A		$113.00	$140.50
Family	N/A		N/A		$140.50	$168.00

Adjustments on the wellness rate will only be refunded back to the date the Home Office is notified of the discrepancy.

SAVE $702 –$1,430 PER YEAR WITH THE WELLNESS RATE

The discounted Wellness Rate will be applied upon completion of all three steps.
See page 10 for more information.

Explanation of Terminology:

SI : Single Individual *EC: Employee + Child(ren)* *SP: Spouse* *FA: Family*

* For Benefit elections, our plan year is April 1st–March 31st. However, deductibles and out of pocket maximums are based on the calendar year. All payments made to your deductible from January 1st through March 31st will rollover to the new plan you choose for April 1st.

PHARMACY OPTIONS

Plan Name:	Traditional PPO		Smart Choice Plan		Spouse/Family	
30-Day Supply	**Synchrony**	**Retail**	**Synchrony**	**Retail**	**Synchrony**	**Retail**
– Tier 1	$4	$15	Deductible 10%	Deductible 10%	Deductible 20%	Deductible 20%
– Tier 2	$35	$45	Deductible 10%	Deductible 10%	Deductible 20%	Deductible 20%
– Tier 3	$55	$65	Deductible 10%	Deductible 10%	Deductible 20%	Deductible 20%
– Specialty	25%	25%	Deductible 10%	Deductible 10%	Deductible 20%	Deductible 20%

Preventive 30-Day	Synchrony	Retail	Synchrony	Retail	Synchrony	Retail
– Tier 1	$4	$15	$4	$15	$4	$15
– Tier 2	$35	$45	$30	$40	$30	$40
– Tier 3	$55	$65	$50	$60	$50	$60
– Specialty	25%	25%	25%	25%	25%	25%

90-Day Supply	Synchrony	Retail	Synchrony	Retail	Synchrony	Retail
– Tier 1	$10	$30	Deductible 10%	Deductible 10%	Deductible 20%	Deductible 20%
– Tier 2	$70	$90	Deductible 10%	Deductible 10%	Deductible 20%	Deductible 20%
– Tier 3	$110	$130	Deductible 10%	Deductible 10%	Deductible 20%	Deductible 20%
– Specialty	N/A	N/A	N/A	N/A	N/A	N/A

Preventive 90-Day	Synchrony	Retail	Synchrony	Retail	Synchrony	Retail
– Tier 1	$10	$30	$10	$30	$10	$30
– Tier 2	$70	$90	$60	$80	$60	$80
– Tier 3	$110	$130	$100	$120	$100	$120
– Specialty	N/A	N/A	N/A	N/A	N/A	N/A

New Pharmacy Option: April 1, 2021, you can refill your maintenance medicine through Synchrony Pharmacy, a subsidiary of PCA. Not only will it be cheaper, your prescription will be delivered to your home. This benefit provides discounted rates, special deliveries and the ability to pay through your FSA, HSA or payroll deduction.

Effective July 1, 2021, Synchrony Pharmacy will be your exclusive provider for all maintenance medications and most specialty medications. See Synchrony Pharmacy FAQ on www.SynchronyHSpharmacy.com for detailed information on Synchrony Pharmacy Service Area.

SYNCHRONY
PHARMACY
A Prescription for Wellness

HEALTH PLAN COMPARISON

MEET JULIE!

Julie is a caregiver with a teenage son. She and her son receive annual preventive exams and screenings each year. It's easy with Trilogy since preventive care is covered at 100% regardless of the plan she is enrolled in.

Julie has high blood pressure and uses Synchrony Pharmacy for her mail order to save money on her maintenance medication. This year, Julie's son, Chad, broke his leg while playing softball. He was seen in the emergency room. Each member of the household saw a primary care doctor at least once during the year, and one visit to the urgent care center. Below are Julie's medical expenses for the year.

Julie saved money by selecting the Smart Choice Plan. Not only did Julie pay less in payroll deductions, she also received $1,500 from Trilogy in HSA contribution and match! This money was deposited into her HSA and used for eligible reimbursable medical and pharmacy expenses.

		Traditional PPO Plan	Smart Choice Plan
	Cost of Service	Employee Responsibility	Employee Responsibility
Annual Screenings • Employee (Julie) • Children (Chad)	 $568.00 $1,362.00	 $0.00 $0.00	 $0.00 $0.00
ER Visit • Julie	 $1,305.00	 $461.00	 $1,305.00
Urgent Care • 3 visits ($55 per visit) or $55 copay	 $228.00	 $165.00	 $228.00
Primary Doctor Office Visits • 3 visits ($59 per visit) or $10 copay	 $177.00	 $30.00	 $177.00
Prescription Drugs • Julie's Prescription Drugs	 $610.50	 $100.00	 $610.50
Total Medical Claim Expenses		**$756.00**	**$2,320.50**
Julie's Payroll Deduction (Wellness Rate)		$5,072.60	$2,054.00
Payroll Deduction plus Medical Claim Expenses		$5,828.60	$4,374.50
Julie's Total HSA Contribution		$0.00	$500.00
Trilogy's Total Contribution To Julie's HSA		$0.00	($1,500.00)
Total Medical Claims and Premium Expenses		**$5,828.60**	**$3,374.50**

HAVE YOU DONE THE MATH?
Employees can estimate healthcare expenses and can save money this year! Contact DirectPath today for assistance at 1-866-253-2273!

This example is for illustrative purposes only; it is intended to show how hypothetical medical and pharmacy expenses are paid out of the Trilogy Smart Choice Plan. The pricing in this example is based on average expenses in the Louisville, KY, metro area. Your expenses may be different.

HOW TO ENROLL

Log in to www.*myadp.com*

1. Select the **Benefits Tile on the left**
2. Select **Enroll Now** to get started
3. You must **review and confirm** your elections by clicking the button marked **Confirm Enrollment** at the end of the process. **YOU WILL NOT RECEIVE BENEFITS UNLESS YOU DO THIS!**
4. **You have completed your enrollment!**

DEPENDENT VERIFICATION

If you add a child(ren) or a spouse to your medical, dental or vision coverage, it is required that you provide proper documentation. You will receive a letter from ADP stating the deadline to provide either the birth certificate of the child(ren) and/or the marriage certificate for the spouse. If there are any questions, you can call ADP Dependent Verification Services at 800-553-3823. If proper documentation is not provided timely, your dependent(s) will not have coverage and exceptions will not be made.

QUALIFYING LIFE EVENT

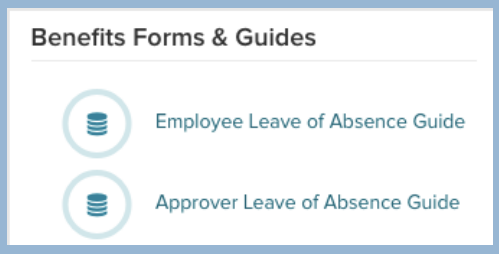
How do I make changes to my benefits?

A Qualifying Life Event (QLE) is an IRS approved event that allows you to change your benefits outside of open enrollment. Contact DirectPath at 866-253-2273 to confirm if you have a Qualified Life Event. You are only allowed to make changes to your benefits if you have a QLE. Examples are; marriage, birth, adoption, divorce, etc. If you have experienced a QLE, first contact DirectPath to confirm you are eligible to make a change to your benefit elections. Upon confirmation, log in to **www.myadp.com** and make the appropriate change for your benefits. The date of the event in MyADP must be the actual date of the life event; birth, marriage, etc. You will be required to provide supporting documentation for the change. *The change and supporting documentation must be completed within 30 days of the date of the Qualifying Life Event.*

To View Plan Documents
Visit www.myadp.com

Click Benefits in the left hand column

Select document or form from the list.



DO YOU HAVE GENERAL BENEFIT QUESTIONS?

NEED HELP WITH GETTING ENROLLED?

Call DirectPath

Your advocate to assist you with Open Enrollment

1-866-253-2273

Monday – Friday
7:00 a.m. – 8:00 p.m. CT
Saturday 8:00 a.m. – 1:00 p.m. CT

COBRA

You may be eligible for COBRA for up to 18 months if you experience a reduction in hours, terminate employment, become Medicare eligible, or a dependent ages out at age 26, etc. If you become eligible, you will receive a packet of information from Wageworks. If you have questions you can call 1-800-526-2720.

STEPS TO COMPLETE WELLNESS RATE

STEP 1:

Register for your Virgin Pulse account at join.virginpulse.com/trilogyfit. Complete the Health Check Survey and set up your Healthy Habits. Examples of Healthy Habits include:

- Getting Active
- Sleeping Well
- Being Productive
- Eating Healthy
- Reducing Stress
- Managing Finances

STEP 2:

OBTAIN A FREE BIOMETRIC SCREENING

Campus, Home Office and PCA Pharmacy Employees:

- Complete a biometric screening. Contact your SDC or ADHS to schedule, **OR,**
- Download the Virgin Pulse Biometric Form and have your medical provider complete the form, including labs *(labs must be within the last 90 days)*.
- Scan and upload your results directly to your Virgin Pulse.com account.
- Employees who do not have a medical provider and wish to be screened outside of the campus may follow the steps below:

Paragon Elite Campus and Select PCA Pharmacy Employees:

1. Log on to **www.trilogyfit.org**
2. Click on Health>Biometric Screenings
3. Select **Paragon Elite/PCA Pharmacy Employees**
4. Read the instructions and then scroll down and select **Register for your LabCorp Biometric Screening** at the bottom of the page
5. Returning users should enter their e-Health Username and Password. New users should **click on the 'Not Yet Registered' red tab and enter the screening key HWS112**.
6. Follow the instructions for your **Username and Password** or log in with your previous Username/ Password.
7. Once you verify the information is correct **select the "Offsite Screening" icon and enter your zip code to locate the nearest LabCorp facility**.
8. Your cotinine (nicotine) test will be completed as part of the LabCorp venipuncture biometric screening.

STEP 3:

SHOW YOU ARE TOBACCO/NICOTINE FREE

Campus, Home Office and select PCA Employees ONLY*:*

- Complete an oral swab cotinine test – contact your SDC or ADHS *(if you completed a cotinine during your pre-onboarding drug test you may use results for up to 90 days).*
- Your nicotine results will be included with your biometric screening results when reported to Virgin Pulse.
- Employees who are unable to show they are tobacco/nicotine free must complete the Clickotine Tobacco Cessation Program to satisfy the "nicotine-free" requirement for the Wellness Rate.

  Download the clickotine mobile app, use code HDFRFF and complete the Clickotine Cessation Program (~8 weeks).

For questions, **email us at trilogyfit@trilogyhs.com.**

FOR ADDITIONAL WELLNESS SUPPORT AND RESOURCES TO HELP YOU ON YOUR HEALTH JOURNEY LOG IN TO JOIN.VIRGINPULSE.COM/TRILOGYFIT.

HEALTH SAVINGS ACCOUNT (HSA)

Trilogy makes contributions when you open an HSA account at Fidelity. You could receive up to $1,500 annually – don't miss out on this incredible benefit!

Trilogy's Contributions					Trilogy's Weekly Matching Contribution
Projected Income	**Single Coverage**	**Employee & Child(ren)**	**Employee & Spouse**	**Family**	**All Coverage Levels**
Annual / Weekly					Trilogy matches 100% of employee contributions up to $300 per plan year.
$0 – $49,999	$500 / $9.62	$1,200 / $23.08	$500 / $9.62	$1,200 / $23.08	
$50,000 – $99,999	$400 / $7.69	$1,000 / $19.23	$400 / $7.69	$1,000 / $19.23	
$100,000 +	$300 / $5.77	$800 / $15.38	$300 / $5.77	$800 / $15.38	

A Health Savings Account (HSA) is a tax-free savings account owned by you and may be used to pay for qualifying healthcare expenses for you and your family. You decide how much you would like to contribute, when and how to spend the money on eligible expenses, and how to invest the balance.

You have the option of specifying how you want your funds to be invested. When your funds grow, your earnings are tax-free. Unused funds roll over each calendar year and if you leave Trilogy the money in your account goes with you.

OPEN YOUR HSA

You **must** open an account with Fidelity. An account maintenance fee of $3.00 per month will be deducted from your balance on a quarterly basis. Once your account is opened, you will receive a Fidelity HSA Visa Card.

HSA ROADMAP

- Pre-tax contributions are deducted through weekly payroll.
- Contributions are deposited into your Fidelity HSA account, **once opened**.
- Use your HSA available funds to pay for qualified medical expenses tax-free. Pay a 20% tax penalty for non-qualified expenses.
- Unused funds remain in your account for future use.

You can change your HSA contribution at any time during the plan year for any reason. Simply go to **www.myadp.com** > Select Benefits > Select Report a Qualifying Change.

VISIT WWW.401K.COM FOR MORE INFO ON HSAs AND HOW TO INVEST YOUR MONEY!

HSA ROAD RULES

Eligibility requirements for the HSA:

- Must be paired with the Smart Choice Plan or the Spouse/Family Plan
- Participants can be covered by another qualifying health plan but must be enrolled in either the Smart Choice Plan or the Spouse/Family Plan.
- Participants cannot participate in a Healthcare Flexible Spending Account or spouse/domestic partner's Healthcare Flexible Spending Account.
- Participants cannot be enrolled in Medicare, including dependents.
- HSA 2021 IRS contribution limits *(these amounts include the company contributions)*:

  Individual: $3,600 per calendar year

  Family: $7,200 per calendar year
- Visit 401k.com to view a full list of HSA eligible expenses.
- If you are 55 or older, you can deposit up to an additional $1,000 per calendar year.
- You can contribute up to the maximum allowed amount for the year at any time up until the tax-filing deadline *(generally April 15th)* of the following year.

HSA DEPENDENT AGE LIMIT

Per the IRS, an employee who owns an HSA account can have expenses submitted for a spouse and any tax dependent, including children up to age 19 or 24 if a full-time student.

ADJUSTMENTS ON MISSED COMPANY MATCH AND WEEKLY CONTRIBUTIONS WILL ONLY BE MADE AS OF THE DATE THE HOME OFFICE BENEFITS TEAM IS NOTIFIED OF THE DISCREPANCY.

FLEXIBLE SPENDING ACCOUNT (FSA)

Employees who elect the Traditional PPO Plan may enroll in the Healthcare Flexible Spending Account (FSA), or the FSA may be elected as a stand-alone benefit if you are not enrolled in Trilogy's health insurance. You have until June 15, 2022, to incur healthcare FSA claims for the April 1, 2021, through March 31, 2022, plan year. The money is withheld from your regular paycheck pre-tax and deposited into your account(s). Eligible expenses are then reimbursed from your account(s).

The website **www.MyFlexOnline.com** allows you to view your balance, file a claim or submit a receipt. Use the same ID and password you use for the MyFlexOnline website. For more information on eligible healthcare and dependent care expenses, call Benefit Marketing Solutions (BMS) at 1-800-919-2674 or visit **www.bmsllc.net.**

FUNDING AND USING YOUR FSA

Your annual contribution amount is divided into equal amounts and taken from your paycheck each pay period. If you enroll in both a Healthcare FSA and a Dependent Care FSA, each account is separate and money cannot be transferred between your accounts. If your employment status changes to PRN or if you terminate employment, your FSA will terminate on the same date and any unused funds will be forfeited. To find a list of eligible expenses, visit the IRS website www.irs.gov.

USE IT OR LOSE IT

If you elect an FSA during this enrollment period (4/1/21 - 3/31/22), any unused funds remaining in your Health FSA after June 15, 2022, will be forfeited.

HOW TO GET REIMBURSED FOR EXPENSES

When you enroll in an FSA you may:

- Use your Flexible Spending Account VISA® debit card and have the eligible expense debited directly from your account.
- Pay for eligible expenses at the point of service and submit a claim for reimbursement *(contact BMS for claim forms)*.

VISA® DEBIT CARD

You can use your Flexible Spending Account VISA® debit card to pay for eligible copays, deductibles, and healthcare products and services from qualified locations, including hospitals, physician offices, vision providers, pharmacies, dependent care FSA, and home healthcare services. Keep all receipts in case you need to submit one or more to BMS for validation.

Healthcare Flexible Spending Account (FSA)	Dependent Care Flexible Spending Account
With a Healthcare FSA, you can use tax-free dollars in your account for reimbursement of eligible medical, dental, and vision expenses for you and your dependents. **The maximum annual contribution is $2,750 per household for 2021.** Allowable reimbursed expenses by the IRS for the Healthcare FSAs are generally those that are not reimbursed or paid for by a health insurance plan. Eligible expenses may include copays, deductibles, and coinsurance.	**The maximum annual contribution is $5,000 per household for 2021.** With the Dependent Care FSA, you can use tax-free dollars for reimbursement of eligible day care expenses, summer day camp, and before- and after-school care expenses.
Eligible Dependents	**Eligible Dependents**
Your eligible dependents include: • A child who is age 26 or younger whom you are entitled to claim as a dependent on your income tax return. • A spouse or other tax dependent who is physically or mentally incapable of caring for him/herself	Your eligible dependents include: • A child under the age of 13 whom you are entitled to claim as a dependent on your income tax return. • A spouse or other tax dependent who is physically or mentally incapable of caring for him/herself

DENTAL INSURANCE

As a Delta Dental of Kentucky member, you can see any licensed dentist and receive discounts *(with no balance billing)* for using a Delta Dental Premier dentist. Deepest discounts are available when using a Delta Dental PPO provider.

For a complete list of Delta Dental PPO or Premier providers, contact Delta Dental of Kentucky at 1-800-955-2030, visit **ky.deltadental.com**, or download the mobile app through the App Store *(Apple)* or Google Play *(Android)* and search for Delta Dental. Dental Premiums are deducted on a pre-tax basis.

YOUR WEEKLY EMPLOYEE PAYROLL CONTRIBUTION

Dental Insurance	Cost
Employee Only	$4.80
Employee + One	$9.27
Family	$15.09

The table below represents a partial list of benefits and services. For a complete list, refer to your certificate of coverage.

Covered Benefits	PPO Network	Premier Network	Non-Network
Deductible* (Individual)	$50	$100	$100
Deductible* (Family)	$150	$300	$300
Annual Maximum Per Person	$1,500	$1,500	$1,500
Diagnostic & Preventive *(Deductible waived)* Diagnostic and preventive services, emergency palliative treatment, sealants, brush biopsy, radiographs. Preventive and diagnostic services do not apply toward the annual maximum benefit of $1,500.	100%	100%	100%
Basic Services Minor restorative services *(fillings, crown repair)*, bite guards, extractions and dental surgery, denture repair.	80%	50%	50%
Major Services *(waiting period applies)* ** Root canals, periodontic service, crowns, implant repair, full/partial dentures, bridgework.	50%	50%	50%
Orthodontics Services ***(Six-month waiting period for services)*** **Braces for dependent children under the age of 19. Not available to part-time employees.**	50%	50%	50%

**Deductible is based on calendar year.*

***Documentation of previous coverage may waive certain waiting periods. Contact Delta Dental for details. There is a $1,000 lifetime maximum on orthodontic services for each dependent.*

Waiting Period – *There is a 12-month waiting period for certain services. Endodontic Services, Periodontic Services, Major Restorative Services, Relines and Adjustments, Fixed Prosthodontic Repair, and Prosthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months.*

VISION INSURANCE

Regular vision care is an important part of your overall health. That's why we offer Anthem Blue View Vision. The table to the right represents a partial list of benefits and services. For a complete list, refer to your certificate of coverage.

Anthem Blue View Vision offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service, visit **Anthem.com** or call 1-866-723-0515. You may also view your benefits, search for a provider or print an ID card online at **Anthem.com**.

Vision plan premiums are deducted on a pre-tax basis.

Covered Benefits	Anthem Blue View Vision In-Network	Non Network Reimbursed
Vision Exam Once every 12 months	$10 copay	Up to $46
Lenses Once every 12 months	$20 copay	Up to $85 reimbursement based on lens type
Frames Once every 24 months	$130 allowance, then 20% off any remaining balance	Up to $47
Contact Lenses *Once every 12 months*		
• Elective *non-disposable*	$130 allowance, then 15% off any remaining balance	Up to $105 reimbursement
• Elective *disposable*	Up to $130 reimbursement	Up to $105 reimbursement
• Non-elective	Covered in full	Up to $210 reimbursement

YOUR WEEKLY EMPLOYEE PAYROLL CONTRIBUTION

Vision Insurance	
Employee Only	$1.00
Family	$2.50

If you are enrolled in the medical plan, you will receive one ID card to use for your medical and vision coverages.

OTHER BENEFITS – METLIFE

SHORT-TERM DISABILITY (STD)

Short-term disability is designed to provide you with continuing weekly income while you are out of work due to an illness, accident, or life event. Benefits begin following a 14 calendar day waiting period from your first date of absence related to the disability, a non work related accident or illness. Short-term disability insurance provides a benefit amount of 60% of your weekly pre-disability earnings, up to a weekly maximum benefit of $750, for as long as you remain disabled up to 24 weeks.

LONG-TERM DISABILITY (LTD)

The LTD plan pays a benefit of 60% of your monthly income up to a maximum of $10,000. Monthly income means the monthly compensation you earn from your normal occupation. It does not include earnings from overtime, bonuses, or any other form of pay. Benefits begin on the 181st calendar day of absence and may last for five years for non-work related accident/ sickness.

ONLY THE LTD PLAN INCLUDES A PRE-EXISTING CLAUSE, INCLUDING PREGNANCY.

IMPORTANT!

If you choose to waive long-term disability during your new hire waiting period and you choose to enroll at a later time, you will be subject to complete a Statement of Health form. MetLife will review your request and notify you of approval or denial.

ACCIDENT INSURANCE *(OFF-THE-JOB)*

Provides a lump-sum payment when you suffer a covered injury or you undergo covered testing, medical services or treatment and you meet the group policy and certificate requirements. Premiums are paid through payroll deduction.

Payments are made directly to you to be used as you see fit. They can be used to help pay for medical plan deductibles and copays, out-of-network treatments for you and your family's everyday living expenses or whatever you need while recuperating from an accident.

Accident insurance is guarantee issue if you enroll during the new hire enrollment period, are actively at work, and dependents to be covered are not under a medical restriction as set forth in the Certificate. There are no medical exams to take and no health questions to answer. Some states require the insured to have medical coverage.

CRITICAL ILLNESS INSURANCE

Helps you cover the extra expenses associated with a serious illness. This coverage provides a lump-sum payment of $15,000 in Initial Benefits upon diagnosis. The Total Benefit Amount available is 3 times the Initial Benefit Amount, *($45,000)* in the event where you suffer from more than one covered condition. Payment(s) will be made in addition to any other insurance and may be spent as the employee sees fit. You may enroll yourself and eligible family members and premiums are paid through payroll deduction.

Critical Illness insurance is guarantee issue if elected during new hire enrollment period and the employee is actively at work.

If you meet the group policy and certificate requirements, Critical Illness insurance provides a lump-sum payment upon diagnosis of the following conditions:

- Full Benefit Cancer
- Stroke
- Alzheimer's Disease
- Partial Benefit Cancer
- Kidney Failure
- Major Organ Transplant
- Heart Attack
- Coronary Artery Bypass Graft
- Occupational HIV
- 22 Listed Conditions *(see your Outline of Coverage for details)*

The plan pays a Recurrence Benefit for the following covered conditions:

- Heart Attack
- Stroke
- Coronary Artery Bypass Graft
- Full Benefit Cancer
- Partial Benefit Cancer

A recurrence benefit is only available if an initial benefit has been paid for the covered condition. There is a benefit suspension period between recurrences.

Critical Illness and Accident plans provide a $50 benefit per calendar year for eligible health screenings/ prevention measures.

OTHER BENEFITS – METLIFE

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Trilogy offers Basic Term Life/AD&D insurance for full-time employees through MetLife **at no cost**. Benefits are reduced after age 65:

- by 35% at age 65
- by 60% at age 70
- by 75% at age 75
- by 85% at age 80

VOLUNTARY SUPPLEMENTAL LIFE INSURANCE

By purchasing voluntary life insurance through work, you take advantage of lower group rates and convenient payroll deducted premiums.

You may purchase voluntary life insurance in multiples of one to five times your annual salary up to a maximum of $250,000 of coverage *(if approved). (See Guarantee Issue information below).*

IMPORTANT GUARANTEE ISSUE INFORMATION

- If you purchase voluntary life insurance during your new hire enrollment, you are guaranteed up to $250,000 of coverage for yourself and $25,000 of coverage for your spouse *(called guarantee issue)*. For any coverage for your spouse above $25,000, your spouse will have to complete a health questionnaire. MetLife will review the request for the amounts over the guarantee issue amount and will notify you of approval or denial.
- If you choose to waive all voluntary life products during your new hire waiting period and you choose to enroll at a later time, you will be subject to complete a Statement of Health form for the entire amount of coverage you purchase. The guarantee issue is no longer available. MetLife will review your request for the additional amounts and will notify you of approval or denial.

Premium rates for short term disability, long term disability and life insurance are based on age and amount of coverage. Rates will be available in the ***www.myadp.com*** *enrollment system.*

SPOUSE AND DEPENDENT CHILD(REN) VOLUNTARY LIFE INSURANCE

If you purchase voluntary life insurance for yourself, you may also purchase voluntary life insurance for your spouse and/or dependent children.

- You may purchase voluntary spouse life benefits up to 50% of your voluntary term life benefit, to a maximum of $50,000. Up to $25,000 of voluntary spouse life may be purchased with no medical questions if you enroll when you are first eligible. Voluntary spouse life may be purchased in $5,000 increments.
- You may purchase voluntary child(ren) dependent life benefits of $10,000 for each child age 15 days to 19 years, or 24 years if a full-time student. The rate for voluntary dependent life is $1.40 per month regardless of the number of children covered. The weekly deduction for this benefit is $0.32.

WILL PREPARATION

By enrolling in voluntary life insurance, you have access to a participating plan attorney who will prepare or update your will or your spouse's will at no cost to you. Contact MetLife at 800-821-6400.

OTHER BENEFITS – HEALTH & WELLNESS

ANTHEM LIVEHEALTH ONLINE

By using LiveHealth Online, you can visit with a board-certified doctor, licensed therapist, or certified lactation consultant through live video on a smartphone, tablet or computer with a webcam. It's an easy and convenient way for you to get the care you need whether at work, home or anywhere in between.

All you have to do is go to www.livehealthonline.com or download the app and sign up to access:

- ***Board-certified doctors***
  Doctors can assess your condition, provide a treatment plan and even send a prescription to the pharmacy you select if needed. English-speaking doctors are available on demand 24/7 with no appointments or long wait times through LiveHealth Online Medical.
- ***Spanish-speaking doctors*** are available by appointment seven days a week using Cuidado Médico on LiveHealth Online. Same-day appointments are available in most states.
- ***Licensed therapists in four days or less***
  If you're feeling anxious or having trouble coping on your own, employees can talk with a therapist online. Appointments are available seven days a week.
- ***Future Moms with Breastfeeding Support on LiveHealth Online***
  Members can have live video visits with a lactation consultant, counselor or registered dietitian experienced in giving support for lactation and nutrition. The lactation consultation sessions through LiveHealth Online are at no cost to you and your eligible dependents enrolled in Trilogy medical insurance.

Use a Virtual Visit for these minor medical needs:

- Bladder/Urinary tract infection
- Bronchitis
- Cold/flu
- Fever
- Rash
- Sinus problems
- Pinkeye
- Sore throat

ENGAGE

Consider Engage as your personal Anthem health assistant. Create an account and access your digital medical card, clearly see what services and benefits are covered by your Anthem medical plan, review how much services will cost, and determine where you have spent your healthcare dollars. Search for a doctor or specialist near you and review their ratings to find high-quality caregivers that are right for you. Anthem helps you manage your medical plan. Download the mobile app or create an account at www.engage-wellbeing.com.

VIRTA HEALTH

Virta Health is a clinically proven program that reverses pre-diabetes and type 2 diabetes so that participants can control their blood sugar and A1c while losing weight and controlling their medicine intake. Virta treatment connects participants with a dedicated health coach to support participants, continuous medical supervision, educational resources, and expert care anytime, anywhere. Virta Health is offered at no cost to Anthem members, ages 18+ (employees, spouses, and dependents) with diabetes or pre-diabetes. Eligible employees may register on the Managing Diabetes page at www.trilogyfit.org.

NOOM

Noom is a mobile-app based weight loss program that customizes your plan based upon a pre-program psychological evaluation. Participants log their food intake, physical activity and have access to a social network to discuss their weight loss journey. With access to designated health coaches Noom is a great and personal way to begin your journey of healthy living. Eligible employees can enroll on the Weight Management page at www.trilogyfit.org.

Noom is open to all part-time and full-time employees, employed at least 6 months with Trilogy who have a BMI of 30.0 or greater.

The cost is $50 + taxes via payroll deduction of $25 over two consecutive pay periods.

TRILOGY 401(k) RETIREMENT SAVINGS PLAN

The Trilogy 401(k) Retirement Savings Plan administered by Fidelity Investments provides you with an excellent way to save for your retirement. If you are unsure of which investment options to chose you can select the default option of the Target Date Fund. The Target Date Fund is a mix of stocks and bonds reallocated for you as you get closer to your retirement age. Simply contact Fidelity for more information.

Eligible Employee Contribution	Trilogy Contribution	Pre-Tax Contributions	After-Tax Roth Contributions
If you are at least age 21 and are a full or part time employee, you may contribute from your pay check up to the plan IRS limit *($19,500 for 2021)*.	Trilogy matches $.25 for every $1.00 you contribute up to 10% of your weekly pay. This applies to both your pre-tax and/or after-tax Roth deferrals. *Temporarily suspended.*	You can elect to defer either pre-tax or after-tax Roth. Simply contact Fidelity at 800-835-5097 or go to www.401k.com.	
If you are age 50 or older, you may be eligible to contribute an additional $6,500 for 2021.	All Trilogy contributions are subject to the 5 year vesting schedule based on your date of hire. However, you are eligible for the employer match as soon as you become eligible to contribute to the plan.	Your deferred contribution is withheld from your paycheck ***before*** taxes.	Your deferred contribution is withheld from your paycheck ***after*** taxes.
You can change the amount you contribute at any time and all employee contributions are immediately 100% vested. Trilogy also accepts eligible rollovers from previous employers.		Funds withdrawn from your account during retirement are subject to income tax, provided you are at least age 59 ½.	Funds withdrawn from your account during retirement are **not** subject to income tax, provided you are at least age 59 ½.

Employees earning $130,000 or above for 2021 may be capped on deferral options

NEED HELP?

Call 800-835-5097 to speak with a Fidelity representative who can answer questions, explain their online Contribution Calculator and walk you through any transaction you want to make in your account.
Additional Financial Wellness resources can be found at: www.bankofamerica.com/financialwellness.

HOW TO ENROLL? WHEN TO ENROLL?

To enroll log on to **www.401k.com** or call Fidelity at **800-835-5097**. You are eligible to defer to the plan on the first of the month after 2 months of employment.

The 401(k) Company Match was suspended on July 1, 2020 and will be reinstated on July 1 2021.

BeWell EMPLOYEE ASSISTANCE PROGRAM

The BeWell Employee Assistance Program (EAP) is an important resource for your overall health and well-being. All employees are eligible for this benefit.
Life is full of changes. It's easier to take them on with some help. All employees are eligible for 5 free counseling sessions per year, per family member per issue. Find articles, interactive tools, podcasts, webinars, discounts, counseling for depression, work/life balance resources, tobacco cessation and more all in one place!

Benefits are provided at **no cost** and available to you, your spouse or domestic partner, dependent children/students or anyone who resides in your home. You do not need to participate in the Trilogy sponsored health insurance program to access BeWell benefits. Whether you need guidance and support during major life events or expert help with life's day-to-day challenges, the EAP is available 24/7/365. Contact Magellan at 800-424-4039 or **www.magellanasscend.com**

METLIFE AUTO & HOME INSURANCE

Choose from a variety of insurance policies to meet your coverage needs, including home, boat, condo, motor home and recreational vehicle, and renter's insurance. You may apply for auto and home insurance through this group program at any time by calling 1-800 GET-MET8 *(1-800-438-6388)* or by visiting **www.metlife.com**.

PETFIRST PET INSURANCE

Benefits include treatments related to accidents and illnesses, including cancer. A Veterinary Pet Insurance (VPI)/NCC policy covers diagnostic tests, X-rays, prescriptions, hospitalization, and more. You can enroll for coverage at any time – just call 1-800-GET-MET8 *(1-800-438-6388)* or visit **metlife.com**.

IDShield

Includes privacy and security monitoring, consultation, and 24/7 covered emergencies with free mobile app, complete identity recovery services by Kroll Licensed Private Investigators and $5 million service guarantee ensure that if your identity is stolen, it will be restored to pre-theft status. Dependents can also be covered if they are up to age 19 or 24 if a full-time student.

LegalShield

Talk to an attorney about an unlimited number of personal legal matters without worrying about the hourly costs. Examples include adoption, child support and custody, divorce, real estate, traffic violations, trusts, power of attorney, bankruptcy consultation and debt collection. Dependents can also be covered if they are up to age 19 or 24 if a full-time student.

METLIFE DISCOUNT PROGRAM

Discounted homeowner, auto, and pet insurance are available through payroll deduction. In addition, MetLife offers an interactive tool – **www.metlifeyourlife.com** – with free information on home and belongings safety, improvement, and maintenance. These discounts include Lowe's, Merry Maids, Enterprise Rent-A-Car, Contractor Connection and others. An interactive tool is available for all employees whether or not you purchase a policy.

PURCHASING POWER®

Purchasing Power lets eligible employees purchase computers, electronics, exercise equipment, education, and household goods through payroll deduction. There is no credit check and the risk often associated with sub-prime financing is eliminated.

Eligible employees are full-time and part-time, non-union staff members who meet all the following criteria:

- Have completed one year of service with Trilogy Health Services, including Paragon and PCA.
- Are at least 18 years of age.
- Earn a minimum of $20,000 annually.
- Have either a bank account or credit card *(to be used in the event of non-payment through payroll deduction)*.

To register for Purchasing Power:

- Go to **www.trilogy.purchasingpower.com or call 888-923-6236**.
- Enter your email address.
- Enter your personal information.
- At the "Employer/ Organization" box type TRILOGY HEALTH SERVICES, LLC *(if a drop-down menu appears, select TRILOGY HEALTH SERVICES, LLC)*.
- Click "REGISTER" and the catalog will appear.

SIGN UP TO GET STARTED.

20%

OFF YOUR FIRST ORDER

DirectPath

To Reduce Health Care Costs

Do you have general benefit questions?

Need help with getting enrolled?

Call DirectPath

Your advocate to assist you with Open Enrollment

1-866-253-2273

Monday – Friday: 7:00 a.m. – 8:00 p.m. CT
Saturday: 8:00 a.m. – 1:00 p.m. CT

TRILOGY PERKS

Trilogy Perks offers local and national discounts, cash-back comparison shopping, hotels, restaurants, movie theaters, theme parks, and more.**Trilogy Perks is available to all Trilogy employees and can be accessed through Trilogy University by following these easy steps:**

- Log in to Trilogy University.
- Select My Benefits and Perks.
- Select "Trilogy Perks".
- First-time visitors/users register with registration code TrilogyPerks411.
- Repeat visitors simply enter your login and password.

*Employees can also visit **trilogyperks.employeediscounts.co/perks** to access the website directly.*

Trilogy Perks has more than 100,000 available discounts and offers including:

Over 150 national attractions and theme parks also participate in the program, including the Walt Disney World Resort, Universal Studios, SeaWorld, Kings Island, and Six Flags! Vendors and/or discounts are subject to change.

GAS BONUS

During times of escalated fuel costs, Trilogy may provide a bonus to full-time and part-time Trilogy employees with at least six months employment.

CONTACT YOUR BUSINESS OFFICE TO LEARN MORE ABOUT THESE GREAT BENEFITS:

DEALS ON MEALS

Employee Meals at the health campus are significantly discounted and available through payroll deduction. Chef's Choice Meals are $3.50. Café Menu Meals, with premium ingredients and customized meal prep, are $5.00. Meal tickets are available on Accuconnect.

CARPOOL PROGRAM *(EASE THE SQUEEZE)*

Employees who participate in carpools enjoy gas savings, less wear and tear on their vehicles, and reduced stress from their commutes. They also help keep the air clean while building friendships with co-workers. Contact your supervisor or Business Office for more information.

smartdollar® | Trilogy Foundation *Heart of ONE*

Welcome TO THE TEAM!

We care about you at Trilogy.

We want to see you reach your professional and financial goals. That's why we've teamed up with SmartDollar—a benefit provided to you that will help you eliminate debt, save for emergencies, and retire with confidence!

Nicole

Top Names in Money *Step-by-Step Plan* *Tools*

With SmartDollar, you get:

1. Engaging and inspirational content from the **top names in money.**
2. A **clear, step-by-step plan** that makes it easy to know what to do next.
3. **Tools** that are tailored to help you wherever you are in the plan.

*Our proven plan is geared to help you succeed. After the **first year** in the program, SmartDollar users report an average of more than:*

$16,200

of Debt Paid + Dollars Saved

SIGN UP TODAY—IT'S FREE!

Text: Trilogy to 33789

— or —

Visit: smartdollar.com/enroll/trilogy

CAREER ADVANCEMENT THROUGH TRILOGY PROVIDED EDUCATION REIMBURSEMENT & CERTIFICATION FUNDS

TUITION REIMBURSEMENT

Assists employees who have paid out of pocket for college tuition related to their job while working for Trilogy.

- Employees must be full time and have six months of service with the company to be eligible.
- Employees agree to work for the company for a period of one (1) year from the completion of the course that they are receiving reimbursement for and agree to reimburse the company a prorated amount based on how close they are to reaching the one (1) year work agreement if they leave employment.
- Employees must submit an invoice for their tuition cost and a copy of their grades from the course to receive reimbursement. Reimbursement covers tuition only.

CAREER & PERSONAL DEVELOPMENT

At Trilogy, we believe our greatest asset is YOU and we commit to providing you opportunities to grow and develop! Current programs include:

- Nurse Mentor / Caregiver Preceptor Program
- Online Learning
- Clinical Leaders of the Future / Administrator in Training Program
- Service Excellence
- Comprehensive Onboarding Programs
- Leadership Development
- Foundation Ambassadors

CERTIFICATION AND TRAINING ASSISTANCE

This program assists employees seeking a certification. These funds are paid directly to the training group or school prior to the beginning of the training.

- Employees agree to work for the company for a period of one (1) year from the completion of the course that they are receiving reimbursement for and agree to reimburse the company a prorated amount based on how close they are to reaching the one (1) year work agreement if they leave employment.
- Employees must apply for this program at least 3-4 weeks prior to when the school requires the funds.

Employees can receive up to $2,000 combined per calendar year of Tuition Reimbursement and Certification Assistance.

PURDUE GLOBAL

- Full-time and part-time employees only are eligible for 180+ degrees at Purdue Global.
- Start dates are available from January - July.
- Any fees or book cost outside of tuition are not covered.
- Participating employees commit to $25 per paycheck
- More information available at: **trilogy.purdueglobal.edu**

FAST TRACK APPRENTICESHIP PROGRAM

At Trilogy, we believe in growing our employees. That's why we offer a number of opportunities to further the careers of those employed at our campuses. Our Fast Track Apprenticeship Program gives full- and part-time employees the option to pursue certifications which will lead directly to promotions and premium pay. Currently we have seven tracks: Nurse Aide, Culinary, Hospitality, Life Enrichment, Business Office, Plant Operations, and Environmental Services.

For more information about the Apprenticeship Program or to apply visit: **trilogyjobs.com/fasttrack**

EMPLOYEE SUPPORT PROGRAMS

EMERGENCY ASSISTANCE TO HELP EMPLOYEES THROUGH TIMES OF STRUGGLE

There are two types of Emergency Assistance Awards:

- Foundation Award: Covers life-threatening medical emergency care for the employee or immediate family member *(including domestic violence)*, property loss due to natural disaster *(fire, tornado, flood, etc.)*, or the death of a immediate family member.
- Campus Designated Awards: Covers non-life threatening medical emergencies, home eviction, car problems, and other situations deemed an emergency *(at the committee's discretion)*. The maximum award is $200.

An employee can receive a maximum of $1,000 in Emergency Assistance every rolling 12-months, from the date awarded.

EDUCATION ASSISTANCE TO HELP EMPLOYEES THROUGH HOPE AND ADVANCEMENT

- Awards are given on a 6-month/Semester basis
- All eligible employees are now required to apply during each Education Assistance Period (Deadlines to apply are May 15 and Oct 15)..
- No Education Assistance applications or awards will 'roll over' to another semester or funding time period

EMPLOYEE & EMPLOYEE DEPENDENT SCHOLARSHIPS

The Scholarship Program empowers our employees to expand their education, achieve higher levels of personal fulfillment, and increase job satisfaction.

- Applications accepted year-round and are reviewed/ approved twice a year, in the spring and fall.
- Employees must have at least six months of service to be eligible and work at least 20 hours a week at the times of payment to receive funds if awarded.
- Employee scholarships are generally between $125 and $1000; Dependent scholarships are $250.

STUDENT LOAN REPAYMENT

- Employees are eligible who have completed their degree and are no longer in school.
- Employees must have at least six months of service to be eligible and work at least 20 hours a week at the times of payment to receive funds if awarded.
- Paid in $100 increments for full time employees and $50 increments for part time employees.

For more information about the Trilogy Foundation or to apply for any of the programs visit: **www.thetrilogyfoundation.org**

OTHER EMPLOYEE ASSISTANCE PROGRAMS:

SUSANS SAVINGS FIRST TIME HOME BUYERS PROGRAM

- Participants agree to payroll deduction for 6 months.
- Every dollar saved is matched by $2. For example, if $1,000 is saved through payroll deduction it is matched with an additional $2,000 for a total of $3,000 for home ownership.

TAX PREPARATION

- The average cost for filling taxes is over $200. Keep this money in your pocket while applying to get the maximum refund that you are entitled to! Tax Slayer offers employees a complete free federal and state tax returns.

Trilogy Foundation
*Heart of **ONE***

DONATIONS

The Trilogy Foundation depends on the charitable giving of our outside sponsors along with our Trilogy, Paragon Rehab, and PCA Pharmacy employees.

ONE CAMPAIGN

- Approximately 70% of employees donate through payroll deduction through the Opportunity Needs Everyone (ONE) campaign, which encourage employees to give at least $1 a day to the general Foundation fund.
- These donations directly fund the employee Emergency Assistance and Education Assistance program to assist employees in needs.
- Donations can be made at **TrilogyOne.org.**

IMPORTANT CONTACTS

DIRECTPATH

Your single source for all benefit-related questions and assistance!

- advocate@directpathhealth.com
- http://advocacy.directpathhealth.com/Trilogy/

HOURS:
Monday – Friday 7:00 a.m. – 8:00 p.m. CT
Saturday 8:00 a.m. – 1:00 p.m. CT

- 1- 866-253-2273

ADP VANTAGE

- www.myadp.com
- ADP Verification Services
  - 1-800-553-3823
  - adpdvs.com
- Garnishment questions: 1-866-324-5191
- Username and Password Assistance: 1-800-551-1236

ANTHEM BLUE CROSS BLUE SHIELD (MEDICAL & VISION)

- Anthem.com
- Medical: 1-833-916-2010
- Vision: 1-866-723-0515

BMS FLEXIBLE SPENDING ACCOUNTS

- 1-800-919-2674
- Email for Claims Submissions: claims@bmsllc.net
- Email for Billing Questions: billing@bmsllc.net
- Flex Online: myflexonline.com
- bmsllc.net

DELTA DENTAL OF KENTUCKY

- 1-800-955-2030
- ky.deltadental.com

FIDELITY

- 401k.com
- 401(k): 1-800-835-5097
- HSA: 1-800-544-3716

LEGALSHIELD / IDSHIELD

- 1-800-654-7757
- www.LegalShield.com
- www.IDShield.com

MAGELLAN HEALTH - BeWell Assistance Program

- MagellanAscend.com/member
- 1-800-424-4039

MetLife (ALL PRODUCTS)

- Life, Critical Illness & Accident: 1-800-438-6388
- Auto, Home, & Pet Insurance: 1-800-438-6388
- Will Preparation: 1-800-821-6400
- Leave of Absence/Disability:
  - 1-877-638-8262
  - mybenefits.metlife.com

PURCHASING POWER

- Purchasing Power Registration: trilogy.purchasingpower.com
- 1-888-923-6236

RX BENEFITS / EXPRESS SCRIPTS / SYNCHRONY PHARMACY

- 1-800-334-8134
- rxhelp@rxbenefits.com

TRILOGY FOUNDATION

- thetrilogyfoundation.org
- Foundation.info@trilogyhs.com

TRILOGY PERKS

- trilogyperks.employeediscounts.co/perks

TRILOGY UNIVERSITY

- Trilogyhs.csod.com

VIRGIN PULSE

- 1-888-671-9395
- join.virginpulse.com/trilogyfit

WAGE WORKS (COBRA)

- 1-800-526-2720

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

ALABAMA – MEDICAID

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – 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

ARKANSAS – MEDICAID

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – HEALTH FIRST COLORADO
(Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA – MEDICAID

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – MEDICAID

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – MEDICAID

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

Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – MEDICAID

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – MEDICAID

Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – MEDICAID

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – MEDICAID

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – MEDICAID

Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – MEDICAID

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – MEDICAID

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEW HAMPSHIRE – MEDICAID

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

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – MEDICAID

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – MEDICAID AND CHIP

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

NEVADA – MEDICAID

Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

SOUTH DAKOTA - MEDICAID

Website: http://dss.sd.gov
Phone: 1-888-828-0059

SOUTH CAROLINA – MEDICAID

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS – MEDICAID

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– MEDICAID

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – MEDICAID

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – MEDICAID

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – MEDICAID AND CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – MEDICAID

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor **U.S. Department of Health and Human Services**

REQUIRED NOTICES

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.

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS
If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. However, you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards 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/or your dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

WOMEN'S HEALTH AND CANCER RIGHTS ACT
On October 21, 1998 Congress passed the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include: Reconstruction of the breast upon which the mastectomy has been performed, Surgery/reconstruction of the other breast to produce a symmetrical appearance, Prostheses, and Physical complications during all stages of mastectomy, including lymphedemas. In addition, the plan may not: interfere with a woman's rights under the plan to avoid these requirements, or offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA PRIVACY NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information in your company plan (herein referred to as the "Plan") creates or receives about you.

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013.

As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

HOW THE PLAN WILL USE OR DISCLOSE YOUR PHI
Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request.

The minimum necessary standard will not apply in the following situations:
- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to HHS;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with legal regulations; and
- Uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan:
For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.
- The PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- The PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For School Records. The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Right to Request Restrictions on PHI Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend. You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, effective January 1, 2013, you can request an accounting of all disclosures by the Plan of your electronic PHI during the three years prior to the date of your request.

Right to Receive Confidential Communications. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.
- The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of you unsecured PHI.

Your Right to File a Complaint. You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information. If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan.

The information in this Benefit Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Benefit Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefit Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Benefit Summary, contact the Benefits Department.

MEDICARE PART D CREDITABLE COVERAGE DISCLOSURE NOTICE
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 Your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Employer has determined that the prescription drug coverage offered by Your Employer 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 Employer coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Your Employer coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About 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).

MEDICARE PART D NON-CREDITABLE COVERAGE DISCLOSURE NOTICE
IMPORTANT NOTICE FROM YOUR EMPLOYER ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Employer has determined that the prescription drug coverage offered by the Your Employer is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Your Employer. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you become eligible.
3. You can keep your current coverage from Your Employer. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you become eligible for Medicare and each year from October 15 to December 7. However, if you decide to drop your current coverage with Your Employer, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Your Employer.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? Since the coverage under Your Employer, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base benefit 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 benefit premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Employer coverage will not be affected. [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] If you do decide to join a Medicare drug plan and drop your current Your Employer coverage, be aware that you and your dependents will be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage. Contact the Your Employer Benefit Department. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Your Employer changes. You also may request a copy of this notice at any time.

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).

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS ** 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 benefit (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."

The following ONLY applies if the Plan provides retiree health 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 [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
- The end of employment or reduction of hours of employment;
- Death of the employee;
- Only if Plan provides retiree coverage: Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

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

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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 period 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.

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

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 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.

Plan contact information. Please contact your Human Resources Department.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE
PART A: GENERAL INFORMATION | FORM APPROVED OMB NO. 1210-0149

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 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.

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