NOTIFICATIONS

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

There is 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. For specific information about open enrollment for health insurance coverage through the Marketplace, please go to www.healthcare.gov.

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

If you (and/or your dependents) have Medicare, or will become eligible for Medicare within the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please read the notice on Page 4 for more details

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

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact your human resources department.

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

** 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% of such costs (Section 36B(c)(2)C)(ii) of the Internal Revenue Code of 1986).*

AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

This Company's group health Plan is required by law to provide notice of the Plan's duties and privacy practices with respect to covered individuals' protected health information by providing a Notice of Privacy Practices (NOPP) to participants. The Plan's NOPP is available upon request. To obtain a copy of the NOPP, or for more information regarding the Plan's privacy policies or your rights under HIPAA, contact this Company's human resources department.

PATIENT PROTECTION DISCLOSURE

This Company's group health plan may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact human resources or go to the insurer's website. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the group health plan or the insurer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact human resources or go to our insurer's website.

HIPAA SPECIAL ENROLLMENT RIGHTS

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in this Company's health plan under "special enrollment provisions" briefly described below.

Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under this Company's health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under this Company's health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.

Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in this Company's health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from your human resources department.

Please contact your human resources department for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this Plan. Therefore, the deductibles and coinsurance shown in the medical section of your benefits guide apply. If you would like more information on WHCRA benefits, call your human resources department.

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).

MICHELLE'S LAW

A new law went into effect for health plans beginning January 1, 2010 called Michelle's law. This law is a result of a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while the child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the child to lose student status for purposes of coverage under the plan.

If the dependent child's treating physician does not provide written documentation the child is suffering from a serious illness or injury and the leave of absence is medically necessary, the plan will not provide continued coverage.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are not eligible for Medicaid, CHIP, or a state premium assistance program you may be able to buy individual insurance coverage through a Health Insurance Marketplace (such as Covered California). 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, you can 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, you can contact your state Medicaid or CHIP office using the information below, or call 1-877-543-7669 or go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the **Department of Labor** at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2018. You should contact your State for further information on eligibility.

STATE	PROGRAM	WEBSITE	PHONE/EMAIL
Alabama	Medicaid	www.myalhipp.com	855-692-5447
Alaska	Medicaid	http://myakhipp.com/, http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	866-251-4861, customerservice@myakhipp.com
Arkansas	Medicaid	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
Colorado	Medicaid and CHIP	https://www.healthfirstcolorado.com/ CHP+ Colorado.gov/HCPF/Child-Health-Plan-Plus	800-221-3943/State Relay 711 800-359-1991 CHP+/State Relay 711
Florida	Medicaid	www.flmedicaidtplrecovery.com/hipp/	877-357-3268
Georgia	Medicaid	http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP)	404-656-4507
Indiana	Medicaid	Healthy Indiana Plan for Low income adults 19-64 - http://www.in.gov/fssa/hip Other Medicaid - http://www.indianamedicaid.com	Healthy Indiana Plan - 877-438-4479 Medicaid - 800-403-0864
Iowa	Medicaid	http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	888-346-9562
Kansas	Medicaid	www.kdheks.gov/hcf/	785-296-3512
Kentucky	Medicaid	http://chfs.ky.gov/dms/default.htm	800-635-2570
Louisiana	Medicaid	http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	888-695-2447
Maine	Medicaid	www.maine.gov/dhhs/ofi/public-assistance/index.html	800-442-6003, TTY Main relay 711
Massachusetts	Medicaid and CHIP	http://www.mass.gov/eohhs/gov/departments/masshealth/	800-862-4840
Minnesota	Medicaid	http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	800-657-3739
Missouri	Medicaid	www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	800-694-3084
Nebraska	Medicaid	http://www.ACCESSNebraska.ne.gov	855-632-7633, Lincoln: 402-473-7000, Omaha: 402-595-1178
Nevada	Medicaid	https://dhcfp.nv.gov	800-992-0900
New Hampshire	Medicaid	www.dhhs.nh.gov/ombp/nhhpp/	603-271-5218 Hotline: NH Medicaid Service Center at 888-901-4999
New Jersey	Medicaid and CHIP	www.state.nj.us/humanservices/dmahs/clients/medicaid/ www.njfamilycare.org/index.html	609-631-2392 800-701-0710 CHIP
New York	Medicaid	www.nyhealth.gov/health_care/medicaid/	800-541-2831
North Carolina	Medicaid	www.ncdhhs.gov/dma	919-855-4100
North Dakota	Medicaid	www.nd.gov/dhs/services/medicalserv/medicaid/	844-854-4825
OKLAHOMA	Medicaid and CHIP	www.insureoklahoma.org	888-365-3742
Oregon	Medicaid	http://healthcare.oregon.gov/Pages/index.aspx, http://www.oregonhealthcare.gov/index-es.html	800-699-9075
Pennsylvania	Medicaid	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm	800-692-7462
Rhode Island	Medicaid	www.ohhs.ri.gov	855-697-4347
South Carolina	Medicaid	www.scdhhs.gov	888-549-0820
South Dakota	Medicaid	http://dss.sd.gov	888-828-0059
Texas	Medicaid	https://www.gethipptexas.com/	800-440-0493
Utah	Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/, CHIP Website: http://health.utah.gov/chip	877-543-7669
Vermont	Medicaid	www.greenmountaincare.org/	800-250-8427
Virginia	Medicaid and CHIP	www.coverva.org/programs_assistance.cfm	800-432-5924 Medicaid 855-242-8282 CHIP
Washington	Medicaid	http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program	800-562-3022 ext. 15473
West Virginia	Medicaid	http://myWVHIPP	855-MyWVHIPP (1-855-699-8447)
Wisconsin	Medicaid and CHIP	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	800-362-3002
Wyoming	Medicaid	https://wyequalitycare.acs-inc.com/	307-777-7531

To see if any more states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, you can contact either: **U.S. Department of Labor, U.S. Department of Health and Human Services. Employee Benefits Security Administration, Centers for Medicare & Medicaid Services** www.dol.gov/ebsa, www.cms.hhs.gov, 866-444-EBSA (3272), 877-267-2323, Menu Option 4, Ext. 61565.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

This notice has information about your current prescription drug coverage with this Company 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: 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. This Company has determined that the prescription drug coverage offered by this Company's group health plan 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.

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).**

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current coverage with this Company will not be affected, that is, you can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Company coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with this Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact your human resources department for more information. NOTE: You'll get this notice each year and if this coverage through this Company 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 or 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).