

November 11, 2014

Enrollment Deadline: 11/14/2014

Dear Worksite Employee:

Congratulations! On behalf of your worksite employer and ADP TotalSource, we are pleased to provide you with important information on how to take advantage of the comprehensive worksite employee benefits available to you. In addition to health benefits, you are also eligible for a variety of supplemental benefits through Marsh Voluntary Benefits program. You will soon receive more information on these terrific benefits directly from Marsh Voluntary Benefits.

Please note if you are a Self-Employed Individual, there are certain tax rules and regulations which affect the taxable nature of the benefits which you may elect to receive through your worksite employer and ADP TotalSource, Inc. Please refer to the Self-Employed Individual Benefit Participation Guide in the Benefits Quick Links section located on www.mytotalsource.com for further details.

If you recently participated in an onsite enrollment meeting or already received and completed the enrollment process for this plan at your worksite, no other action is required.

Please note, your eligibility date is fast approaching. To more effectively expedite the enrollment process and receive any carrier ID cards, we encourage you to enroll online today!

Important Information for the 2014 - 2015 Plan Year!

Health Care Reform Legislation

As you know, Health Care Reform legislation known as the Affordable Care Act (ACA) was passed early in 2010 with many of the legislations' requirements being phased in over time. ADP TotalSource is committed to keeping you informed if there's a provision that may impact your benefits or could affect the benefit election choices for you and your family. As such, we have included a Health Care Reform flyer in this enrollment kit on specific ACA provisions becoming effective for the ADP TotalSource, Inc. Health and Welfare Plan year beginning June 1, 2014. Please refer to this informative flyer for the latest information on Health Care Reform provisions.

Flexible Spending Account (FSA) Enrollment

The Health Care FSA and Dependent Care FSA let you pay for certain health care and dependent care expenses tax-free. The maximum contribution limits for the 2014 - 2015 Plan year are \$2,500 for the Health Care FSA and \$5,000 (\$2,500, if married filing separately) for the Dependent Care FSA, however, highly compensated employees will only be permitted to contribute up to \$2,000 per Plan Year to the Dependent Care FSA. Please refer to the enclosed Dependent Care FSA Summary if you have questions about who is considered a highly compensated employee for this purpose. Please be advised that if your employer does not offer group health coverage then a Health Care FSA will not be offered to you. Also note that participation by a Self-Employed Individual (SEI) in the Dependent Care FSA may be further limited by IRS guidelines. Please refer to the FSA benefit summaries in this kit for Plan details and SEI participation rules.

Please note that the claims filing deadline for FSA expenses incurred during the 2014 - 2015 Plan year is July 30, 2015.

Dependent Eligibility

The Health Care Reform Act requires group health plans and health insurance issuers to extend dependent coverage for adult children until age 26. Additionally, several states have passed legislation allowing parents to extend health coverage for their over age dependent children beyond age 26 that meet certain eligibility criteria. Please refer to the Dependent Eligibility Reference Guide in the Benefits Quick Links section located on www.mytotalsource.com for further details.

Tax Treatment of Non-Tax Dependents Benefits Coverage

If your enrolled dependent is not a tax dependent as defined by the Internal Revenue Code Section 152, you will be subject to federal and, if applicable, state income tax on the value of the coverage provided to such dependent(s).

This value is considered "imputed income". TotalSource will determine the amount of imputed income periodically during the calendar year and will make adjustments to your taxable income as applicable. Please refer to the Employee Certification of Dependent Tax Status Form in this kit and the Non-Tax Dependent Imputed Income FAQ in the Benefits Quick Links section located on www.mytotalsource.com for further details.

Dependents' Social Security Numbers Required for Enrollment

The Centers for Medicare and Medicaid Studies (CMS) requires Social Security numbers (SSNs) for health plan subscribers and their dependents in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. In order to ensure compliance with these reporting requirements, our health insurance carriers require worksite employees to provide SSNs for all covered dependents. **As such, we will be unable to process health plan enrollments for your identified dependents without the required SSN information.** ADP TotalSource, as well as each of our health insurance carriers, takes strict precautions to ensure the security of your personal information, including your Social Security number. If you have questions about the security measures your health insurance carrier has in place, please call their Customer Service phone number before completing your enrollment elections.

Simply review your Enrollment Kit and make your elections. Please refer to the instruction pages that follow for more details on the process. If you do not have access to enroll online and are electing to make changes by completing the Health and Welfare Benefits Enrollment Form, please return the forms to the address or fax number indicated below.

ADP TotalSource
Attn: Benefits Center
10200 Sunset Drive
Miami, FL 33173
FAX: 1-866-616-8858

Thank you in advance for your cooperation.



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Action Section

If you are making a benefit election for the 2014–2015 Plan Year, please enroll online or complete, sign and return all the forms in this section before your enrollment deadline. If you are waiving benefits, you must either enter your waiver online or complete the ADP TotalSource Health & Welfare Enrollment Form in this section.





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Enrollment Instructions: Plan Year 2014–2015

These instructions will help you quickly and easily enroll in your 2014–2015 benefits. Enrolling online is the fastest way to choose your benefits. If you don't have Internet access, see the next page for instructions on completing the paper enrollment form in this kit. Please be sure to enroll before the enrollment deadline.

WHY ENROLL ONLINE?

The secure online Benefits Enrollment Wizard walks you through the process and helps you enroll quickly and correctly. It even includes a Learning Center with quick and helpful videos.

TO ENROLL ONLINE:

• Log in to My TotalSource® (mytotalsource.com).

- If you're logging in to My TotalSource for the first time, follow the instructions below:
 1. Open a new browser window.
 2. Copy the following URL, paste it into the address bar of the browser and click **Go** or press the **Enter** key:
<https://totalsource.adp.com/ts/login.do>
 3. Click on the **Register Now** link. *If you've already registered, please skip to step 9.*
 4. Enter your **registration pass code**. If you don't know your registration pass code, please contact the Employee Service Center at 800-554-1802.
 5. Click the **Next** button.
 6. Follow the online instructions and complete the registration.
 7. Close the browser window.
 8. Open a new browser window, copy the following URL, paste it into the address bar of your browser and click **Go**:
<https://totalsource.adp.com/ts/login.do>
 9. Click the **Employee Login** button.
 10. Enter your new user ID and password on the next screen to log in.

• Follow the step-by-step directions on the website to enroll.

1. Click **Myself** and then select **Benefit Enrollment**.
2. Click **GET STARTED** to access the Benefits Enrollment Wizard.
3. Follow the enrollment process and make your benefit selections.

4. After you've enrolled in or waived all coverage options, review your benefit elections carefully on the **Review and Submit Elections** page.
 5. If your elections are correct, read and accept the Acknowledgements that appear at the bottom of the **Review and Submit Elections** page and choose **Submit**.
Congratulations – you're done!
- For your records, print your benefits confirmation by clicking the **Print this Confirmation** link at the top of the **Confirmation** page. If applicable, click the temporary insurance card graphic to open and print your temporary card.

The benefits you elect will be effective through May 31, 2015 and cannot be changed until the next annual Open Enrollment period, unless you experience an IRS-qualified change in status (see the Summary Plan Description for details). After you make your election, you will receive a confirmation statement summarizing your benefit elections.



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TO ENROLL BY PAPER FORM:

Follow the instructions below to complete the two-page Health and Welfare Benefits Enrollment Form in this kit. Incomplete forms will delay the processing of your benefit elections.

To Waive/Cancel All Coverage(s):

If you are not enrolling in **any** of the benefits offered:

- Complete the **Personal Information** section or verify the preprinted information for accuracy.
- Check (V) **Waive/Cancel All Coverage(s)** above the **Medical Options** section.
- Place a check (V) beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- Complete the **Beneficiary Information** section (if life insurance is offered to you).
- Sign and date the enrollment form.

To Enroll in Benefits Coverage:

- Complete the **Personal Information** section or verify the preprinted information for accuracy.
- **Medical Options** – Place a check (V) beside the plan and coverage level you want. If you don't want to enroll in a medical plan, place a check (V) beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- **Dental Options** – Place a check (V) beside the plan and coverage level you want, or check (V) **Waive Coverage**.
- **Vision Options** – Place a check (V) beside the plan and coverage level you want, or check (V) **Waive Coverage**.
- **Basic Life and AD&D / Long-Term Disability / Short-Term Disability Plans** – If these benefits are offered to you, the level of coverage is indicated. You don't need to do anything.
- **FSA Options** – Write in the amount you want to contribute for the 2014–2015 Plan Year, or check (V) **Waive**.
- **Health Savings Account (HSA) Option*** – If you're currently contributing to the JPMorgan Chase HSA and if the HSA remains available to you, you can change the amount you contribute on the enrollment form.
- Complete the entire **General Information** section.

- **Dependent Information and PCP Designation**** – All applicable fields in this section must be completed.

- If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, indicate for yourself and each covered dependent a primary care physician (PCP) or primary care dentist (PCD) by name and identification number.
- If you want dependent coverage under any benefit plans, you must provide each dependent's name, relationship to you, Social Security number, date of birth, and gender. Indicate with an "X" if they are to be enrolled in the medical, dental and/or vision plans (and provide PCP/PCD information, if applicable).
- ADP TotalSource® and our health insurance carriers require worksite employees to provide dependents' SSNs in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.
- **Beneficiary Information** – Complete the table for each person you would like to designate as a beneficiary for basic life and AD&PL insurance, if applicable.
- **Authorization** – Sign and date the form at the bottom of page 2. If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, state law requires that your spouse also sign your enrollment form.

** If you are enrolling in the HSA for the first time, you must log in to the JPMorgan Chase Online Enrollment Website. To access the site, log in to My TotalSource at mytotalsource.com and click **Myself** and then **Benefit Programs**. The JPMorgan Chase link is located in the Health & Welfare Sites section of the webpage.*

*** It is very important that you write the date of birth, Social Security number and primary care physician/dentist name and identification number for each dependent to be covered, if applicable.*

Information about PCPs: If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, you must identify a primary care physician (PCP) or dentist (PCD) for you and each of your covered dependents by writing the provider's name and identification number (available in the plan's provider directory or on the plan's website) in the table. If you do not provide the PCP's or PCD's name and identification number, the carrier may assign a provider to you, or your plan identification cards will be delayed.

Personal Information

Name: _____	SSN: _____
Address: _____	Gender: M / F - -
Phone #:()	Date of Birth: / /
	Date of Hire: / /

IMPORTANT: This form has multiple pages. All pages must be completed (including your signature on the last page) and submitted, or your benefit elections may be delayed.

() **Waive/Cancel All Coverage(s).** (Medical option waiver section must be completed)

Medical Options- Elect one (1) Medical plan or Waive coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
UHC-CP-3M7-1000-100-A1-OH	BAVM1	() \$ 165.00	() \$ 786.00	() \$ 707.00	() \$1,309.00
UHC-CP-3N1-1000-80-A1-OH	BAVN1	() \$ 105.00	() \$ 658.00	() \$ 587.00	() \$1,123.00
UHC-CP-3N5-2000-100-A1-OH	BAVO1	() \$ 77.00	() \$ 598.00	() \$ 531.00	() \$1,036.00
UHC-CP-3N9-3000-100-A1-OH	BAVR1	() \$ 42.00	() \$ 524.00	() \$ 463.00	() \$ 929.00

Company:	Family Entertainment Group LLC
Paygroup:	14E / 557087
Region:	Mid-West
HRG:	Amy Mieding
Ben Rep:	Denise King
~~~~~	
Class Code:	A / All Employees
Class State:	OH
Waiting Pd:	30 Days

<b>Waive Medical Coverage</b>
(    ) I certify that I am declining medical coverage at this time because I am currently covered under another health plan.
(    ) I certify that I am declining medical coverage at this time and I am NOT currently covered under another health plan

Dental Options - Elect one (1) Dental plan or Waive coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Guardian-Value Midwest	ACOU1	(    ) \$ 28.08	(    ) \$ 56.19	(    ) \$ 58.85	(    ) \$ 90.16

<b>Waive Dental Coverage</b>
(    ) Waive Coverage

Vision Options - Elect or Waive Vision coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
VSP- Choice Vision Plan	ASCX1	(    ) \$ 6.46	(    ) \$ 12.93	(    ) \$ 13.84	(    ) \$ 22.12

<b>Waive Vision Coverage</b>
(    ) Waive Coverage

Life and Disability Plan Options

Plan Type	Plan Offering(s)	Plan Eligibility
Life	Basic \$10,000	Life offered only to those who elect medical benefits
LTD	LTD Basic 50% \$1,000/mo-180	LTD offered only to those who elect medical benefits

Flexible Spending Account (FSA) Plan Options

	Minimum Contribution	Maximum Contribution	Plan Year Election
(    ) I wish to enroll in the Health Care Flexible Spending Account	\$50	\$2,500.00	\$ _____
(    ) I wish to enroll in the Dependent Care Flexible Spending Account	\$50	\$5,000.00 (\$2,500 if married filing separately)	\$ _____

<b>Waive Flexible Spending Account Coverage</b>
(    ) Waive Health Care FSA Coverage
(    ) Waive Dependent Care FSA Coverage



# Health and Welfare Benefits Enrollment Form (2014-2015 Plan Year)

Enrollment Deadline is 11/14/2014

Effective Date:

Company: Family Entertainment Group LLC

Paygroup: 14E / 557087 / Mid-West

## DEPENDENT INFORMATION AND PCP DESIGNATION

In this section, list yourself and all of your eligible dependents whom you wish to cover under a benefit plan. Provide complete information for each dependent, and identify the benefit plan(s) in which you wish to enroll each dependent by marking "X" under the appropriate benefit plan option(s).

Name	Relation	SS#	Date of Birth	Gender	-----Election Information-----			Vision
					Medical PCP	Dental PCD		
	Employee							

## BENEFICIARY INFORMATION (List individual(s) you wish to designate as Basic Life Insurance beneficiaries)

Name	Relation	SS#	Date of Birth	Address	Amt. or		Primary or
					%	Basic Life	

## AUTHORIZATION

I have read the explanation of my Health and Welfare benefits options for the current Plan Year. I authorize the elections I have made, as well as any pre-tax payroll deductions required for these elections unless I complete an additional form requesting that benefit deductions be taken on a post-tax basis. I understand that during this or any future open enrollments if I do not make changes to my then-current health plan elections, my elections will default to either the same health plan election or a designated replacement health plan election specified in the personal statement for that enrollment period, and that such a default may result in a higher cost and increased deduction from my pay. By signing this Form, I am also authorizing any pre-tax deductions required to cover the defaulting elections.

I understand that if I am considered a Self-Employed Individual, according to the Internal Revenue Code, I am not eligible to pay for my benefits under the ADP TotalSource, Inc. Health and Welfare Plan ("Plan") on a pre-tax basis, except for the Dependent Care FSA. Additionally, I am not eligible to make contributions to the Health Care FSA.*

I acknowledge that in the event of the termination of my employment, my health, dental, vision and group life insurance coverage will continue through the end of the month in which my termination occurs. Other coverage, such as disability and participation in the FSA plan (if applicable), will end on the date of my employment termination. I agree that upon my termination, the amount needed to cover my contributions to my insurance premium(s) for that month's coverage becomes immediately due and payable and will be deducted from my final paycheck(s). I understand that this final deduction amount may be higher than the amounts deducted in previous pay periods. I understand that I cannot change my elections before the next annual enrollment period, unless a qualified change in status occurs and my requested election change is consistent with the change in status event.* I understand that if I am a newly-eligible employee waiving medical coverage because I am covered under another medical plan, I must indicate this under the medical options section by choosing the first "Waive Coverage" option. Absence of this indication may affect my eligibility for HIPAA special enrollment period should I lose this other coverage at a later date.*

I hereby certify that the above information is complete and accurate.

Worksite Employee Signature _____ Date _____ Spouse's Signature _____ Date _____

Required only for married residents of AZ,CA,IL,LA,NV,NM,TX,WA and WI who are designating a non-spouse beneficiary for the life insurance option.

*Please see the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description for further details.



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## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS-NOW** or visit **[www.insurekidsnow.gov](http://www.insurekidsnow.gov)** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or by calling toll-free 1-866-444-EBSA (3272).

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. You should contact your state for further eligibility information.**

ALABAMA – MEDICAID	ALASKA – MEDICAID
<b>Website:</b> <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a> <b>Phone:</b> (855) 692-5447	<b>Website:</b> <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> <b>Phone (Outside of Anchorage):</b> (888) 318-8890 <b>Phone (Anchorage):</b> (907) 269-6529
ARIZONA – CHIP	COLORADO – MEDICAID
<b>Website:</b> <a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a> <b>Phone (Outside of Maricopa County):</b> (877) 764-5437 <b>Phone (Maricopa County):</b> (602) 417-5437	<b>Website:</b> <a href="http://www.colorado.gov/">http://www.colorado.gov/</a> <b>Phone (In state):</b> (800) 866-3513 <b>Phone (Out of state):</b> (800) 221-3943
FLORIDA – MEDICAID	GEORGIA – MEDICAID
<b>Website:</b> <a href="https://www.flmedicaidtplrecovery.com/">https://www.flmedicaidtplrecovery.com/</a> <b>Phone:</b> (877) 357-3268	<b>Website:</b> <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> Click on <b>Programs</b> , then <b>Medicaid</b> , then <b>Health Insurance Premium Payment (HIPP)</b> <b>Phone:</b> (800) 869-1150
IDAHO – MEDICAID	INDIANA – MEDICAID
<b>Website:</b> <a href="http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx">http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx</a> <b>Phone:</b> (800) 926-2588	<b>Website:</b> <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a> <b>Phone:</b> (800) 889-9949

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IOWA – MEDICAID	KANSAS – MEDICAID
<b>Website:</b> <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> <b>Phone:</b> (888) 346-9562	<b>Website:</b> <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> <b>Phone:</b> (800) 792-4884
KENTUCKY – MEDICAID	LOUISIANA – MEDICAID
<b>Website:</b> <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> <b>Phone:</b> (800) 635-2570	<b>Website:</b> <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a> <b>Phone:</b> (888) 695-2447
MAINE – MEDICAID	MASSACHUSETTS – MEDICAID AND CHIP
<b>Website:</b> <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a> <b>Phone:</b> (800) 977-6740 <b>TTY:</b> (800) 977-6741	<b>Website:</b> <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> <b>Phone:</b> (800) 462-1120
MINNESOTA – MEDICAID	MISSOURI – MEDICAID
<b>Website:</b> <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on <b>Health Care</b> , then <b>Medical Assistance</b> <b>Phone:</b> (800) 657-3629	<b>Website:</b> <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> <b>Phone:</b> (573) 751-2005
MONTANA – MEDICAID	NEBRASKA – MEDICAID
<b>Website:</b> <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a> <b>Phone:</b> (800) 694-3084	<b>Website:</b> <a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a> <b>Phone:</b> (800) 383-4278
NEVADA – MEDICAID	NEW HAMPSHIRE – MEDICAID
<b>Website:</b> <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> <b>Phone:</b> (800) 992-0900	<b>Website:</b> <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</a> <b>Phone:</b> (603) 271-5218
NEW JERSEY – MEDICAID AND CHIP	NEW YORK – MEDICAID
<b>Medicaid Website:</b> <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> <b>Medicaid Phone:</b> (609) 631-2392 <b>CHIP Website:</b> <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> <b>CHIP Phone:</b> (800) 701-0710	<b>Website:</b> <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> <b>Phone:</b> (800) 541-2831
NORTH CAROLINA – MEDICAID	NORTH DAKOTA – MEDICAID
<b>Website:</b> <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a> <b>Phone:</b> (919) 855-4100	<b>Website:</b> <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> <b>Phone:</b> (800) 755-2604

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OKLAHOMA – MEDICAID AND CHIP	OREGON – MEDICAID AND CHIP
<b>Website:</b> <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> <b>Phone:</b> (888) 365-3742	<b>Website:</b> <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a> <a href="http://www.hijossaludablesoregon.gov">http://www.hijossaludablesoregon.gov</a> <b>Phone:</b> (800) 699-9075
PENNSYLVANIA – MEDICAID	RHODE ISLAND – MEDICAID
<b>Website:</b> <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a> <b>Phone:</b> (800) 692-7462	<b>Website:</b> <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a> <b>Phone:</b> (401) 462-5300
SOUTH CAROLINA – MEDICAID	SOUTH DAKOTA – MEDICAID
<b>Website:</b> <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a> <b>Phone:</b> (888) 549-0820	<b>Website:</b> <a href="http://dss.sd.gov">http://dss.sd.gov</a> <b>Phone:</b> (888) 828-0059
TEXAS – MEDICAID	UTAH – MEDICAID AND CHIP
<b>Website:</b> <a href="http://www.gethipptexas.com/">http://www.gethipptexas.com/</a> <b>Phone:</b> (800) 440-0493	<b>Website:</b> <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a> <b>Phone:</b> (866) 435-7414
VERMONT – MEDICAID	VIRGINIA – MEDICAID AND CHIP
<b>Website:</b> <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> <b>Phone:</b> (800) 250-8427	<b>Medicaid Website:</b> <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a> <b>Medicaid Phone:</b> (800) 432-5924 <b>CHIP Website:</b> <a href="http://www.famis.org/">http://www.famis.org/</a> <b>CHIP Phone:</b> (866) 873-2647
WASHINGTON – MEDICAID	WEST VIRGINIA – MEDICAID
<b>Website:</b> <a href="http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx">http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx</a> <b>Phone:</b> (800) 562-3022, Ext. 15473	<b>Website:</b> <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a> <b>Phone:</b> (877) 598-5820, HMS Third Party Liability
WISCONSIN – MEDICAID	WYOMING – MEDICAID
<b>Website:</b> <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a> <b>Phone:</b> (800) 362-3002	<b>Website:</b> <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a> <b>Phone:</b> (307) 777-7531

To see if any more states have added a premium assistance program since July 31, 2014, or for more information about special enrollment rights, you can contact either:

**U.S. Department of Labor**  
**Employee Benefits Security Administration**  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
(866) 444-EBSA (3272)

**U.S. Department of Health and Human Services**  
**Centers for Medicare & Medicaid Services**  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
(877) 267-2323, menu option 4, Ext. 61565



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ADP TOTALSOURCE®

# Employee Certification of Dependent Tax Status

**INSTRUCTIONS:** Complete and return this form only if you're enrolling one or more dependents in the following categories for benefits coverage:

- Adult children who have reached age 26
- Civil union partners and their children

## Certification of Tax Dependent

I understand that the following rules apply to the federal income tax treatment of benefits coverage:

If my above-mentioned dependent is not a tax dependent as defined below, I will be subject to federal and, if applicable, state income tax on the value of the coverage provided to my dependent. The taxable value of the coverage is considered imputed income, and the amount of imputed income will be determined by ADP TotalSource® periodically during the calendar year. ADP TotalSource will make this adjustment on periodic payrolls during the calendar year, and I'll be notified prior to any payroll adjustments. I understand that this adjustment may increase my federal and, if applicable, state income tax liability.

- **For an adult child who has reached age 26:**

Federal and, if applicable, state tax will apply to any coverage provided to an adult child beginning January 1 of the calendar year in which the adult child will attain age 27, unless the adult child qualifies as a tax dependent due to being permanently and totally disabled, as described in Code Section 152(c).

- **For civil union partners:**

- You provide more than half of your civil union partner's total support for the calendar year;
- You and your civil union partner have the same principal place of abode for the entire calendar year, except for temporary reasons such as vacation, military service or education;
- Your civil union partner is a member of your household for the entire calendar year (and the relationship doesn't violate local law);
- Your civil union partner isn't your (or anyone else's) "qualifying child" under Code Section 152(c); and
- Your civil union partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico.

- **For a civil union partner's child who isn't also your child:**

Your civil union partner's child who isn't also your child (a "covered child") may qualify as your tax dependent for health coverage purposes if they satisfy the above test or if they satisfy the "qualifying child" test found in Code Section 152(c).



IN THE BUSINESS OF YOUR SUCCESS®

## Employee Certification of Dependent Tax Status

Please consult with your tax advisor before certifying below whether your enrolled dependent is a tax dependent for health coverage purposes as defined by the Internal Revenue Code. Also list any dependent(s) you're enrolling from the above-listed dependent categories and indicate their tax status.

Last Name	First Name	Dependent Relationship	Dependent Tax Status	
			<input type="checkbox"/> Tax Dependent	<input type="checkbox"/> Not a Tax Dependent
			<input type="checkbox"/> Tax Dependent	<input type="checkbox"/> Not a Tax Dependent
			<input type="checkbox"/> Tax Dependent	<input type="checkbox"/> Not a Tax Dependent
			<input type="checkbox"/> Tax Dependent	<input type="checkbox"/> Not a Tax Dependent

I certify the tax status of my dependent(s) listed above as defined by the Internal Revenue Code. I understand that ADP TotalSource will rely on this certification to determine my federal and, if applicable, state income and employment taxes. I further understand that I must notify ADP TotalSource if conditions change that would cause my dependent(s) to no longer qualify as my tax dependent(s).

_____  
Employee Name

_____  
Last 4 Digits of SSN or Employee ID

_____  
Employee Signature

_____  
Date

### EMAIL, FAX OR MAIL COMPLETED FORM TO:

**ADP TOTALSOURCE**  
**Attention: Benefits Center**  
**10200 Sunset Drive**  
**Miami, FL 33173**  
**Fax: 1-866-616-8858**  
**Email: TotalSourceBenefits@adp.com**



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ADP TOTALSOURCE®

# Reference Section

The contents of this section are for review only.  
Nothing in this section needs to be returned.





IN THE BUSINESS OF YOUR SUCCESS®

## IMPORTANT ANNUAL BENEFIT NOTICE(S)

### **Annual Notice Regarding the Women's Health and Cancer Rights Act**

**This law requires plans that provide medical and surgical benefits for mastectomies to provide coverage for the following procedures, as requested from the patient in consultation with her physician:**

- **Reconstruction of the breast on which the mastectomy has been performed;**
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis (e.g., breast implant); and
- Treatment for physical complications of all stages of the mastectomy, including lymphedemas.
- 

### **HIPAA Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Also, under the Children's Health Insurance Program Reauthorization Act you or your dependent that is eligible, but not enrolled in the Plan, may enroll if either of the following two conditions are met:

- (1) You or your dependent are covered under a Medicaid plan or under a State child health plan and the coverage is terminated due to loss of eligibility and you request coverage under the Plan no later than 60 days after the loss of eligibility; or
- (2) Your or your dependent become eligible for assistance for coverage under the Plan, Medicaid plan or State child health plan and you request coverage under the Plan no later than 60 days after you or your dependent are determined to be eligible for assistance.

### **PATIENT PROTECTION - PRIMARY CARE PHYSICIAN (PCP) AND OB/GYN SELECTION**

Many of the ADP TotalSource health plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the ADP TotalSource health insurance carriers or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health insurance carrier at the phone number indicated on the Benefit Summary provided in your benefits enrollment kit.



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.welcometouhc.com](http://www.welcometouhc.com) or by calling **1-800-782-3740**.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	Network: \$1,000 Indiv / \$3,000 Family Non-Network: \$2,000 Indiv / \$6,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes, Network: \$4,000 Indiv/ \$8,000 Family Non-Network: \$8,000 Indiv/ \$16,000 Family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the insurer pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of network <b>providers</b> , see <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-800-782-3740.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan does not cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-800-782-3740 or visit us at [www.welcometouhc.com](http://www.welcometouhc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-487-2365 to request a copy.



- **Co-payments (copay)** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$50 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$25 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded	Includes preventive health services specified in the health care reform law.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.



Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition.</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> .	Tier 1 - Your Lowest-Cost Option	Retail : \$15 copay Mail-Order: \$37.50 copay	Retail : \$15 copay Mail-Order: \$37.50 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. If you use a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : \$40 copay Mail-Order: \$100 copay	Retail : \$40 copay Mail-Order: \$100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : \$75 copay Mail-Order: \$187.50 copay	Retail : \$75 copay Mail-Order: \$187.50 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
<b>If you need immediate medical attention</b>	Emergency room services	\$250 copay per visit	\$250 copay per visit	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	\$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs.</b>	Mental/Behavioral health outpatient services	\$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	\$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
<b>If you are pregnant</b>	Prenatal and postnatal care	0% co-ins, after ded	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
<b>If you need help recovering or have other special health needs</b>	Home health care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	\$25 copay per outpatient visit	20% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative Services	\$25 copay per outpatient visit	20% co-ins, after ded	Services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over \$1,000 or no coverage.
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	No coverage for Eye Exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up

# Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)				
• Acupuncture	• Bariatric surgery	• Cosmetic surgery	• Dental care (Adult/Child)	• Glasses
• Infertility treatment	• Long-term care	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Routine eye care (Adult/Child)
• Routine foot care	• Weight loss programs			
Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).				
• Chiropractic care - limitations may apply	• Hearing aids - limitations may apply			

**Your Rights to Continue Coverage:**  
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.  
For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Your Grievance and Appeals Rights:**  
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Employee Benefits Security Administration at 1-866-444-3272 or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Ohio Department of Insurance at 1-800-686-1526 or visit [www.insurance.ohio.gov](http://www.insurance.ohio.gov).

**Does this Coverage Provide Minimum Essential Coverage?**  
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**  
**Does this Coverage Meet the Minimum Value Standard?**  
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

**Language Access Services:**  
Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.  
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.  
若需要中文协助，请拨打本文件内的客户服务电话。  
Dine k'ehji shich'i' hadoodzih ninizingo, koj' hodilinih dine yikah 'anidaatwoji ei blnumber dii naaktsoos bikaa doo.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page. _____

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,320
- Patient pays \$1,220

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,000
Co-pays	\$20
Co-insurance	\$0
Limits or exclusions	\$200
<b>Total</b>	<b>\$1,220</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,320
- Patient pays \$2,080

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,000
Co-pays	\$1,000
Co-insurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,080</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

* **No** . Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

* **No** . Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes** . When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes** . An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-782-3740 or visit us at [www.welcometouhc.com](http://www.welcometouhc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-487-2365 to request a copy.



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.welcometouhc.com](http://www.welcometouhc.com) or by calling **1-800-782-3740**.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	Network: \$1,000 Indiv / \$3,000 Family Non-Network: \$2,000 Indiv / \$6,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes, Network: \$4,000 Indiv/ \$8,000 Family Non-Network: \$8,000 Indiv/ \$16,000 Family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the insurer pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of network <b>providers</b> , see <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-800-782-3740.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan does not cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-800-782-3740 or visit us at [www.welcometouhc.com](http://www.welcometouhc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-487-2365 to request a copy.



- **Co-payments (copay)** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 copay per visit	40% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$50 copay per visit	40% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$25 copay per visit	40% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	40% co-ins, after ded	Includes preventive health services specified in the health care reform law.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No Charge	40% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.



Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition.</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> .	Tier 1 - Your Lowest-Cost Option	Retail : \$15 copay Mail-Order: \$37.50 copay	Retail : \$15 copay Mail-Order: \$37.50 copay	<p>Provider means pharmacy for purposes of this section.  Retail : Up to a 31 day supply.  Mail-Order: Up to a 90 day supply.  You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.  Certain drugs may have a Pre-Authorization requirement or may result in a higher cost.  If you use a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.  You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.  See the website listed for information on drugs covered by your plan. Not all drugs are covered.  Tier 1 contraceptives are covered at No Charge.</p>
	Tier 2 - Your Midrange-Cost Option	Retail : \$40 copay Mail-Order: \$100 copay	Retail : \$40 copay Mail-Order: \$100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : \$75 copay Mail-Order: \$187.50 copay	Retail : \$75 copay Mail-Order: \$187.50 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% co-ins, after ded	40% co-ins, after ded	None
<b>If you need immediate medical attention</b>	Emergency room services	\$250 copay per visit	\$250 copay per visit	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	None
	Urgent care	\$75 copay per visit	40% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% co-ins, after ded	40% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs.</b>	Mental/Behavioral health outpatient services	\$50 copay per visit	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	\$50 copay per visit	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
<b>If you are pregnant</b>	Prenatal and postnatal care	20% co-ins, after ded	40% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	20% co-ins, after ded	40% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% co-ins, after ded	40% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	\$25 copay per outpatient visit	40% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative Services	\$25 copay per outpatient visit	40% co-ins, after ded	Services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	20% co-ins, after ded	40% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	20% co-ins, after ded	40% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over \$1,000 or no coverage.
	Hospice service	20% co-ins, after ded	40% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	No coverage for Eye Exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)				
• Acupuncture	• Bariatric surgery	• Cosmetic surgery	• Dental care (Adult/Child)	• Glasses
• Infertility treatment	• Long-term care	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Routine eye care (Adult/Child)
• Routine foot care	• Weight loss programs			
Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).				
• Chiropractic care - limitations may apply	• Hearing aids - limitations may apply			

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit [www.cciio.cms.gov](http://www.cciio.cms.gov).

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Employee Benefits Security Administration at 1-866-444-3272 or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Ohio Department of Insurance at 1-800-686-1526 or visit [www.insurance.ohio.gov](http://www.insurance.ohio.gov).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.  
Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.  
若需要中文协助，请拨打本文件内的客户服务电话。  
Dine k'ehji shich'i' hadoodzih ninizingo, koj' hodiiinih dine yikah 'anidaatwoji ei blnumber dii naaktsoos bikaa doo.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page. _____

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,220
- Patient pays \$2,320

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,000
Co-pays	\$20
Co-insurance	\$1,100
Limits or exclusions	\$200
<b>Total</b>	<b>\$2,320</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,320
- Patient pays \$2,080

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,000
Co-pays	\$1,000
Co-insurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,080</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

* **No** . Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

* **No** . Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes** . When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes** . An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.welcometouhc.com](http://www.welcometouhc.com) or by calling **1-800-782-3740**.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	Network: \$2,000 Indiv / \$6,000 Family Non-Network: \$4,000 Indiv / \$12,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes, Network: \$5,000 Indiv/ \$10,000 Family Non-Network: \$10,000 Indiv/ \$20,000 Family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the insurer pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of network <b>providers</b> , see <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-800-782-3740.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan does not cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about <b>excluded services</b> .

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- **Co-payments (copay)** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

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	Specialist visit	\$50 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$25 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded	Includes preventive health services specified in the health care reform law.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.



Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition.</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> .	Tier 1 - Your Lowest-Cost Option	Retail : \$15 copay Mail-Order: \$37.50 copay	Retail : \$15 copay Mail-Order: \$37.50 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. If you use a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : \$40 copay Mail-Order: \$100 copay	Retail : \$40 copay Mail-Order: \$100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : \$75 copay Mail-Order: \$187.50 copay	Retail : \$75 copay Mail-Order: \$187.50 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
<b>If you need immediate medical attention</b>	Emergency room services	\$250 copay per visit	\$250 copay per visit	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	\$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs.</b>	Mental/Behavioral health outpatient services	\$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	\$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
<b>If you are pregnant</b>	Prenatal and postnatal care	0% co-ins, after ded	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
<b>If you need help recovering or have other special health needs</b>	Home health care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	\$25 copay per outpatient visit	20% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative Services	\$25 copay per outpatient visit	20% co-ins, after ded	Services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over \$1,000 or no coverage.
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	No coverage for Eye Exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up

# Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)				
• Acupuncture	• Bariatric surgery	• Cosmetic surgery	• Dental care (Adult/Child)	• Glasses
• Infertility treatment	• Long-term care	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Routine eye care (Adult/Child)
• Routine foot care	• Weight loss programs			
Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).				
• Chiropractic care - limitations may apply	• Hearing aids - limitations may apply			

**Your Rights to Continue Coverage:**  
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.  
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**Does this Coverage Provide Minimum Essential Coverage?**  
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**  
**Does this Coverage Meet the Minimum Value Standard?**  
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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Dine k'ehji shich'i' hadoodzih ninizingo, koj' hodilinih dine yikah 'anidaatwoji ei blnumber dii naaktsoos bikaa doo.

_____ *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* _____

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,320
- Patient pays \$2,220

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$2,000
Co-pays	\$20
Co-insurance	\$0
Limits or exclusions	\$200
<b>Total</b>	<b>\$2,220</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,420
- Patient pays \$1,980

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,000
Co-pays	\$900
Co-insurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,980</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

* **No** . Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

* **No** . Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes** . When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes** . An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.welcometouhc.com](http://www.welcometouhc.com) or by calling **1-800-782-3740**.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	Network: \$3,000 Indiv / \$9,000 Family Non-Network: \$6,000 Indiv / \$18,000 Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes, Network: \$6,000 Indiv/ \$12,000 Family Non-Network: \$12,000 Indiv/ \$24,000 Family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the insurer pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of network <b>providers</b> , see <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> or call 1-800-782-3740.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan does not cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 5 or 6. See your Policy or plan document for additional information about <b>excluded services</b> .

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- **Co-payments (copay)** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$60 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$30 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded	Includes preventive health services specified in the health care reform law.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.



Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition.</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.welcometouhc.com">www.welcometouhc.com</a> .	Tier 1 - Your Lowest-Cost Option	Retail : \$15 copay Mail-Order: \$37.50 copay	Retail : \$15 copay Mail-Order: \$37.50 copay	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. If you use a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : \$40 copay Mail-Order: \$100 copay	Retail : \$40 copay Mail-Order: \$100 copay	
	Tier 3 - Your Highest-Cost Option	Retail : \$75 copay Mail-Order: \$187.50 copay	Retail : \$75 copay Mail-Order: \$187.50 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
<b>If you need immediate medical attention</b>	Emergency room services	\$250 copay per visit	\$250 copay per visit	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	None
	Urgent care	\$100 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs.</b>	Mental/Behavioral health outpatient services	\$60 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	\$60 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
<b>If you are pregnant</b>	Prenatal and postnatal care	0% co-ins, after ded	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered. Network routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply. Your cost for inpatient services only. Delivery see above.
<b>If you need help recovering or have other special health needs</b>	Home health care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	\$30 copay per outpatient visit	20% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative Services	\$30 copay per outpatient visit	20% co-ins, after ded	Services provided under and limits are combined with Rehabilitation Services above. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over \$1,000 or no coverage.
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	No coverage for Eye Exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up

# Excluded Services & Other Covered Services

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Prescriptions	\$200
Radiology	\$200
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#### Patient pays:

Deductibles	\$3,000
Co-pays	\$20
Co-insurance	\$0
Limits or exclusions	\$200
<b>Total</b>	<b>\$3,220</b>

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- Amount owed to providers: \$5,400
- Plan pays \$3,420
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#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,000
Co-pays	\$900
Co-insurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,980</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

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- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
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IN THE BUSINESS OF YOUR SUCCESSSM



2014/2015

**Plan Description:** Guardian Value Midwest  
**Product:** Dental - PPO  
**Network:** DentalGuard Preferred

**Provider:** Guardian Dental  
**Member Services Phone #:** 1-800-541-7846  
**Plan Website Address:** <http://www.guardianlife.com>

Benefit	In-Network	Out-of-Network
<b>Deductibles &amp; Maximum Amounts</b>		
Calendar Year Benefit Maximum	• \$1,000	• \$1,000
Calendar Year Deductible - Individual	• \$50	• \$50
Calendar Year Deductible - Family	• \$150	• \$150
<b>Preventive &amp; Diagnostic Services</b>		
Preventive & Diagnostic Services	• 100%	• 100% of In-Network Established Fee
<b>Basic / Restorative Services</b>		
Basic / Restorative Services	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
<b>Major Services</b>		
Major Services	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
<b>Orthodontic Services</b>		
Orthodontic Lifetime Maximum	• \$1,000 lifetime maximum for child(ren) under age 19. Adult ortho not covered	• \$1,000 lifetime maximum for child(ren) under age 19. Adult ortho not covered
Orthodontic Deductible	• None	• None
Orthodontic Coinsurance	• 50%	• 50% of In-Network Established Fee
Diagnosis	• 50%	• 50% of In-Network Established Fee
Initial Placement of Orthodontic Appliance	• Covered as part of Active and Retention Treatments	• Covered as part of Active and Retention Treatments
Active and Retention Treatments	• 50%	• 50% of In-Network Established Fee
<b>Services</b>		
Oral Examination Copay / Coinsurance	• 100%	• 100% of In-Network Established Fee
Dental X-Rays	• 100%	• 100% of In-Network Established Fee
Prophylaxis - Adult	• 100%	• 100% of In-Network Established Fee
Prophylaxis - Child	• 100%	• 100% of In-Network Established Fee
Topical Application of Fluoride	• 100%	• 100% of In-Network Established Fee
Topical Application of Sealants	• 100%	• 100% of In-Network Established Fee
Fillings	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Periodontic Services	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Extractions	• Simple and Surgical Extractions: Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Endodontics	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Oral Surgery	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Inlays	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Crowns	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Dentures	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Bridges	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee

This benefit summary has been prepared by a licensed Insurance carrier or broker based on documents provided by the applicable licensed Insurance carrier. Please refer to the Plan Document and Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document or COC, the Plan Document and COC govern. This health insurance plan is part of a large group health plan, as such Medicare is the secondary payer for any insured member that is enrolled in Medicare and this plan. If eligible for Medicare due to ESRD, Medicare becomes primary payer after thirty months of Medicare eligibility. If member is a COBRA participant, Medicare is the primary payer.

2014/2015

**Plan Description:** Choice Vision Plan

**Product:** Vision

**Network:** VSP Choice

**Provider:** VSP

**Member Services Phone #:** 1-800-877-7195

**Plan Website Address:** <http://www.vsp.com>

	In-Network	Out-of-Network **
<b>General Plan Information</b>		
Well Vision Exam	• \$5 copay	• Up to \$45
Prescription Glasses (material)	• \$10 copay	• Not applicable
<b>Prescription Glasses (Lenses)</b>		
Single Vision	• Covered at 100%	• Up to \$45
Lined Bifocal	• Covered at 100%	• Up to \$65
Lined Trifocal	• Covered at 100%	• Up to \$85
Polycarbonate lenses for children	• Covered at 100%	• Not applicable
Lens Options	• Average 20% savings on all non-covered lens options	• Not applicable
<b>Prescription Glasses (Frames)</b>		
Allowance for frame	• \$180 allowance	• Up to \$70 allowance
Discount off the amount exceeding the allowance	• 20%	• Not applicable
<b>Contacts (instead of glasses)</b>		
Allowance for contacts and fitting evaluations (You may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses)	• \$150 allowance	• \$150 allowance for Elective Contact Lens/ \$210 allowance for Necessary Contact Lens
<b>Laser Vision Correction (instead of glasses or contacts)</b>		
Allowance for both eyes	• \$150 allowance	• \$150 allowance
Discount off regular price or	• 15%	• Not applicable
Discount on promotional price from VSP contracted facilities	• 5%	• Not applicable
Low Vision	• Up to \$1,000 every two years	• Not applicable
If you have had laser surgery, you can use your frame allowance (if eligible) for non-prescription sunglasses from a VSP doctor.		
<b>Extra Savings and Discounts</b>		
Prescription Glasses	• 20% off additional glasses and sunglasses, including lens options from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam*	
Contacts	• 15% off cost of contact lens exam (fitting and evaluation)*	• Not applicable

* Available from any VSP doctor within twelve months of your last eye exam.

Frequency: Every year beginning in June

**In Network copays apply to billed amounts for out of network services and materials

This benefit summary has been prepared by a licensed Insurance carrier or broker based on documents provided by the applicable licensed Insurance carrier. Please refer to the Plan Document and Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document or COC, the Plan Document and COC govern.





IN THE BUSINESS OF YOUR SUCCESS™



2014/2015

**Plan Description:** Basic Life \$10K  
**Product:** Life Plan

**Provider:** AETNA  
**Member Services:** 1-800-554-1802 (Claim Submission & Eligibility Inquiries)  
**Life Claims Center:** 1-800-523-5065 (Claim Status Inquiries)  
**Plan Website Address:** [www.AetnaLifeEssentials.com](http://www.AetnaLifeEssentials.com)

<b>Eligibility</b>	Covers a regular full-time or part-time employee eligible for the Basic plan who is residing or working in the United States; is working 30 hours or more per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.
<b>Date Coverage Starts</b>	Coverage starts on the first day of the month coinciding with or following completion of the worksite employer's waiting period; or the day the worksite employer becomes covered under the plan. If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day.
<b>Benefit Options</b>	An amount equal to \$10,000 for Life; \$10,000 for Accidental Death & Personal Loss (AD&PL)
<b>Age Reduction</b>	Total amount of Term automatically reduces as follows: to 65% at age 65 to 69, to 50% at age 70 to 74, and to 35% at age 75 and over. Benefit Reduction Rule will be based on the employee's age as of the June 1st that coincides with or follows the member's date of birth.
<b>Benefit Features</b>	
Conversion	Employee will have the opportunity to convert their term life insurance to an individual policy at termination, if no longer eligible for coverage, or if coverage reduces due to age. There is a 60-day conversion application period. Should the employee die during the conversion period, benefits will be payable equal to the maximum amount the employee had a Right to Convert, whether or not he or she applied for an individual policy.
Portability	Employees can port their Life coverage and the Accidental Death rider in the same amount at termination. There is a 60-day application period for portability. Associates may NOT port coverage for themselves if they are sick or injured and away from active work when their life insurance coverage ends. Coverage ported will reduce starting at age 65 and reduced amounts may NOT be converted.
Accelerated Death Benefit (ADB)	<p>If the employee has a terminal illness with a life expectancy of no longer than 24 months, the policy will pay, while employee is still alive, up to 75% of the life insurance benefit up to a maximum of \$500,000.00.</p> <p>This benefit can help with expenses not covered by the employee's medical plan, pay other bills, enable the employee to visit relatives and help the employee get his or her affairs in order.</p> <p>It pays an advance benefit and ensures that the employee's beneficiary will receive the rest of the life insurance benefit upon the employee's death. Repayment is not required should the employee recover within 24 months.</p> <p>The advance benefit may be requested once for the employee. The employee should consult with a tax advisor prior to making the request because the benefit received may be subject to income tax.</p>
Passenger Restraint and Airbag	In the event that a covered person is properly using a passengers restraining device and an airbag is activated, and neither contributes to saving the person's life, this benefit will supplement the accidental death benefit.
Repatriation of Remains	In the unfortunate event that a covered person dies while 200 or more miles from home, this benefit offers financial assistance for preparation and return of the deceased's body to a mortuary. For additional benefit features, please refer to the Certificate of Coverage.
Premium Waiver	If the employee is less than age 60 and has been permanently and totally disabled for at least 6 months (as approved by Aetna), premium payments are waived until the employee recovers or reaches age 65.

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.

2014/2015

**Plan Description:** LTD 50% \$1,000/mo-180  
**Product:** Long Term Disability

**Provider:** AETNA  
**Member Services Phone #:** 1-800-554-1802  
**Disability Call Center:** 1-888-200-6790 (Claims Submission/Status/Questions)  
**Plan Website Address:** www.AetnaLifeEssentials.com

<b>Eligibility</b>	Covers an active member of an employer that elected to provide LTD benefits to its employees under the Policyholder's Flexible Benefits Plan and is working 30 hours or more per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.
<b>Date Coverage Starts</b>	Coverage starts on the first day of the month coinciding with or next following completion of the worksite employer's waiting period; or day worksite employer becomes covered under the plan.  If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day.
<b>Elimination Period</b>	To be eligible for benefits, the employee must be out of work for 180 continuous days due to an occupational or non-occupational injury or illness.
<b>Monthly Benefit</b>	The plan provides income protection to replace up to 50% of the employee's pre-disability monthly earnings.
<b>Minimum Monthly Benefit</b>	\$100 or 10% of gross monthly benefit level, whichever is greater.
<b>Maximum Monthly Benefit</b>	\$1,000 (combined with other income benefits, as specified, in the Certificate Booklet/Summary).
<b>Benefit Duration</b>	As long as the employee remains totally disabled, LTD benefit payments will continue according to the certificate booklet.  <i>*Normal retirement age means the Social Security normal retirement age as stated in the 1983 according revision of the United States Social Security Act.</i>  <i>* Mental Health &amp; Substance Abuse are limited to 24 months. See the Certificate Booklet/Summary for more details.</i>
<b>Disability Provision</b>	Own Occupation Period is the first 24 months for which LTD Benefits are paid. Any Occupation Period is from the end of the Own Occupation period to the end of the Maximum Benefit Period.
<b>Feature and Limitations</b> Rehabilitation	Our ultimate goal is to help the employee return to gainful employment. Our consultants review each Disability claim and determine if Aetna rehabilitation services would be appropriate and effective. After reviewing the employee's claim, if Aetna feels the employee would benefit from our services, we will contact the employee.
Pre-existing Conditions	A disease or injury if, during the 3 months prior to the employee's effective date of coverage: -it was diagnosed or treated; or -services were received for the diagnosis or treatment of the illness or injury; or the employee took drugs or -the employee took drugs or medicines prescribed or recommended by a physician for that condition and the employee has been covered under The Plan for 12 consecutive months.
<b>Benefit Coordination &amp; Deductible Income</b>	LTD benefits are coordinated with Social Security, Workers Compensation, State or Federal government disability or retirement benefits. For details regarding coordination of benefits please refer to the Certificate Booklet/Summary
<b>Conversion Option</b>	None

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.



IN THE BUSINESS OF YOUR SUCCESS®

2014–2015

Plan Description: Health Care Flexible Spending  
Account Summary  
Product: Health Care FSA

Member Services Phone #: 1-800-554-1802  
Website Address: mytotalsource.com

Health Care Flexible Spending Accounts	
Plan Year	June 1 – May 31
Maximum Plan Year Contribution ¹	\$2,500
Who Is Covered?	Employee plus eligible dependents
How Are Contributions Processed?	Payroll deduction from pretax income
Balance Carryover Allowance ²	\$500
<b>Health Care FSA</b> What expenses are eligible?	<p>The following expenses are eligible for reimbursement if they are not otherwise covered by insurance or any other source:</p> <ul style="list-style-type: none"> <li>• Medical or dental copayments, deductibles and/or co-insurance payments</li> <li>• Medical expenses³</li> <li>• Prescription drug expenses</li> <li>• Over-the-counter medications (if prescribed by a physician)⁴</li> <li>• Dental and orthodontic treatment</li> <li>• Vision care, including eyeglasses and contact lenses</li> <li>• Routine physicals, vaccinations and screening tests</li> <li>• Medical monitoring/testing devices and supplies, including for diabetes</li> </ul> <p><b>PLEASE NOTE:</b> If you choose to enroll in a High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) any time during the 2014–2015 Plan Year, you are not eligible to participate in the Health Care FSA. See below for Limited Health Care FSA details.</p>
<b>Limited Health Care FSA</b> What expenses are eligible?	<p>You can participate in the <b>Limited Health Care FSA</b> if you enroll in a qualified High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) at any time during the 2014–2015 Plan Year. You can use this account to pay for eligible <b>dental and vision</b> expenses with tax-free dollars. The Limited Health Care FSA will not reimburse medical expenses. Federal regulations do not allow individuals to receive reimbursement for medical expenses tax-free through a Health Care FSA <b>and</b> contribute to an HSA during the same Plan Year.</p> <p>The following expenses are eligible for reimbursement under the Limited Health Care FSA:</p> <ul style="list-style-type: none"> <li>• Dental and vision copayments, deductibles and/or co-insurance payments</li> <li>• Dental and orthodontic treatment</li> <li>• Vision care, including eyeglasses and contact lenses</li> <li>• Certain preventive care expenses, such as immunizations and routine examinations and procedures</li> </ul>

¹ Health Care Reform legislation includes a provision that limits the amount of salary reduction contributions an individual can make to a Health Care Flexible Spending Account (FSA) to \$2,500 per plan year beginning June 1, 2013 for the ADP TotalSource, Inc. Health and Welfare Plan.

² IRS rules require that unused Health Care FSA contribution balances in excess of \$500 be forfeited after the end of the plan year filing deadline (i.e., July 30). Please plan carefully when electing your FSA contributions to minimize the risk of FSA contribution forfeiture. For complete details, please refer to the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description and Summary of Material Modifications located on My TotalSource® at mytotalsource.com.

³ If you plan on contributing to a Health Savings Account at any time during the 2014–2015 Plan Year, you can only elect to enroll in the Limited Health Care FSA. Only eligible dental and vision expenses can be submitted for reimbursement under the Limited Health Care FSA. The Limited Health Care FSA **will not** reimburse medical expenses.

⁴ In accordance with Health Care Reform legislation, individuals cannot use the ADP TotalSource Health Care FSA for the cost of over-the-counter (OTC) medications unless prescribed by a physician. This rule does not apply to reimbursements for the cost of insulin, which are permitted, even if the insulin is purchased without a prescription.



IN THE BUSINESS OF YOUR SUCCESS®

2014–2015

Plan Description: Dependent Care Flexible Spending      Member Services Phone #: 1-800-554-1802  
Account Summary      Website Address: mytotalsource.com  
Product: Dependent Care FSA

### Dependent Care Flexible Spending Accounts

Plan Year	June 1 – May 31
Maximum Plan Year Contributions	\$5,000 (\$2,500 if married filing separately ¹ )
(Highly Compensated Employees) ² Maximum Plan Year Contributions	\$2,000
Who Is Covered?	Employee and spouse (if applicable) who need dependent care in order to work or look for work.
How Are Contributions Processed?	Payroll deduction from pretax income • A self-employed individual (SEI) may only participate on a post-tax basis and only if he or she is receiving W-2 wages.
What Expenses Are Eligible?	Care of a dependent ³ under 13 years of age, including fees charged by: • Qualified child care centers or nursery schools • In-home babysitters or nannies • After-school programs that enable employee and spouse to hold gainful employment • Non-nursing care of a dependent age 13 or older who is physically or mentally incapable of self-care • Nonmedical care of an elderly dependent whose caregiver spends at least 8 hours a day at the taxpayer's home

**IMPORTANT NOTE:** Outlined above are examples of eligible expenses. Qualified expenses under the Dependent Care FSA include eligible dependent care costs that you must pay to enable you to work or look for work. **The Dependent Care FSA does NOT cover medical expenses for you or your dependents.** IRS rules require that unused FSA contribution balances be forfeited after the end of the plan year filing deadline (i.e., July 30). Please plan carefully when electing your FSA contributions to minimize the risk of FSA contribution forfeiture. For complete details, please refer to the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description and Summary of Material Modifications located on My TotalSource® at [adptotalsource.com](http://adptotalsource.com).

¹ Note that if more than \$5,000 (\$2,500 if married filing separately) is contributed to the Plan during a single Calendar Year, the excess amount will be included in your taxable income.

² Highly compensated employees are only permitted to contribute up to \$2,000 per Plan Year to the ADP TotalSource, Inc. Dependent Care FSA. In addition, ADP TotalSource® may, at any time before or during the Plan Year (June 1 – May 31), notify a highly compensated employee that he or she must discontinue pretax contributions to the Dependent Care FSA or that he or she must limit such pretax contributions to a particular dollar amount below the \$2,000 maximum if ADP TotalSource determines in its discretion that such action is necessary or advisable in order to satisfy the nondiscrimination requirements applicable to the Dependent Care FSA.

For the 2014–2015 Plan Year, a “highly compensated employee” is defined by the IRS as an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a client company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of \$115,000 annually. Please note that the definition of a highly compensated employee may change for future Plan Years.

³ Certain IRS rules apply with respect to caregiver/provider eligibility.