SOUTHERN MUTUAL CHURCH
INSURANCE COMPANY

2018-2019 Benefits Enrollment Guide

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Presented by:

ONEDIGITAL
HEALTH AND BENEFITS

The following descriptions of available benefit elections options, are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Locate your enrollment/change forms or log on to your benefit administration system.
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer states otherwise
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee and you may not be eligible to enroll.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Did you know?

Open Enrollment is the only chance to make changes, unless you experience a "change in status."

Medical Plans

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

Southern Mutual Church Insurance
Health Insurance Benefits

The Benefits Shown are In-Network Benefits Out-of-Network Benefits are paid at a lower rate and members can be balance-billed	United Healthcare w/AmFirst	UHC with AmFirst Net Benefit Summary
	Covered Insured Pays:	**Covered Insured Pays:**
Individual Deductible:	UHC $3,500 EE pays $1,500	$1,500
Family Deductible:	UHC $7,000 EE pays $1,500 per person	$1,500 per person
Calendar or Benefit Year Deductible:	Calendar Year	Calendar Year
Aggregate or Embedded Ded/MOOP:	Embedded/Embedded	Embedded/Embedded
Coinsurance Amount:	EE 50% & AmFirst 50%, then Allsavers 100%	50%
Individual Coinsurance Limit:	EE pays $1,000 using UHC & AmFirst	$1,000
Family Coinsurance Limit:	EE pays $1,000 per Family using UHC & AmFirst	$1,000 per person
Individual Total Out-of-Pocket Maximum:	UHC $7,350, EE pays $2,500 & AmFirst pays $4,850	$2,500
Family Total Out-of-Pocket Maximum:	UHC $14,700, EE pays $2,500 per person & AmFirst pays $4,850 per person	$2,500 per person
In & Out Patient Hospital Services:	Deductible + Coinsurance	Deductible + Coinsurance
In & Out Patient Testing:	Deductible + Coinsurance	Deductible + Coinsurance
Primary Care Office Visit Copay:	$30	$30
Specialist Office Visit Copay:	$60	$60
Preventive Care* Office Visit (In-Network Only):**	Covered at 100%	Covered at 100%
Urgent Care:	$100	$100
Emergency Care:	$300	$300
Prescription Benefits:	$15/$35/$75/$250	$15/$35/$75/$250
Mail Order Prescription Benefits:	2.5x Copay	2.5x Copay
Maximum Lifetime Benefit:	Unlimited	Unlimited

Claim Example 1: Bob has a hospital charge of $2,700. He pays the first $1,500 plus 50% of the $1,200 balance, for a total of $600 more.
Bob's total cost is $2,100.

Claim Example 1: Mary has a hospital charge of $5,700. She pays the first $1,500 plus 50% of the next $2,000, for a total of $1,000 more.
Mary's total cost is $2,500.

Note: With our 2017-18 benefits, Bob would have paid $2,700 and Mary would have paid $3,500.

SMCI Pays 100% of EE Cost and 50% of Dependent Cost				
Coverage Level	**Monthly Premium**	**SMCI Monthly Cost**	**Employee Monthly Cost**	**Employee Cost per Pay Period**
Single	$621.80	$621.80	$0.00	**$0.00**
EE + Sp	$1,329.69	$975.75	$353.95	**$176.97**
EE + Ch	$1,151.26	$886.53	$264.73	**$132.37**
Family	$1,852.54	$1,237.17	$615.37	**$307.69**

Dental Plan

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

DELTA DENTAL®

PREVENTIVE SERVICES *No Waiting Period*	BASIC SERVICES *No Waiting Period*	MAJOR SERVICES *No Waiting Period*
Zero Deductible 100% Coverage	$50 Calendar Year Deductible 80% Coverage	$50 Calendar Year Deductible 50% Coverage
Oral Exams / Cleanings *(1 per 6 months)*	Fillings Full Mouth X-rays *(1 per 36 months)*	Inlays, Onlays, Crowns Oral Surgery & General Anesthesia
Oral Exams / Problem Focused *(Combined w/ Exam Limit)*	Endodontics & Periodontics *(root canals)*	Bridges and Dentures
Bitewing x-rays *(<14: 1 per 12 months)* *(19+: 1 per 12 months)*	Simple Extractions	Repair & Maintenance of Crowns, Bridges & Dentures
Fluoride Treatment *(<16: 1 per 12 months)*	Sealants & Space Maintainers *(age & frequency limits apply)*	Implants

Calendar Year Annual Maximum: $1,500 per member

ORTHODONTICS - $1,000 Lifetime Maximum per member (dependents to age 19 only)

Www.deltadental.com

DENTAL INSURANCE COSTS

COVERAGE LEVEL	TOTAL MONTHLY COST	SMCI Pays 100% of the EE Cost Semi-Monthly Contributions on Your Behalf	Employee Pays Dependent Cost Only! Semi-Monthly Payroll Deductions
EMPLOYEE	$44.05	$22.03	$0.00
EMPLOYEE & SPOUSE	$90.68	$22.03	$23.32
EMPLOYEE & CHILD(REN)	$100.63	$22.03	$28.29
EMPLOYEE & FAMILY	$157.40	$22.03	$56.68

Vision Plan

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

IN NETWORK BENEFITS

- Comprehensive eye exam every 12 months with a $10 copay.
- $150 material allowance every 12 months towards glasses and/or contact lens* with a one-time $25 copay.
- After your material allowance has been used, receive a 15% discount on glasses contact lens at most
- providers**.
- Discounts of 10%-15% on refractive surgery including LASIK at participating providers.
- Standard contact lens fitting fee of no more than $55 or 10% discount off the usual and customary fitting for non-standard contact lens*** at most providers*.
- No claims or paperwork to file.

**Material allowance does not cover non-prescription lenses, non-prescription or cosmetic contact lenses, or non-prescription sun-glasses.*

OUT OF NETWORK BENEFITS

- If you choose to use an out-of-network provider, you will be reimbursed the following amounts:
  - Exam including contact lens fitting: $40 reimbursement
  - Materials: $105 reimbursement

IMPORTANT INFORMATION:

- You will be mailed a membership card.
- To find an in-network provider near you, go to www.eyemed.com or call 1.866.939.3633
- Please visit www.eyemed.com for participating refractive surgery providers and discounts.
- To make an appointment, call an in-network provider and let them know that you are an EyeMed member
- You are responsible for payment to the in-network provider of any amount exceeding the material allowance, any copays and any contact lens fitting fees.
- This is a routine vision program. Medical and surgical treatments of the eyes are not covered benefits.

VISION INSURANCE COSTS:

TYPE OF COVERAGE	Employee Pays Total Cost Semi-Monthly Payroll Deductions
EMPLOYEE	$4.30
EMPLOYEE & SPOUSE	$8.17
EMPLOYEE & CHILD(REN)	$8.60
EMPLOYEE & FAMILY	$12.63

Life / AD&D Plans

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EMPLOYER PAID SHORT-TERM DISABILITY

- Benefit is 60% of your weekly pre-disability earnings, to a maximum of $1,500 per week.
- Payable on the 31st day of an accident or the 31st day for an illness.
- 9 Week benefit duration.
- Your benefit will be taxable, as Southern Mutual pays 100% of your monthly premiums.

EMPLOYER PAID LONG-TERM DISABILITY

- Benefit is 60% of your monthly pre-disability earnings, to a maximum of $7,500 per month.
- Payable after 90 days of a total or partial disability.
- Own Occupation Period is 24 months.
- Maximum duration of benefits is to Social Security Normal Retirement Age (SSNRA).
- If you remain actively at work beyond your normal retirement age, your benefit will never be paid for less than 12 months, as long as you remain disabled.
- Unlimited Return to Work Incentive.
- 3 months survivor benefit.
- Your benefit will be taxable, as Southern Mutual pays 100% of your monthly premiums.

Group Number G000AY4G

Customer Service: (800) 228-7104 **Website: www.mutualofomaha.com**

Disability Plans

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EMPLOYER PAID BASIC LIFE INSURANCE

- **$50,000 Life and Accidental Death & Dismemberment Insurance**
- **Southern Mutual pays 100% of the premium**

VOLUNTARY LIFE INSURANCE

- **Employee Max Benefit - Lesser of 5x annual earnings or $100,000 in increments of $10,000, rounded to the next higher $1,000**
  Guarantee Issue for New Hires = $100,000
- **Spouse Max Benefit - 50% of employee amount, up to $20,000**
  Guarantee Issue for Spouses of New Hires = $20,000.
- **Child Max Benefit - $10,000, in increments of $2,000**
  Guarantee Issue for Children of New Hires = $10,000

			Sample Employee	Sample Employee
	Employee	Spouse	Per-Pay-Period	Per-Pay-Period
Age Bracket	Monthly Cost Per $10,000	Monthly Cost Per $10,000	Cost for $20,000	Cost for $100,000
0-24	$1.12	$1.12	$1.12	$5.60
25-29	$1.25	$1.25	$1.25	$6.25
30-34	$1.33	$1.33	$1.33	$6.65
35-39	$1.56	$1.56	$1.56	$7.80
40-44	$1.95	$1.95	$1.95	$9.75
45-49	$2.72	$2.72	$2.72	$13.60
50-54	$4.18	$4.18	$4.18	$20.90
55-59	$6.77	$6.77	$6.77	$33.85
60-64	$10.42	$10.42	$10.42	$52.10
65-69	$16.88	$16.88	$16.88	$84.40
70-74	$29.18	$29.18	$29.18	$145.90
75-79	$48.80	$48.80	$48.80	$244.00

Child Term Life Rate for $10,000: $1.30

Group Number G000AY4G

Customer Service: (800) 228-7104

Website: www.mutualofomaha.com

Special Benefits

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

What you need to know about your Health Flexible Savings Account through TASC: 800-422-4661

What is a Flexible Spending Account? A Medical Flexible Spending Account (FSA) is an account to which you contribute part of your pay before FICA, State and Federal Income (withholding) Tax to pay for qualified medical, dental and certain vision expenses for yourself, your spouse, and/or your dependents.

What are qualified expenses? Any IRS Section 213 (D) expenses are eligible to be reimbursed through your Medical FSA. These expenses include most medical, Rx, dental & vision related services.

Why should I participate in a Medical Reiumbursement FSA? Normally, you would receive an income tax deduction for qualifying medical, dental and vision expenses that exceed 10% of your adjusted gross family income. (Few taxpayers ever meet that qualification or receive a tax deduction.)

How can I participate? First determine regular medical, dental and vision expenses you and your dependent(s) will incur during this plan year (1/1/2019 to 12/31/2019). Enter the amount you want to set aside before taxes on the Election Form. Each pay period, SMCI will deduct this amount from your paycheck and deposit the funds directly into your Flexible Spending Account.

Can I revoke my annual election amount? Generally, no. However, if you have a qualified change in status (marriage, divorce, birth, adoption, unpaid leave of absence, change in employment status of you or your spouse from full-time to part-time or vice-versa) you can revoke your annual elected amount and make a new election for the remainder of the plan year.

Do I have a "Use It Or Lose It" rule? You may submit a request for reimbursement for expenses ***incurred*** through December 31, 2019. You will have a 60-day timeframe to submit the Reimbursement Request Form for expenses incurred during that time. SMCI allows up to $500 of unused funds to be rolled over to the next calendar year.

When can I elect to participate, and how much may I contribute? Each year, during the Open Enrollment period and prior to the Plan renewal date, you must complete a new Election Form for the upcoming plan year if you are making a change. The 2018 annual maximum contribution limit for Healthcare Reimbursement is $2,650. In 2019 it will be $_____.

What expenses are not eligible? Over-the-counter medicines cannot be purchased with FSA money without a prescription. Cosmetic procedures are also not eligible.

What happens if my request for Medical Care Reimbursement is greater than the amount of money in my account? The annual amount is available to you from the beginning of the 1/1/2019 plan year, and if you request more than the annual elected amount, only the elected amount will be available to you.

MEDICAL FSA ELIGIBLE EXPENSES

- Artifidal limbs or teeth
- Birth control pills, contraceptive devices & sterilization procedures
- Childbirth classes
- Co-pays, co-insurance, & deductibles
- Durable medical equipment
- Dental exams, cleanings & other qualified services
- Hearing devices
- Hospital bills
- Insulin, diabetic supplies, and test kits
- Medical tests and other services
- Orthodontia
- Some over the counter items when accompanied by a prescription from a medical provider

REQUIRED NOTICES

Newborn and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy , including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.

REQUIRED CHIP NOTICE

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

Alabama – Medicaid	Arkansas – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
Alaska – Medicaid	**Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711

REQUIRED CHIP NOTICE (CONT)

Florida – Medicaid	Maine – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
Georgia – Medicaid	**Massachusetts – Medicaid and CHIP**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
Indiana – Medicaid	**Minnesota – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
Iowa – Medicaid	**Missouri – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
Kansas – Medicaid	**Montana – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
Kentucky – Medicaid	**Nebraska – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
Louisiana – Medicaid	**Nevada – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

REQUIRED CHIP NOTICE (CONT)

New Hampshire – Medicaid	Rhode Island – Medicaid
Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
New Jersey – Medicaid and CHIP	**South Carolina – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
New York – Medicaid	**South Dakota - Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://dss.sd.gov Phone: 1-888-828-0059
North Carolina – Medicaid	**Texas – Medicaid**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
North Dakota – Medicaid	**Utah – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
Oklahoma – Medicaid and CHIP	**Vermont– Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org Phone: 1-800-250-8427
Oregon – Medicaid	**Virginia – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
Pennsylvania – Medicaid	**Washington – Medicaid**
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473

REQUIRED CHIP NOTICE (CONT)

West Virginia – Medicaid	Wyoming – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
Wisconsin – Medicaid and CHIP	
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

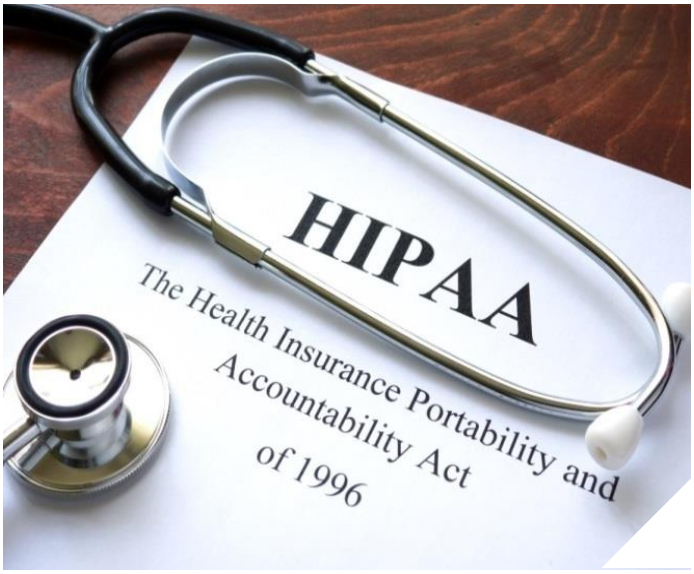
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

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

(OMB Control Number 1210-0137 (expires 12/31/2019).

HIPAA Notice



HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants. All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI. If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.
More information can be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html
Link to model notice: http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/nppbooklet_health_plan.pdf
Link to OneDigital's privacy policy: https://www.onedigital.com/privacy-policy/
Model Special Enrollment Notice
The following is language that group health plans may use as a guide when crafting the special enrollment notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within the appropriate time period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

More information can be found at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance

Link to model notice: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

For additional information on your employer's privacy policy, please contact your HR department.

CONFIDENTIALITY NOTICE

OneDigital Health and Benefits, a division of Digital Insurance, LLC does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

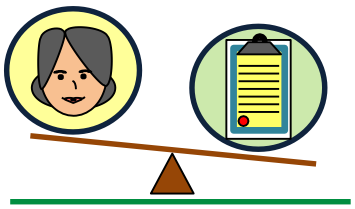
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

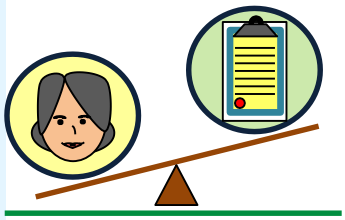
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

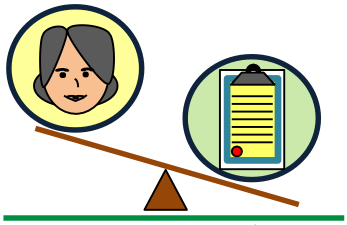
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

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