BENEFITS GUIDE

JANUARY 1, 2024 - DECEMBER 31, 2024

PSHCG
PUBLIC SECTOR HEALTH CARE GROUP
AUTHORITY
EST 2010

2024

Berthoud Fire Protection District

PUBLIC SECTOR HEATHCARE GROUP

WELCOME

Thank you for taking the time to learn more about the employee benefits available to you in 2024. Your employer is a member of the Public Sector Health Care Group (PSHCG), an association of like-minded political entities who know the value of employee benefits and more importantly, maintaining your health and income should you become ill or injured. This benefit booklet offers an overview of the key features of the plans. Benefits are more fully described in the formal provisions of the plan documents. If there is a conflict between the highlights and the plan documents, the plan documents govern. If you have questions, please contact Human Resources. We thank you for contributing to our success!

OPEN ENROLLMENT KEY POINTS

It's Open Enrollment time, and that means this is your one opportunity to make your benefit choices for the calendar year, 2024. Outside of a qualifying life event, like marriage or the birth of a child, your benefit selections will remain in place through December 31, 2024. Also, it is important to know that life events only allow you to add or terminate coverage for you or your dependents. They never allow you to change medical insurance plans, if your employer offers a choice. If you do have a life change, please talk with your employer to clear up any questions you have and execute the change within 30 days of the date of your qualifying event.

DATES

Open Enrollment will be held from November 1st through November 20th. Your employer might have specific dates in mind, so look for further communication.

NEW HIRES

You are eligible to join the benefits once you satisfy the new hire waiting period, which is determined by your employer. Contact Human Resources for more information.

NEW HMO MEMBERS

If you elect the HMO plan, it is important that you designate a primary care physician (PCP). This plan requires electronic referrals from your PCP for all services. To select an HMO doctor, go to www.navigate.welcometouhc.com.

WHO IS ELIGIBLE?

Full-time employees (as defined by your employer) are eligible to join the PSHCG plans. Check with your HR representative to further clarify their full-time status rules.

Eligible dependents include:

- Your legally married spouse, domestic partner or common law partner
- Dependent children up to age 26 (adopted children and/or stepchildren)

QUESTIONS?

Please contact your HR representative for any questions related to open enrollment and benefits.

CARRIER INFORMATION

United Healthcare - Group #0906675 - www.myuhc.com - 800-357-0978
HealthiestYou - Group #0906675 - www.healthiestyou.com - 866-703-1259
MetLife - Group #5348811 - www.metlife.com - 800-275-4638
Optum RX - Group #0906675 - www.optumrx.com - 800-356-3477
Optum Employee Assistance Program - 866-374-6061 - Access Code: PSHCG

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EST 2010

MEDICAL - UNITED HEALTHCARE

CHOICE PLUS PPO PLAN B	
BENEFITS	**IN-NETWORK**
Dr. Office Visit - Primary Care Physician	$30 copay
Specialist Visit	$50 copay
Preventive Care	Plan pays 100% for approved services
Individual Deductible	$3,000
Family Deductible	$6,000
Co-Insurance Percentage	You pay 0% after deductible
Individual Out-of-Pocket Max	$6,000
Family Out-of-Pocket Max (after which plan pays 100%)	$12,000
Inpatient Hospital	You pay a $500 copay and deductible
Outpatient Services	You pay 0% after deductible
Emergency Room	$400 copay
Urgent Care	$30 copay
MRI, CT, PET Scans	You pay 0% after deductible
Prescription Drug Copays	$15 / $40 / $70 / 25% max $500

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

MEDICAL - UNITED HEALTHCARE

CHOICE PLUS PPO PLAN C	
BENEFITS	**IN-NETWORK**
Dr. Office Visit - Primary Care Physician	$0 copay
Specialist Visit	$50 copay
Preventive Care	Plan pays 100% for approved services
Individual Deductible	$3,000
Family Deductible	$6,000
Co-Insurance Percentage	You pay 20% after deductible
Individual Out-of-Pocket Max	$6,500
Family Out-of-Pocket Max (after which plan pays 100%)	$13,000
Inpatient Hospital	You pay 20% after deductible
Outpatient Services	You pay 20% after deductible
Emergency Room	You pay 20% after deductible
Urgent Care	$0 copay
MRI, CT, PET Scans	$750 copay
Prescription Drug Copays	$5 / $40 / $60 / 25% max $500

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

MEDICAL - UNITED HEALTHCARE

CHOICE PLUS PPO PLAN D HSA	
BENEFITS	**IN-NETWORK**
Dr. Office Visit - Primary Care Physician	You pay 0% after deductible
Specialist Visit	You pay 0% after deductible
Preventive Care	Plan pays 100% for approved services
Individual Deductible	$2,500
Family Deductible	$5,000 per family * COMBINED
Co-Insurance Percentage	You pay 0% after deductible
Individual Out-of-Pocket Max	$3,500 per employee only
Family Out-of-Pocket Max (after which plan pays 100%)	$7,000 per family *COMBINED
Inpatient Hospital	You pay 0% after deductible
Outpatient Services	You pay 0% after deductible
Emergency Room	You pay 0% after deductible
Urgent Care	You pay 0% after deductible
MRI, CT, PET Scans	You pay 0% after deductible
Prescription Drug Copays	Deductible then $15 / $40 / $70 / 25% max $500

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

***Combined Deductible:** each member of the family uses and pays for health care services and the amount they pay out-of-pocket for those services is credited toward the family's deductible. After the combined total of those expenses reaches the combined family deductible, the health plan begins to pay health care expenses for the entire family.

Ex: One family member has $2,500 in expenses, another family member has $2,000 in expenses, another has $2,500 in expenses. The family COMBINED deductible is then met and after-deductible benefits kick in.

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A health plan that's always with you

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Register for your personalized website on myuhc.com® and download the UnitedHealthcare® app. These digital tools are designed to help you understand your benefits and make informed decisions about your care.

- Find care and compare costs for providers and services in your network
- Check your plan balances, view your claims and access your health plan ID card
- Access wellness programs and view clinical recommendations
- 24/7 Virtual Visits – Connect with providers by phone or video* to discuss common medical conditions and get prescriptions,** if needed
- View your health care financial account(s) such as HSA, FSA or HRA
- Compare prescription costs and order refills

Register today

Scan the QR code or go to **myuhc.com** and click **Register Now**

See next page for registration steps

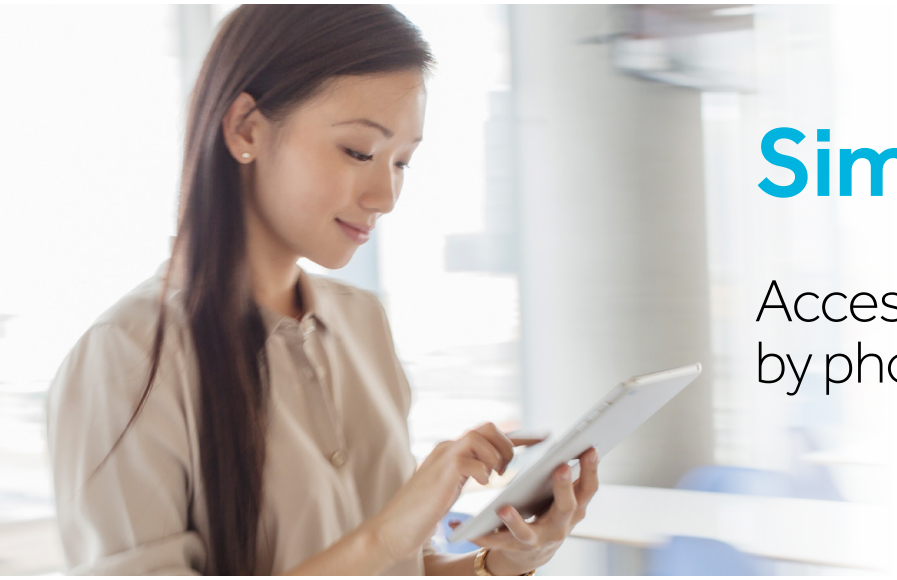
Download the app
Available for iPhone and Android

*Data rates may apply.
**Certain prescriptions may not be available, and other restrictions may apply.

continued

United Healthcare

VIRTUAL MEDICINE - HEALTHIESTYOU



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Take control of your health with HealthiestYou.

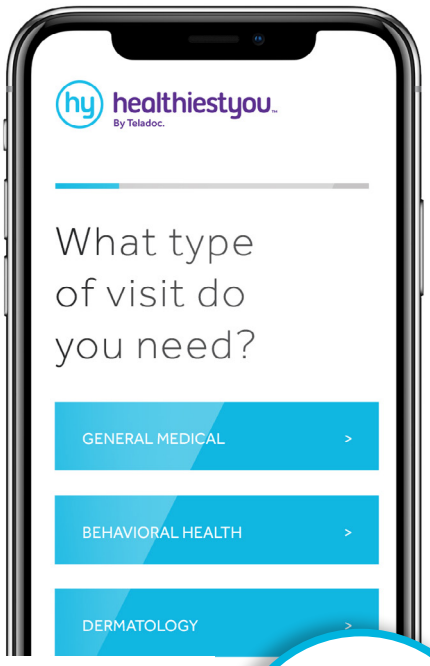
Download the app to access general medical care, confidential counseling, relief from skin issues, and more. Cost will vary based on plan*.

Talk to a doctor 24/7 FOR FREE
For conditions like the flu, bronchitis, allergies, sore throats, and more.
$0 Consults

Confidential counseling 7 days a week
If you're feeling stressed, overwhelmed, down, or not like yourself.
$85, $95, or $200 Consults

Relief from skin issues
For acne, eczema, rashes, psoriasis, and much more by uploading images on the app.
$75 Consults

*Download the app and set up your account to see what services are available to you and how much they cost.



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Download the app for access to healthcare on the go

HealthiestYou.com | 866-703-1259

Download on the App Store | GET IT ON Google Play

VISIT MYUHC.COM TO VIEW HEALTH HISTORY

Good care starts with good information.

Remembering the medications you've been prescribed, procedures you've had and conditions you've been treated for isn't always easy. With the new Individual Health Record feature on **myuhc.com®** and the UnitedHealthcare® app, you don't have to.

Discussing your health history just got easier.

Your Individual Health Record puts over a year's worth of history—from all of your providers*—in the palm of your hand. So now, each time you visit a doctor, you can bring it along to help ensure they have a better picture of your overall health.

One place provides access to your:

- Allergies
- Care Team
- Conditions
- Immunizations
- Prescriptions
- Procedures

View your health history on the spot:

- **Go to myuhc.com > Account/Profile > Individual Health Record.**
- **Go to UnitedHealthcare app > Menu Icon > Individual Health Record.**

*Individual Health Record only applies to care you've received as a UnitedHealthcare member, so newer members will have less history.

Your Individual Health Record only has information on care you've received as a UnitedHealthcare member during a certain timeframe. Information in the Individual Health Record is not a substitute for medical or behavioral health care advice. If you have questions about information in your Individual Health Record, please talk with your doctor or call the IHR Dedicated Service Team toll-free at 1-844-585-1471.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

Facebook.com/UnitedHealthcare **Twitter**.com/UHC **Instagram**.com/UnitedHealthcare **YouTube**.com/UnitedHealthcare

UnitedHealthcare®

REAL APPEAL - WEIGHT MANAGEMENT PROGRAM

Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal®, an online weight management support program.

Get healthier, at no additional cost to you

Real Appeal on Rally Coach™ is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way

Feel supported with personalized messages, online group sessions led by coaches and a caring community of members.

Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

Join today at enroll.realappeal.com or scan this code

United Healthcare | Real Appeal®

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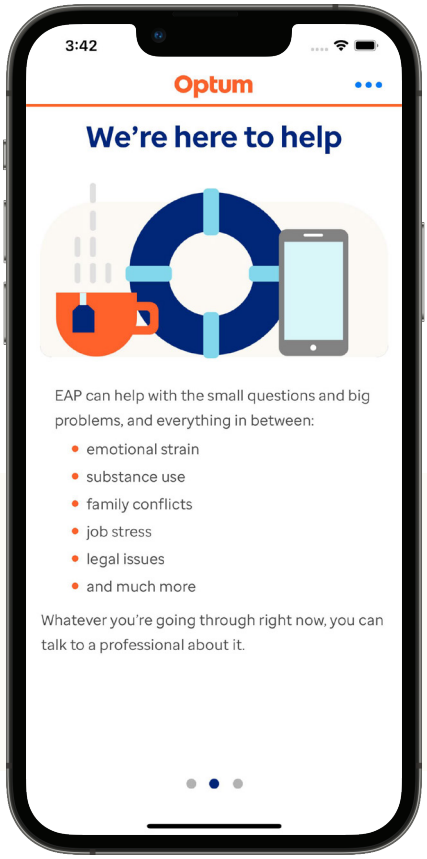
Optum

YOU, supported

When you want 24/7 access

Life happens 24/7, and with the Optum Assist app, support is available for every moment. Use it to:

- Learn about your Employee Assistance Program (EAP)
- Talk with an EAP specialist
- Get 4 no-cost counseling sessions per issue, per year
- Find a provider and schedule an appointment
- Access videos and articles about anxiety, caregiving, parenting, relationships, depression and more



ACCESS CODE: PSHCG

Download Optum Assist today.

Log in with your company access code PSHCG.

Download on the App Store

GET IT ON Google Play

DENTAL - METLIFE

DENTAL		
Benefit Summary	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$50 per individual / max $150 per family	$50 per individual / max $150 per family
Deductible Applies to	Type II & III	Type II & III
Dental Calendar Year Maximum	$1,500 per individual in your family	$1,500 per individual in your family
Orthodontia Lifetime Maximum	$1,500 for children up to age 19	$1,500 for children up to age 19
Benefit Summary	**In-Network**	**Out-of-Network**
Type I - Diagnostic & Preventive	100%	100%
Type II - Basic Services	80%	80%
Type III - Major Services	50%	50%
Type IV - Orthodontic Services	50%	50%
Endodontics / Periodontics	80%	80%
Benefit Summary	**In-Network**	**Out-of-Network**
Waiting Period	Waiting periods only apply for late entrants *(members who do not join the plan at their initial enrollment opportunity)*	

The table above shows the plan details. Please refer to your plan descriptions for a full list of covered services and limitations.

Features of the PDP Dental Plan:

- Use any dentist (keep in mind, your greatest savings will be with dentists participating in the MetLife PDP network)
- You pay a coinsurance for services
- Preventive cleanings are covered at 100% and may be scheduled every six months
- Orthodontia is covered for dependent children up to age 19

Search for a Dentist Online:

You can search for a dentist online at www.metlife.com/dental. Click on "Find a dentist" on the right-hand side of your screen and follow the prompts on the next screen.

Provider networks change, so it is always a good idea to call and confirm your dentist's participation in the network.

ID Cards: MetLife will not send you an ID card. If you need an ID card, you can request one online. Go to www.metlife.com/dental and log in to your account.

VISION - METLIFE

VISION		
Key Points Summary	**In-Network**	**Out-of-Network**
Eye Exam	$10 copay	$45 allowance
Prescription Glasses: Lenses	$10 copay	$30 - $100 allowance
Prescription Glasses: Frames	$150 retail allowance	$70 allowance
Contact Lenses	$150 allowance	$105 allowance
Benefit Frequency	**In-Network**	**Out-of-Network**
Eye Exam	Every 12 months	Every 12 months
Prescription Glasses: Lenses	Every 12 months	Every 12 months
Prescription Glasses: Frames	Every 24 months	Every 24 months
Contact Lenses	Every 12 months in lieu of glasses	Every 12 months in lieu of glasses
Network Discounts	**In-Network**	**Out-of-Network**
Laser Vision Correction	15% Savings	N/A
Prescription Glasses	20% Savings	N/A
Contact Lenses	15% off evaluation	N/A

The vision plan covers an eye exam and your choice of lenses or contacts every 12 months. It also covers frames every 24 months. Please note that if you choose an out-of-network doctor or facility, then MetLife will only reimburse you up to the allowable amount outlined in the table to the right. Please refer to your plan description for full details.

Need to find an eye doctor in the MetLife Network?

For a complete list of providers near you, use the MetLife Provider Locator on www.metlife.com/vision and choose the "Find Vision Provider", then click Vision PPO. You may also call MetLife at 1-855-MET-EYE-1.

Using your vision benefits:

You will not receive a MetLife ID card. When you schedule your appointment, simply tell them you have MetLife for your vision benefits. That's all you need to do!

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is an account funded to help you save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment.

WHO CAN HAVE AN HSA?

Any adult can have an HSA if you:

- Have coverage under an HSA-qualified, High Deductible Health Plan (HDHP)
- Are not enrolled in Medicare or another health plan
- Cannot be claimed as a dependent on someone else's tax return

Contributions to your HSA can be made by you, your employer, or both. However, the combined contributions are limited annually. If you make a contribution, you can deduct the contribution (even if you do not itemize deductions) when completing your federal income tax return. Alternatively, some employers will allow you to make your HSA contributions through pre-tax payroll deductions.

Contributions to the account must stop once you are enrolled in Medicare or another health plan that is not a qualified High Deductible Health Plan (HDHP). However, you can still use your HSA funds to pay for medical expenses tax-free.

2024 ANNUAL HSA CONTRIBUTION LIMITS

You can make contributions to your HSA each year that you are eligible. The IRS contribution limits include both employee and employer contributions and tax penalties may apply if you over contribute. Visit www.irs.gov/publications/p969 for more information regarding HSA contributions.

- Single coverage: $4,150
- Family coverage: $8,300

Individuals ages 55 and older can make additional "catch-up" contributions for up to $1,000 annually.

USING YOUR HSA

You can use money in your HSA to pay for any qualified health-care expense permitted under federal tax law. This includes most medical care services, dental and vision care. Money contributed to an HSA is portable. If you leave employment, the account is yours to keep.

HUMANA - VOLUNTARY TERM LIFE AND AD&D

VOLUNTARY TERM LIFE AND AD&D
Employee Options: $15,000 - $100,000, Guarantee Issue: <10 employee $0, 10+ employees $50,000, 50+ employees $100,000
Spouse Options: $5,000 - $50,000 Guarantee Issue: <10 employees $0, 10+ employees $20,000
Child Cost (to age 26): $5,000 for $1 per month

HUMANA EMPLOYEE / SPOUSE COST PER MONTH						
Amounts	$15,000	$20,000	$40,000	$60,000	$80,000	$100,000
MONTHLY PREMIUMS						
<30	$1.35	$1.80	$3.60	$5.40	$7.20	$9.00
30-34	$1.35	$1.80	$3.60	$5.40	$7.20	$9.00
35-39	$1.80	$2.40	$4.80	$7.20	$9.60	$12.00
40-44	$2.40	$3.20	$6.40	$9.60	$12.80	$16.00
45-49	$3.45	$4.60	$9.20	$13.80	$18.40	$23.00
50-54	$5.10	$6.80	$13.60	$20.40	$27.20	$34.00
55-59	$7.95	$10.60	$21.20	$31.80	$42.40	$53.00
60-64	$10.95	$14.60	$29.20	$43.80	$58.40	$73.00
65-69	$17.85	$23.80	$47.60	$71.40	$95.20	$119.00

Your employer offers you offers you the opportunity to supplement your basic life and AD&D with Voluntary Life and AD&D amounts for yourself and your family at competitive group rates through Humana.

- You may purchase $15,000 to $100,000 of voluntary life insurance for yourself in $10,000 increments (not to exceed five times your salary).
- You may purchase $15,000 to $100,000 of life insurance for your spouse, in $5,000 increments (not to exceed 50% of your voluntary life amount).
- You may purchase $5,000 of life benefit for your children six months to 19 years of age (to age 25 for full-time students).

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

SPECIAL ENROLLMENT

Loss of Other Coverage

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

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

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

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 already enrolled in Medicaid or CHIP, 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 at www.insurekidsnow.gov or dial toll free 1-877-KIDSNOW 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.

BREAK TIME FOR NURSING MOTHERS UNDER THE FLSA

Time and Location of Breaks

Employers are required to provide a reasonable amount of break time to express milk as frequently as needed by the nursing mother. The frequency of breaks needed to express milk as well as the duration of each break will likely vary.

A bathroom, even if private, is not a permissible location under the Act. The location provided must be functional as a space for expressing breast milk. If the space is not dedicated to the nursing mother's use, it must be available when needed in order to meet the statutory requirement. A space temporarily available when needed by the nursing mother is sufficient, provided that the space is shielded from view, and free from any intrusion from co-workers and the public.

Coverage and Compensation

Only employees who are not exempt from section 7, which includes the FLSA's overtime pay requirements, are entitled to breaks to express milk. While employers are not required under the FLSA to provide breaks to nursing mothers who are exempt from the requirements of Section 7, they may be obligated to provide such breaks under State Law.

Employers with fewer than 50 employees are not subject to the FLSA break time requirement if compliance with the provision would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business. All employees who work for the covered employer, regardless of work site, are counted when determining whether this exemption may apply.

Employers are not required under the FLSA to compensate nursing mothers for breaks taken for the purpose of expressing milk. However, where employers already provide compensated breaks, an employee who uses that break time to express milk must be compensated in the same way that other employees are compensated for break time. In addition, the FLSA's general requirement that the employee must be completely relieved from duty or else the time must be compensated as work time applies.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT OF 1996

The group health coverage provided by Public Sector Health Care Group complies with the Newborns' and Mothers' Health Protection Act of 1996.

Under this law group health plans and health insurance insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn 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 and her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 ours (or 96 hours).

WOMEN'S HEALTH & CANCER RIGHTS ACT

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. Therefore, deductibles and coinsurance apply.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

What is COBRA Continuation Coverage?

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

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

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

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

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

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

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

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee become entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Continuation 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. When the qualifying event is the end of employment, reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare Benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. The continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries under the Plan, including special enrollment rights.

How long will continuation coverage last?
In the case of a loss of coverage due to the end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continued coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to qualified beneficiaries.

Can you extend the length of an 18 period of continuation coverage?
If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Human Resources of a disability or second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability: An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the plan of that fact within 30 days after SSA's determination.

Second Qualifying Event: An 18-month extension will be available to spouses and depended children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both, or a dependent child's ceasing to be eligible for coverage as a depended under the Plan). These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event has not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Loss of Eligibility for COBRA Continuation Coverage
Continuation coverage will be terminated before the end of the maximum period if any of the following occur:

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitation on plans' imposing a pre-existing condition exclusion and such exclusion with become prohibited beginning in 2014 under the Affordable Care Act)
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage
- The employer ceases to provide any group health plan for its employees

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant of beneficiary not receiving continuation coverage (such as fraud).

How do you elect COBRA Continuation Coverage?
To elect continuation coverage, you must complete an election form and return it to Human Resources. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. The employee can elect continuation coverage on behalf of a qualified spouse. A parent, the employee or his or her spouse may elect to continue coverage on behalf of any dependent children. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

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.
- Public Sector Health Care Group has determined the United medical plans, 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.

HIPAA BASICS - YOUR RIGHT TO PRIVACY

In April 2003, the final regulations that place restrictions on how personally identifiable health information (PHI) may be used and disclosed by certain organizations became effective.

These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protections for all health information. In summary, the HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed
- Require that individuals be told how their health information will be used and disclosed
- Provide individuals with a right to access, amend or copy their medical records
- Give individuals a right to receive an accounting of disclosures, to request special restrictions, and to receive confidential communications
- Impose fines where the requirements contained within the regulations are not met

PATIENT PROTECTION MODEL

Health insurance companies generally require the designation of a primary care provider for services and claims to be covered. You have the right to designate any primary care provider who participates in your selected plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

If you do not choose a primary care physician upon enrolling in a health insurance plan, the insurance company may randomly designate one for you. Some insurance plans will not cover any claims or services if you see a primary care physician or specialist that is not assigned to you and the correct referral process followed.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your group administrator.

If you're nearing retirement age, or are over 65 and still working, you may have questions about Medicare.

WHAT IS MEDICARE?

Medicare is health insurance for people are age 65 or older, under 65 with certain disabilities, or any age with End-stage Renal Disease (permanent kidney failure).

Types of Medicare

There are four types of Medicare.

Medicare Part A helps cover impatient care in hospitals, skilled nursing facilities, and hospice and home health care. Generally, there is no monthly premium if you qualify and paid Medicare taxes while working.

Medicare Part B helps cover medical services like doctors' services, outpatient care and other medically necessary services that Part A doesn't cover. You need to enroll in Medicare Part B and pay a monthly premium determined by your income, along with a deductible.

Many people also purchase a supplemental insurance policy, such as a Medigap plan, to handle any Part A and B coverage gaps.

Medicare Advantage Plans, also known as Medicare Part C, are combination plans managed by private insurance companies approved by Medicare. They typically are a combination of Part A, Part B and sometimes Part D coverage, but must cover medically necessary services. These plans have discretion to assign their own copays, deductibles and coinsurance.

Medicare Part D is prescription drug coverage and is available to everyone with Medicare. It is a separate plan provided by private Medicare-approved companies, and you must pay a monthly premium.

Getting Started

Medicare sends you a questionnaire about three months before you're entitled to Medicare coverage. Your answers to these questions, including whether you have group health insurance through an employer or family member, help Medicare set up your file and make sure your claims are paid correctly.

Coordination of Coverage

If you have Medicare and another type of insurance, the question of who should pay or who should pay first can be tricky. For example, generally a group health plan would pay before Medicare, but there are several exceptions. Visit www.medicare.gov for additional information.

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when can't control who is involved in your care - like when have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency Services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for the post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles, that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact: Department of Health and Human Services at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.