



EMPLOYEE BENEFIT GUIDE

PLAN YEAR | 2020-2021

FIELD BENEFIT GUIDE



Brown & Brown
INSURANCE®

EMPLOYEE BENEFITS



WELCOME TO YOUR 2020 BENEFITS!

NSC Technologies, LLC offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This enrollment booklet has been designed to provide you with the knowledge you need to make the best possible benefit decisions along with the Carrier Enrollment Materials. If after reviewing the enclosed information you have any questions, please contact Human Resources.

BENEFIT PLANS

EFFECTIVE NOVEMBER 1, 2020

Information provided in this booklet is intended to serve as a convenient reference guide. If any information contained in this booklet differs from any plan documentation, please revert to plan documentation.

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565



CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors.
For general information contact Human Resources.

COMPANY	PLAN	CONTACT INFORMATION
	Human Resources	Julie Ross 757-399-1738 x 1690 Heather Neill 757-399-1738 x 4
	Benefits Consulting Team	Patricia Berger Senior Account Executive 954-331-1353 Pberger@bbftlaud.com Analisa VanDelinder Senior Claims Analyst 954-331-1361 Avandelinder@bbftlaud.com Antonio Tavares Vice President 954-331-1545 atavares@bbftlaud.com Laura Sherwin Vice President 954-331-1383 LSherwin@bbftlaud.com
	Medical	Customer Service 1-833-592-9956 anthem.com
	Health Equity	Customer Service 1-866-346-5800 healthequity.com
	MEC / Fixed Indemnity	Customer Service 1-866-866-3424 theamericanworker.com
	Dental	Customer Service 1-800-547-9515 standard.com
	Vision	Customer Service 1-800-547-9515 standard.com
	Vol Life	Customer Service 1-800-378-6059 standard.com
	Supplemental Insurance	Customer Service 1-800-348-4489 allstatebenefits.com/mybenefits/User/Login/
	LifeLock	Customer Service 1-800-543-3562 lifelock.com
	Pre-Paid Legal	Customer Service 1-800-821-6400 members.legalplans.com/home
	401K	Customer Service 1-844-203-9586. mykplan.com

INTRODUCTION

Welcome to **NSC Technologies, LLC**! This Benefits Guide has been prepared for you as a summary to get you started, and to help you make the most of your benefits with **NSC Technologies, LLC**.

NSC Technologies, LLC offers medical, dental, vision, MEC and indemnity benefits, voluntary life and AD&D, identity theft and legal services benefits.

You must sign up during your first 30 days of employment. Your insurance will go into effect on the first day of the month following 60 days of employment.

NSC Technologies, LLC offers **401K** with immediately eligibility upon hire. You may sign up at any time. Your 401K will begin coming out on the first day of the following month after enrollment.


This guide has been designed to introduce you to **NSC Technologies, LLC's** benefits offerings; it does not replace more comprehensive benefits summary materials. **NSC Technologies, LLC** makes full SBC's and benefit summaries available at www.nsctechbenefits.com. Once you have reviewed your benefit options call the Benefits Call Center at 1.877.282.0808. They are available Monday-Friday 7:00am-5:00pm CST.

You may request a paper copy of these documents at any time by contacting Human Resources at (757) 399-1738 opt 4 or emailing HR@nsc-tech.com.



MEDICAL INSURANCE

NSC Technologies, LLC offers two medical insurance plans through Anthem Blue Cross Blue Shield, **effective November 1, 2020.**

	ANTHEM BCBS PPO+ HSA LUMENOS
SERVICES	IN-NETWORK
Calendar Year Deductible (CYD) Individual / Family	\$2,800 / \$5,600
Coinsurance	80% / 20%
Provider Services	Open Access
Primary Care Office Visit	20% After CYD
Specialist Office Visit	20% After CYD
Adult Wellness (Includes Preventive Lab)	\$0
Hospital Services	
Inpatient Hospital	20% After CYD
Inpatient Physician Services	20% After CYD
Outpatient Hospital	20% After CYD
Emergency Room (waived if ad-mitted)	20% After CYD
Ambulatory Surgery Center	20% After CYD
ASC Physician Services	20% After CYD
Minor Diagnostic Lab / X-Ray	20% After CYD
Major Diagnostic (MRI, CAT, NM, PET)	20% After CYD
Urgent Care	20% After CYD
Annual Out-of-Pocket Maximum	
Includes Deductible	Yes
Individual / Family	\$5,000 / \$10,000
Lifetime Maximum	Unlimited
Prescription Drugs (30 day supply)*	
Tier 1/Tier 2/Tier 3/Tier 4	20% After CYD
Mail Order (90 Day Supply)	20% After CYD
OUT-OF-NETWORK BENEFITS	
Coinsurance	60% / 40%
Emergency Room Facility	20% After INN CYD
All Other Services	40% After CYD
Deductible - Individual/Family	\$5,600 / \$11,200
Annual Out-of-Pocket - Indiv/Family	\$10,000 / \$20,000
Lifetime Maximum	Unlimited


For more detailed information regarding the medical benefits, refer to the summary of benefits.

RATES MEDICAL – WEEKLY PAYROLL CONTRIBUTIONS		
	Tobacco-Free Discount	Regular Rate
Employee	\$26.18	\$37.72
Employee + Spouse	\$138.12	\$161.19
Employee + 1 Child	\$59.58	\$71.12
Employee + Child(ren)	\$119.16	\$130.69
Family	\$213.94	\$237.02

*All Maintenance Medication must be filled via Mail Order or your Local Smart 90 Pharmacy after the first 90 day supply.

MEDICAL INSURANCE

NSC Technologies, LLC offers two medical insurance plans through Anthem Blue Cross Blue Shield, **effective November 1, 2020.**

	ANTHEM BCBS PPO KEYCARE
SERVICES	IN-NETWORK
Calendar Year Deductible (CYD) Individual / Family	\$500 / \$1,000
Coinsurance	80% / 20%
Provider Services	Open Access
Primary Care Office Visit	\$25
Specialist Office Visit	\$50
Online Medical Visit	\$15
Adult Wellness (Includes Preventive Lab)	\$0
Hospital Services	
Inpatient Hospital	20% After CYD
Inpatient Physician Services	20% After CYD
Outpatient Hospital	20% After CYD
Emergency Room	20% After CYD
Ambulatory Surgery Center	20% After CYD
ASC Physician Services	20% After CYD
Minor Diagnostic Lab / X-Ray	20% After CYD
Major Diagnostic (MRI,CAT, NM, PET)	20% After CYD
Urgent Care	\$50
Annual Out-of-Pocket Maximum Includes Deductible Individual / Family	Yes \$4,000 / \$8,000
Lifetime Maximum	Unlimited
Prescription Drugs (30 day supply)* Tier 1/Tier 2/Tier 3/Tier 4	\$10/\$40/\$60/20% to \$250
Mail Order (90 Day Supply)	\$25/\$100/\$150/20% to \$250
OUT-OF-NETWORK BENEFITS	
Coinsurance	60% / 40%
Emergency Room Facility	20% After INN CYD
All Other Services	40% After CYD
Deductible - Individual/Family	\$1,000 / \$2,000
Annual Out-of-Pocket - Indiv/Family	\$8,000 / \$16,000
Lifetime Maximum	Unlimited

For more detailed information regarding the medical benefits, refer to the summary of benefits.

RATES MEDICAL – WEEKLY PAYROLL CONTRIBUTIONS		
	Tobacco-Free Discount	Regular Rate
Employee	\$56.43	\$67.96
Employee + Spouse	\$205.88	\$228.95
Employee + 1 Child	\$101.02	\$112.56
Employee + Child(ren)	\$180.57	\$192.11
Family	\$307.11	\$330.19

***All Maintenance Medication must be filled via Mail Order or your Local Smart 90 Pharmacy after the first 90 day supply.**



WHAT IS AN HSA?

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

A health savings account is a bank account funded with tax exempt (pre-tax) dollars that can be funded by employee through payroll contributions, and that employees can use to help pay for eligible medical expenses, some of which might include: deductibles, coinsurance, prescriptions, etc.

HOW DO I SIGN UP FOR AN HSA?

When you enroll in the HSA Lumenos and your insurance becomes effective, you may be eligible for a health savings account with our H.S.A. vendor partner, Health Equity. Any H.S.A. account contributions you make are **separate** from your weekly premiums. Look for additional information close to your effective date from Human Resources, or contact HR at hr@nsc-tech.com.

When and how do I use my HSA? Visit a physician or facility. Your medical claim will be submitted to your carrier for payment. The physician or facility will receive an Explanation of Benefits (EOB) stating the allowed charge. The physician or facility will then send you a bill for the allowable charge. You can use your HSA money to pay the claim or save it for other medical expenses. The amount of the claim will be credited towards your deductible and maximum out-of-pocket. Note: In some instances, facilities may be able to contact the carrier with the CPT code for your service and require payment to be made on the date of service.

WHAT ARE THE BENEFITS OF AN HSA?

An HSA provides several financial benefits:

- You contribute pre-tax dollars into an HSA and funds accumulate tax-free.
- Tax free money to pay for qualified medical expenses
- HSA's carry over year to year, and can even be saved to use after you retire.
- HSA funds are yours to keep (or invest!) even if you leave the company.
- It saves you money – Lower premiums
- Controlling your expenses.
- HSA's allow you to shop around for care based on quality and cost

WHAT ARE MY HSA BANK OPTIONS?

Checking Account: Visa Debit Card or checks in lieu of card, which is interest bearing & includes free electronic statements. Checking Account option includes a \$2.50 monthly fee which is paid by the employee. If employee desires to investment in Mutual Funds through Health Equity's investment program, the employee must maintain a minimum of \$2,000 balance in HSA account to do this. There are varied investment options and monthly fees, which are paid by the employee and vary based on the amount of investment advice and account monitoring elected by the employee.

TOBACCO FREE DISCOUNT

To promote the health and wellness of all NSC Technologies, LLC employees by discouraging use of tobacco products, lower medical insurance premium rates will be available to employees and employee spouses who are tobacco-free OR who have completed an approved tobacco cessation program. The tobacco-free discount will save enrolled and eligible employees \$50 per month on medical insurance premiums; employees will save an additional \$50 per month on medical insurance premiums for an enrolled and eligible spouse. The Affidavit must be completed by all enrolling employees.

In order to be eligible for the tobacco-free discount, employees must meet one of the following criteria:

- Employee/Spouse has not used tobacco products (including cigarettes, cigars, loose tobacco smoked via pipe or hookah, chewing tobacco, snuff, dip, electronic cigarettes, vaporizers) **in the last 60 days**; or
- Employee/Spouse has completed a tobacco cessation program within the last 60 days such as 1-800-QUIT-NOW, or is currently enrolled in such a program. The employee will be asked to provide the certificate or documentation of completion.

We understand that meeting the eligibility requirements for the tobacco-free discount may not be universally medically advisable. If a physician is currently treating you for a medical condition (e.g. nicotine addiction), please contact Human Resources at HR@nsc-tech.com to request the Physician's Affidavit Form and an alternate way to qualify for the discount.

The choice of tobacco cessation program is up to the employee. Virginia Residents may be eligible for free assistance through the Quit Now Virginia Program, and non-Virginia residents may receive direction to free state-based programs through 1-800-QUIT-NOW. Additionally, Anthem Blue Cross Blue Shield offers benefits for members who are trying to quit. FDA-approved prescription drugs that help you stop smoking or reduce your dependence on tobacco products are often covered under the "preventative care benefits" that Anthem pays for 100%, when obtained with a prescription for a member age 18 or over. For additional information on covered prescription drugs, you can contact Anthem at 1-800-451-1527.

If your eligibility for the tobacco-free discount changes during the plan year, you are responsible for notifying Human Resources within 30 calendar days. The discount will be removed or applied for the first time on the first day of the following month, or as soon as administratively feasible.

Integrity is a core value of NSC Technologies, LLC. Misrepresenting eligibility for the tobacco-free discount will have disciplinary consequences, including but not limited to: repayment of all ill-obtained tobacco free discounts, a formal written corrective counseling, documentation in employee personnel file of integrity and company policy violation, and three day suspension without pay.



MEC COVERED SERVICES

The American Worker Minimum Essential Coverage (MEC) plan satisfies the individual mandate for minimum essential coverage set forth by Affordable Care Act (ACA) and covers a multitude of common screenings and preventive services at 100%. You MUST visit a First Health Network provider for services to be covered. Services from out-of-network providers are NOT covered. To find a provider, visit FirstHealthLBP.com.

If you are currently enrolled in the Minimum Essential Coverage (MEC) plan and do not wish to make any changes, no further action is needed, coverage will carryover into the new plan year.

Most Popular Services

- Cholesterol Tests
- Flu Shots
- Annual Well-Woman Exams
- Contraceptives
- Mammograms
- Colon Cancer Screening
- Childhood Immunizations
- Well-Child Checkups



The American Worker®

Provided by Fringe Benefit Group

ADDITIONAL SERVICES AT A GLANCE

ADULTS

Screenings: Abdominal Aortic Aneurysm, Alcohol Misuse, Blood Pressure, Cholesterol, Colorectal Cancer, Depression, Diabetes (Type 2), Hepatitis B, Hepatitis C, HIV, Lung Cancer, Obesity, Syphilis, Tobacco Use, Tuberculosis

Immunizations: Diphtheria, Hepatitis A, Hepatitis B, Herpes Zoster, HPV, Influenza (flu shot), Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rubella, Tetanus, Varicella (Chickenpox)

WOMEN INCLUDING PREGNANT WOMEN OR WOMEN WHO MAY BECOME PREGNANT

Screenings: Anemia, Breast Cancer Mammography, Cervical Cancer, Chlamydia, Diabetes, Domestic and Interpersonal Violence, gestational Diabetes, Gonorrhea, Hepatitis B, HIV, HPV, Maternal Depression, Osteoporosis, Preeclampsia, Rh Incompatibility, Syphilis, Tobacco Use, Urinary Incontinence, Urinary Tract Infection

Counseling: Breast Cancer Chemoprevention, Breast Cancer Genetic Testing (BRCA), Breast-feeding, Contraception, Domestic and Interpersonal Violence, HIV, Sexually Transmitted Infection

CHILDREN

Screenings: Autism, Bilirubin Concentration, Blood, Blood Pressure, Cervical Dysplasia, Depression, Developmental, Dyslipidemia, Hearing, Hematocrit or Hemoglobin, Hemoglobinopathies or Sickle Cell, Hepatitis B, HIV, Hypothyroidism, Lead, Obesity, Phenylketonuria (PKU), Sexually Transmitted Infection, Tuberculin, Vision

Immunizations: Diphtheria, Haemophilus Influenzae Type B, Hepatitis A, Hepatitis B, HPV, Inactivated Poliovirus, Influenza (flu shot), Measles, Meningococcal, Pertussis, Pneumococcal, rotavirus, Tetanus, Varicella (Chickenpox)

RATES – WEEKLY PAYROLL CONTRIBUTIONS

Plan	Employee	Employee + Spouse	Employee + Child(ren)	Family
MEC*	\$11.31	\$15.46	\$16.85	\$23.77

*MEC/Indemnity programs are not offered to employees living in NH, VT, WA, and HI

FIXED INDEMNITY



The American Worker Fixed Indemnity Plan may be purchased with the MEC Plan and provides additional reimbursement for qualified healthcare expenses. The Plan pays a set reimbursement for each specific medical expense as opposed to a share of total covered costs. This is a reimbursement program and does not meet minimum value testing under healthcare reform.

The Fixed Indemnity Plan is underwritten by Nationwide Life Insurance Company. The plan includes the New Benefits Discount Program, which is provided by a separate vendor.

The Fixed Indemnity Plan can only be purchased with the Minimum Essential Coverage (MEC) Plan.

Services	Standard
Physician's Office	\$75 per day; 6 days per year
Outpatient Diagnostic Lab	\$50 per testing day; 3 days per year
Outpatient Diagnostic X-Ray	\$100 per testing day; 3 days per year
Advanced Studies	\$100 per testing day; 3 days per year
Accidental Injury Care	Up to \$500 maximum per occurrence
Emergency Room Sickness	\$75 per day; 4 days per year
Additional Benefits - Inpatient - Outpatient - Outpatient Minor - Outpatient Benefit Maximum	\$500 per day, 1 day per year \$250 per day \$50 per day 1 day per year
Anesthesia	30% of Surgical Benefit
Daily Hospital Indemnity	\$100 per day; 500 day lifetime maximum
Intensive Care Unit	\$200 per day; 30 days per year
Substance Abuse	\$50 per day; 30 days per year
Mental Illness	\$50 per day; 30 days per year
Skilled Nursing	\$50 per day; 60 days per stay
New Benefits Discount Program	Included

WEEKLY RATES - MINIMUM ESSENTIAL COVERAGE (MEC) PLAN AND FIXED INDEMNITY PLAN				
Plan	Employee	Employee + Spouse	Employee + Child(ren)	Family
MEC + Indemnity*	\$23.60	\$44.22	\$37.92	\$54.73

*MEC/Indemnity programs are not offered to employees living in NH, VT, WA, and HI



FIXED INDEMNITY

FIRST HEALTH NETWORK (ONLY AVAILABLE WITH THE MEC PLAN)

Members have access to the First Health Network, which provides savings on Physician and Hospital services. By visiting a First Health provider you can reduce your out-of-pocket expenses.

- Over 490,000 provider locations across the country
- Network providers submit claims for you to simplify the claim process
- To locate a provider online, visit www.FirstHealthLBP.com

NEW BENEFITS PHARMACEUTICAL DISCOUNT PROGRAM (FIXED INDEMNITY FEATURE)

The Neighborhood Pharmacy discount program assures members the lowest price on prescription drugs, saving 10% to 85% on most prescriptions. Pharmacists will calculate the discount at point-of-service and the member pays the discounted price. There are more than 60,000 participating pharmacies including national and regional chains as well as independent pharmacies. Visit www.RxPriceQuotes.com to look up drug prices or locate a participating pharmacy.

Pharmacy Discounts are not insurance and are Not Intended as a Substitute for Insurance. The discount is only available at participating pharmacies.

NEW BENEFITS DISCOUNT PROGRAM (FIXED INDEMNITY FEATURE)

This package of health service and discount programs can help reduce out-of-pocket expenses and provide savings on a variety of services that promote health living. Detailed information on all programs will be provided after enrollment.

- **Teladoc:** 24/7/365 access to a network of U.S. board -certified doctors that will diagnose, treat and prescribe medication, when necessary, over the phone for medical issues including cold or flu symptoms, allergies, bronchitis and more.
- **Medical Bill Saver™:** Can help lower out-of-pocket costs on medical or dental bills over \$400 through provider negotiation
- **Medical Health Advisor¹:** Access to Personal Health Advocates that can assist in resolving insurance claim and billing issues.
- Nurse Hotline and Personal Counseling Services

In addition, members will receive discounts on the following services or supplies at participating providers.

- Lab and Imaging²
- Vision
- Diabetic Supplies
- Vitamins
- Chiropractic
- Hearing
- Durable Medical Equipment


¹Health Advisor does not replace health insurance, provide medical care or recommend treatment. ²Savings may vary based on geographic location, provider selected and procedure performed. The lab network portion of this benefit is not available in MA, MD, ND, NE, NJ, NY, RI, or SD.

The fixed indemnity program is not a substitute for medical insurance, and is not creditable coverage. Please see the American Worker Guide for additional disclosures.



DENTAL INSURANCE

NSC Technologies, LLC is pleased to announce we will be moving our dental plan to **The Standard** effective **November 1, 2020**.

	PPO - LOW PLAN	
	IN-NETWORK	OUT-OF-NETWORK
BENEFITS		
Deductible Individual / Family	\$50/\$150	\$50/\$150
Deductible Waived – (Class I)	Yes	Yes
Benefit Description		
Preventive (Class I)	100%	100%
Basic (Class II)	80%	80%
Major (Class III)	50%	50%
Maximum Annual Benefit	\$1,000	\$1,000
Orthodontic Treatment	\$1,000 Child Only	\$1,000 Child Only
BENEFITS		
Reimbursement Schedule	Fee Schedule	MAC
Routine Exams - 9430	100%	100%
Teeth Cleaning - 1110	100%	100%
Full Mouth/Panoramic X-rays - 0330	100%	100%
Simple Extractions - 7111	80%	80%
Root Canal (Endodontics) - 3330	50%	50%
Perio. Scaling/Root Planning - 4341	50%	50%
Full or Partial Dentures - 5110	50%	50%
Crowns - 6752	50%	50%


For more detailed information regarding dental benefits refer to the summary of benefits

RATES DENTAL – WEEKLY PAYROLL CONTRIBUTIONS				
Plan	Employee	Employee + Spouse	Employee + Child(ren)	Family
LOW	\$3.59	\$7.05	\$8.24	\$11.70



DENTAL INSURANCE

NSC Technologies, LLC is pleased to announce we will be moving our dental plan to **The Standard** effective **November 1, 2020**.

	PPO – HIGH PLAN	
	IN-NETWORK	OUT-OF-NETWORK
BENEFITS		
Deductible Individual / Family	\$50/\$150	\$50/\$150
Deductible Waived – (Class I)	Yes	Yes
Benefit Description		
Preventive (Class I)	100%	100%
Basic (Class II)	90%	90%
Major (Class III)	60%	60%
Maximum Annual Benefit	\$2,000	\$2,000
Orthodontic Treatment	\$1,500	\$1,500
BENEFITS		
Reimbursement Schedule	Fee Schedule	MAC
Routine Exams - 9430	100%	100%
Teeth Cleaning - 1110	100%	100%
Full Mouth/Panoramic X-rays - 0330	100%	100%
Simple Extractions - 7111	90%	90%
Root Canal (Endodontics) - 3330	60%	60%
Perio. Scaling/Root Planning - 4341	60%	60%
Full or Partial Dentures - 5110	60%	60%
Crowns - 6752	60%	60%

For more detailed information regarding dental benefits refer to the summary of benefits

RATES DENTAL – WEEKLY PAYROLL CONTRIBUTIONS				
Plan	Employee	Employee + Spouse	Employee + Child(ren)	Family
HIGH	\$5.33	\$10.46	\$12.70	\$17.83



Your Dental Benefits Portal

How to log in and manage your benefits from any device



Access your Dental benefits from The Standard[‡] using our secure member portal. It's designed to work on any web-enabled device. So you can check your Dental benefits, show your ID card or find a dentist anytime. We're here to help make things easy. Let's get started.

Log In or Register in 3 Simple Steps

1

Go to standard.com/dental:

Choose where you receive your benefits.

- Select **"Log In For Benefits,"** unless your employer is in New York.
- Select **"Log In For Benefits (In NY)"** if your employer is in New York.

2

Log in or register for a new account:

- Existing members: Choose **"Members"** and log in with your user ID and password, if you already have an account.
- New members: Choose **"Members,"** then **"New Users"** and register to create a user ID and password.

3

If prompted, complete the 2-step verification process for security:

- Request a one-time security passcode by selecting your preferred contact method — text or a phone call.
- Enter the code to verify your identity and complete your registration. You're all set!

Review Your Benefits or Select a Dentist

Once you're logged in, you can:

- Print an ID card
- Review your benefits summary or certificate
- Check the status of claims
- Review your Explanation of Benefits
- Find or suggest a dental provider



Need help logging in?

Please contact your HR department. Or call The Standard's Dental customer service team at **800.547.9515**. If your employer is based in New York, call **888.396.8641**. You can count on us for fast answers and support.

[‡] The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue of Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 360 Hamilton Avenue, Suite 210, White Plains, New York. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

Dental Portal Login Flyer 19615 (2/18) SI/SNY



PolicyLinkSM Dental + Vision Plan

Benefits That Give You The Freedom To Choose



No two people have the same health care needs. That's why your employer has partnered with The Standard to provide you with Dental and Vision benefits that are flexible enough to fit your lifestyle. This plan combines Dental and Vision into a single benefits package that gives you more control over your health care budget.

\$200 Vision Max

Choose Your Own Dental And Vision Providers

Your Dental care is backed by one of the largest networks in the country. And there are no restrictions on your Vision care – choose any provider you wish.

Decide How Your Health Care Budget Is Spent

With this plan, your Dental and Vision benefits share one plan maximum, and you can choose to apply unused Vision benefits toward Dental care – giving you more flexibility to spend your health care budget where you need it most. That includes preventive care, which contributes toward maintaining your overall health.

A Single Carrier To Manage Two Benefits

Combining Dental and Vision into a single plan means you only need to call one number to manage both your Dental and Vision care. Dental claims are automatically submitted by your care provider. With our Vision coverage, you'll submit a claim for reimbursement after paying at the point of care.

Insurance From A Nationwide Leader

Plus, the plan is backed by the comprehensive services and support of The Standard, a nationally recognized carrier of group Disability, Life, Dental and Vision insurance.

Standard Insurance Company

**The Standard Life Insurance
Company of New York**

www.standard.com

PolicyLink Dental + Vision Plan EE
21693 (8/20) SI/SNY

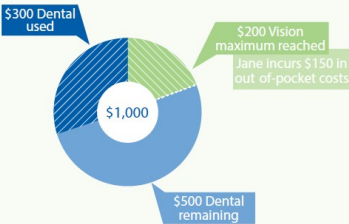
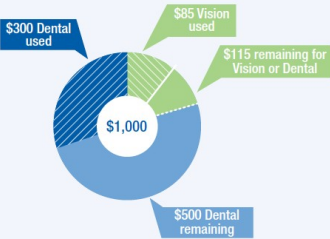
How Your PolicyLinkSM Dental + Vision Plan Works

Meet The Johnsons

Each member of the Johnson family has unique health needs. This example demonstrates how the PolicyLink Dental + Vision Plan works for each of them. John's employer has chosen a plan maximum of \$1,000 per family member. \$200 of that maximum also may be used on Vision care.

Meet John

John uses his plan for preventive care. His annual dental cleanings, exams and X-rays use \$300 of his \$1,000 annual maximum. His annual eye exam is \$85, which applies to his \$200 Vision maximum. John has \$500 remaining for Dental care and \$115 eligible for either Vision or Dental care.

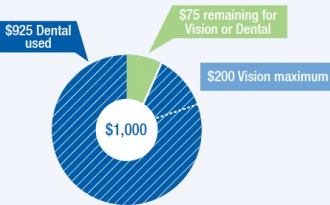


Meet Jane

John's wife, Jane, spends \$300 on preventive Dental care each year, just like her husband. She also wears disposable contact lenses and has regular eye exams, bringing her total Vision expenditures to \$350 for the year. Because the Johnsons' plan includes a Vision maximum of \$200, Jane incurs out-of-pocket costs of \$150 and has \$500 remaining for Dental care.

Meet Jessie

John and Jane's daughter, Jessie, has several cavities that require fillings – procedures that will total \$925. Because the \$200 reserved for Vision also can be spent on Dental, Jessie is able to cover those expenditures using her combined plan maximum of \$1,000. She has \$75 left for either Dental or Vision care.



For more information, contact your HR representative or visit us at www.standard.com.


This policy provides DENTAL and VISION insurance only.

This policy has exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or terminated. Please contact The Standard for additional information, including costs and complete details of coverage.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Ore. in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of White Plains, N.Y. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

VISION INSURANCE

NSC Technologies, LLC is pleased to announce we will be moving our vision plan to **The Standard** effective **November 1, 2020**. Please note out of network reimbursement will vary based on using the Eyemed network versus the VSP network. Please refer to the benefit summary for additional information.

	IN-NETWORK	OUT-OF-NETWORK VSP
NETWORK PROVIDER		
Eye Care Wellness		
Eye Exam	\$10 Copay	up to \$45
Frequency	Every 12 Months	
Lenses		Reimbursement
Single Vision	\$25 Copay	up to \$30
Bifocals	\$25 Copay	up to \$50
Trifocal	\$25 Copay	up to \$65
Frequency	Every 12 Months	
Frames		Reimbursement
Selected Frames	\$130 allowance + 20% discount over	up to \$65
Frequency	Every 12 Months	
Contacts		Reimbursement
Medically Necessary	100%	up to \$200
Elective Contacts	\$130 allowance	up to \$104

For more detailed information regarding vision benefits refer to the summary of benefits.


RATES VISION – WEEKLY PAYROLL CONTRIBUTIONS

Employee	Employee + Spouse	Employee + Child(ren)	Family
\$1.42	\$2.70	\$3.17	\$4.46



VOLUNTARY LIFE AND AD&D INSURANCE

NSC Technologies, LLC is pleased to offer voluntary life insurance within its benefits program. This plan will be offered through the convenience of payroll deductions and are designed to supplement your personal insurance needs.

	VOLUNTARY LIFE AD&D INSURANCE
Eligibility	All Eligible Employees Actively Working
Benefit Description	
Employee	Up to \$500,000 in increments of \$10,000 cannot exceed six times your annual salary
Spouse	Up to \$250,000 in increments of \$5,000 cannot exceed 50% of the employee life benefit
Children	Birth to age 25, up to \$10,000 in increments of \$2,000
Guarantee Issue Amount	Employee, \$150,000; Spouse \$50,000; Child \$10,000
Reduction Schedule Age 65 Age 70 Age 75 Age 80	 to 65% to 40% to 25%
Additional Benefits Accelerated Benefit Waiver of Premium Conversion Portability	 75% to \$375,000 Included Included Included

Weekly Rates per \$1,000	Employee & Spouse
<30	\$.0342
30-34	\$.0372
35-39	\$.0441
40-44	\$.0625
45-49	\$.0939
50-54	\$.1435
55-59	\$.2220
60-64	\$.3194
65-69	\$.3480
70+	\$.9065
Child	\$.0531 per \$1,000



VOLUNTARY SUPPLEMENTAL INSURANCE

Through **Allstate** you have the option of obtaining additional, supplemental coverage should you, your spouse or your dependents get injured or become ill. This coverage is optional and is paid for entirely by the employee via payroll deductions.

NSC Technologies, LLC does not contribute towards the premium for these plans.

PLANS AVAILABLE THROUGH **ALLSTATE**:

ACCIDENT INSURANCE - Accidents happen! Accident insurance provides you cash benefits in the event of accidental injuries and death.

CRITICAL ILLNESS (INCLUDING CANCER) - Critical Illness insurance complements your major medical coverage by paying a lump-sum benefit that you can use to pay the direct or indirect costs related to the diagnosis and treatment of a covered critical illness.

WHOLE LIFE - With Group Whole Life Insurance from Allstate Benefits, you get simplified and straightforward coverage. You decide how much coverage and who to cover. You get guaranteed rates for the life of the policy and a guaranteed death benefit to be paid to your beneficiaries. As the policy builds cash value, you can achieve your financial goals or borrow against it should you need to.



IDENTITY THEFT PROTECTION WITH LIFELOCK

Lifelock Elite includes access to the Lifelock Identity Alert System, Lost Wallet Protection, Address Change Verification, Black Market Website Surveillance, Live Member Service Support, Lifelock Privacy Monitor, Reduced Pre-Approved Credit Card Offers, Identity Restoration Support, \$1 Million Service Guarantee, Fictitious Identity Monitoring, Court Records Scanning, Data Breach Notifications, and Investment Account Activity Alerts.

Lifelock Ultimate Plus includes all Lifelock Elite services, as well as Credit Card Activity Alerts, Check and Savings Account Activity Alerts, Checking and Savings Account Application Alerts, Bank Account Takeover Alerts, Credit Inquiry Alerts, Online Annual Credit Score and Report, Monthly Credit Score Tracking, File Sharing Network Searches, Sex Offender Registry Reports, and Priority Live Member Service Support.

RATES – WEEKLY PAYROLL CONTRIBUTIONS		
	Lifelock Elite	Lifelock Ultimate Plus
Employee	\$1.96	\$5.88
Employee + Child(ren)	\$3.92	\$11.76
Employee + Spouse	\$3.43	\$8.33
Family	\$5.39	\$14.22

LEGAL ASSISTANCE WITH HYATT LEGAL PLANS

Hyatt’s group benefits include document preparation, document review, telephone advice, and office consultation for many legal needs, including but not limited to:

- credit card debt, debt collection defense
 - traffic tickets
 - landlord negotiations
 - foreclosure or refinancing
 - purchase of a home or condo
 - adoption
 - school hearing
 - will preparation
- tax audits
 - property sale
 - power of attorney
 - living wills
 - leases and deeds
 - nursing home/assisted living agreements
 - Medicare/Medicaid questions
 - prescription plan questions

Please see the plan summaries in our benefits enrollment portal for additional information about covered services and exclusions. Services **NOT** covered include but are not limited to: divorces, DUIs, and defense in criminal lawsuits.

RATES – WEEKLY PAYROLL CONTRIBUTIONS	
Flat Fee – Family Included	\$4.50



FAQS

When can I use my insurance? Medical, dental and vision is effective first of the month following 30 days of employment. If your hire date is January 10th, your insurance is effective March 1st. When do I start paying for my insurance? You will start paying when your insurance is effective. When do I get my insurance cards? The medical and dental insurance companies will mail you insurance cards directly. You will receive them on or around the date your insurance becomes effective.

What happens if I lose my insurance card? Our insurance companies have user friendly websites that enable you to access your cards and coverage information from your mobile phone! The Anthem Anywhere app provides easy access to your cards as well. You can always call customer service or HR to reorder your cards or for help obtaining your group and policy numbers to seek treatment.

I don't want to sign up for insurance right now. Can I sign up at any time? NO! There are only certain times when you can sign up for insurance: a) You may enroll within 30 days of your first day of work, b) you may enroll for the first time or make changes to your insurance during Open Enrollment.

3. You may enroll within 30 days of a "qualifying event", with supporting documentation. For example, if you had previous coverage through your spouse's insurance plan and your spouse lost his/her job, you would have 30 days to provide documentation of loss of coverage and enroll in NSC Technologies, LLC's plan.

4. If you are rehired with NSC Technologies, LLC more than 180 days from your separation date, you are considered a new hire when you return and may enroll within 30 days of your first day of work.

Can I cancel my insurance at any time? NO! There are only certain times when you can cancel.

1. You may retract your insurance elections at any time prior to the effective date.

2. You may cancel your insurance during open enrollment.

3. You may cancel your insurance within 30 days of a qualifying event. For example, if you were newly eligible for Medicare and obtained coverage through Medicare, you would have 30 days to submit proof of Medicare coverage and your cancellation form.

I am no longer with the company. What happens to my insurance? *Your last day of dental, vision, life, LTD, and STD coverage is the last day that you physically work on the job. Your last day of medical coverage is the last day of the month following your termination. After your insurance cancellation has been processed, you will receive in the mail a COBRA notification from Flexible Benefit Administrators. If you like the insurance you had with NSC Technologies, LLC and you wish to continue with the same insurance paying the full price your own, you may sign up for COBRA coverage with Flexible Benefit Administrators. You must enroll within the deadline outlined in your COBRA notification.*

In order to expedite your enrollment in COBRA coverage, you may contact the Benefits Coordinator at 757-399-1738x4 and request a second copy of your COBRA notification via email. Please allow 1-2 business days to receive your email.

Please note: if you have coverage through the PPO H.S.A. Lumenos and you leave the company, you will no longer have coverage through the PPO H.S.A. Lumenos plan unless you enroll in COBRA. However, you will be able to use any funds that you have saved through additional payroll deferrals in your Health Equity health savings account.

Do you have a question not answered here? Please feel free to contact HR at 757-399-1738x4 between the hours of 8 am and 5 pm EST, Mon-Fri. All messages will be answered in a timely fashion.



HEALTHCARE REFORM

NOTICE OF HEALTH CARE REFORM CHANGES

As a reminder, the following changes to our **NSC Technologies, LLC** Medical Plans are still valid for the 2020 plan year.

- The lifetime benefit limit will be unlimited on essential services. There will be no annual limit on essential benefits.

Essential benefits may include:

- o Ambulatory Patient Services
- o Emergency Services
- o Hospitalization
- o Maternity and Newborn Care
- o Mental Health and Substance Abuse Disorders
- o Prescription Drugs
- o Rehabilitative and Facilitative Services and Devices
(including durable medical equipment)
- o Laboratory Services
- o Prevention and Wellness Services
- o Chronic Disease Management
- o Pediatric Services, including oral and vision care

- Certain Preventive services are now covered 100% at no charge when you use **Anthem Blue Cross** network providers.

These include:

- o Routine adult physical
- o Routine Well child Exams
- o Routine Gynecological exams (includes pap and related fees)
- o Colorectal Cancer Screening
- o Routine mammograms

- Most Generic Oral Contraceptive Medications & Products for \$0 cost-share. (FDA Approved Contraceptive Methods for women). Items available without a prescription are not covered under the Health Care Reform law.

- Pre-existing Condition exclusions do not apply

- Dependents are covered until age 26 – Age 30 if specific criteria are met. Dependents under age 26 may enroll within 30 days of renewal for coverage effective November 1, 2020.

- Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

- Gynecological and obstetric services: Authorization or referral for gynecologic or obstetric care will not be required.

- The out of pocket maximum will include deductible, coinsurance, and copays (including covered prescription drug copays)



NOTICE OF MEDICARE PART D CREDITABLE COVERAGE

FOR MEDICARE-ELIGIBLE EMPLOYEES ENROLLED IN THE ANTHEM BLUE CROSS PLANS

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 that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

2. NSC Technologies, LLC has determined that the prescription drug coverage offered by the Anthem Blue Cross Plans are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. **Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to 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 through 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.

In addition, if you lose or decide to leave employer/union-sponsored coverage, you will be eligible to join a Part D plan at the time using an Employer Group Special Enrollment Period.

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.

If you decide to join a Medicare drug plan, your NSC Technologies, LLC coverage will not be affected. If you decide to join a Medicare drug plan and drop your employer sponsored prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop coverage or lose your group coverage and do not 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.

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).

Note: You'll get this notice each year. You may also request a copy.

For more information about your option under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will be mailed a copy from Medicare each year. For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (or see "Medicare & You" Handbook)
- 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).

Date:	November 1, 2020
Name of Entity/Sender:	NSC Technologies, LLC
Contact / Position:	www.hr@nsc-tech.com
Address:	950 East Paces Ferry Rd NE, Ste. 1650 Atlanta Georgia 30326
Phone Number:	757-399-1738 x 4



NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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



PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer name: NSC Technologies, LLC	4. Employer Identification Number (EIN) 54-2016950	
5. Employer address: 950 East Paces Ferry Rd Ste 1650	6. Employer phone number: 757-399-1738 x 4	
7. City: Atlanta	8. State: GA	9. ZIP code: 30326
10. Who can we contact about employee health coverage at this job? Jainee Pandya		
11. Phone Number (If different from above)	12. Email address: HR@nsc-tech.com	

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

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

- ☐ All employees. Eligible employees are:
- ☒ All Full-time Eligible Employees and COBRA Participants

• With respect to dependents:

- ☐ We do offer coverage. Eligible dependents are:

Spouse/Same-Sex Domestic Partners (Registered). Dependents of employees up to age 26; and dependents who are age 26+ under the guidelines of the State of Florida (FSS 627.6562)

- ☒ We do not offer coverage.

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

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

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



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 benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your 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, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

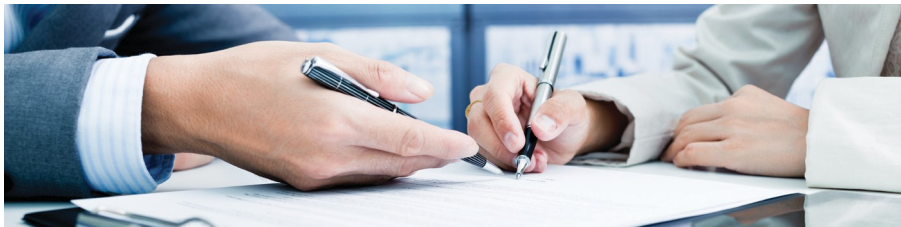
If you have questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. 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 HealthCare.gov.

Keep your Plan informed of address changes

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

SPECIAL ENROLLMENT NOTICE



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

LOSS OF OTHER COVERAGE

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

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

MARRIAGE, BIRTH, OR ADOPTION

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

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

MEDICAID OR CHIP

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

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



NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NMHPA)



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

- ✓ 48 hours following a vaginal delivery; and
- ✓ 96 hours following a delivery by cesarean section.

A group health plan may also not require a physician or other health care provider to obtain authorization from the plan for prescribing the minimum hospital stay for the mother or newborn. However, the health plan may impose cost sharing, such as deductibles or coinsurance, on hospital stays related to childbirth.

COVERAGE REQUIREMENTS

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

HOSPITAL LENGTH OF STAY

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

- When a delivery occurs in the hospital, the stay begins at the time of delivery, not at the time of admission or beginning of labor.

WE MAKE YOUR PEOPLE OUR BUSINESS

- If there are multiple births, the stay begins at the time of the last delivery.
- For deliveries that occur outside of the hospital, the stay begins at the time the mother or newborn is admitted.

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

ATTENDING PROVIDER DEFINITION

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

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

PROHIBITION ON INCENTIVES

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

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

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

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

NOTICE REQUIREMENTS

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

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



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

STATE INSURANCE MANDATES

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

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

ENFORCEMENT

There are no specific penalties for failing to comply with the NMHPA. However, plan participants or the DOL could use ERISA's enforcement scheme to compel compliance with the NMHPA's requirements. For example, a plan participant could bring a lawsuit for benefits due under the NMHPA, and could seek interest and attorneys' fees. In addition, the Internal Revenue Service (IRS) may impose an excise tax of \$100 per day on a group health plan that does not comply with the NMHPA, subject to certain limitations and exceptions depending on the nature of the noncompliance.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ENROLLMENT NOTICE - WHCRA

**KNOW
YOUR
BENEFITS.**



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; External breast forms that fit into your bra for before or during reconstruction
- Treatment of physical complications of the mastectomy, including lymphedema.

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

If you would like more information on WHCRA benefits, call your plan administrator.



MICHELLE'S LAW



MICHELLE'S LAW—COVERAGE FOR DEPENDENT STUDENTS

Michelle's Law was enacted in 2008 to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law is named after a New Hampshire college student, Michelle Morse, who continued her studies while battling colon cancer in order to maintain health insurance coverage under her parents' plan. Michelle died of colon cancer in November 2005 at the age of 22.

The Affordable Care Act (ACA) further expanded coverage requirements for dependents, effective for plan years beginning on or after Sept. 23, 2010. Under the ACA, group health plans or insurers that provide coverage for dependent children must continue to make coverage available until a child attains age 26, regardless of student status.

COVERAGE REQUIREMENTS

Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under Michelle's Law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

NOTICE REQUIREMENTS

If a group health plan requires a certification of student status for coverage under the plan, it must send a Michelle's Law notice along with any notice regarding the certification requirement. The Michelle's Law notice must be written in language understandable to a typical plan participant and must describe the terms of the continuation coverage available under Michelle's Law during medically necessary leaves of absence.

IMPACT OF the ACA

The ACA's adult child coverage mandate diminished the impact of Michelle's Law on many health plans. Under the ACA, if a group health plan or insurer provides dependent coverage for children, the plan or insurer must continue to make the coverage available until the child attains age 26, regardless of student status. Thus, the impact of Michelle's Law on group health plans will generally be limited to health plans that provide coverage to dependent students who are age 26 or over.

MEDICAID & 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 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 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 askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPPI.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	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
ARKANSAS – Medicaid	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPPI (855-692-7447)	

FLORIDA – Medicaid	GEORGIA – Medicaid
Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA – Medicaid	IOWA – Medicaid and CHIP (Hawki)
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	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	KENTUCKY – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid	MAINE – Medicaid
Website: www.medicaid.la.gov or www.idh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	MINNESOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”] Phone: 1-800-657-3739
MISSOURI – Medicaid	MONTANA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid	NEVADA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	NEW JERSEY – Medicaid and CHIP
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	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



WE MAKE YOUR PEOPLE OUR BUSINESS

NEW YORK – Medicaid	NORTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medical-services/medicaid/ Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	PENNSYLVANIA – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	TEXAS – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	VERMONT– Medicaid
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	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 January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.



OMB Control Number 1210-0137 (expires 1/31/2023)

HIPAA NOTICE

Your Information. Your Rights. Our Responsibilities.

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.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

HIPAA NOTICE

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.



HIPAA NOTICE

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

HIPAA NOTICE

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

OTHER INSTRUCTIONS FOR NOTICE

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

SMBO Benefits – NSC



1.877.282.0808

Don't get left behind



Benefit plans are subject to change. NSC Technologies, LLC reserves the right at any time, in its sole discretion, to amend, modify, reduce the benefits provided by, or terminate any of its plans. Any amendment, modification, reduction or termination may be made without prior notice to participants, except as required by law. This Benefit Booklet is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this benefit booklet conflicts in any way with the Certificate of Coverage, the COC shall prevail. It is recommended that you review your COC for an exact description of the services, and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information.

Note: While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits 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 this summary, contact Human Resources.