2021

BENEFITS ENROLLMENT GUIDE

Effective | January 1, 2021 – December 31, 2021

BENEFITS OVERVIEW

Goodwill of Colorado offers a comprehensive benefits package to promote health and wellness along with financial security for both you and your family. The complete benefit package is briefly summarized in this enrollment guide. Please be sure to review it carefully so that you are able to elect the coverage that is most appropriate for your personal situation. If there is any discrepancy between the insurance carrier's Summary Plan Description (SPD) and this guide, the insurance carrier's SPD is the prevailing document.

For information about…	Go to…	
Your Benefits	**GOODWILL HUMAN RESOURCES (HR)** **HRHelpdesk@discovermygoodwill.org**	
	Sara Nelson, Benefits Manager 303-412-4786 benefits@goodwilldenver.org	
	Carla Headley Benefits Coordinator 719-442-2074 benefits@goodwilldenver.org	Dianne Krening Benefits Coordinator 719-785-9212 benefits@goodwilldenver.org
Customer Service Support	Tina Neuendorf 719-314-3505 tina.neuendorf@nfp.com	Robert West 719-314-3524 robert.west@nfp.com
What's Happening in 2021? **Page 3**		
How to Enroll **Page 4**	**https://n23.ultipro.com**	
Benefit Program Information **Page 5**		
Member Navigator **Page 6**	HealthAdvocate 1-866-799-2731 **www.HealthAdvocate.com/members**	
Direct Primary Care **Page 8**	PeakMed 1-844-673-2563 **www.peakmed.com**	
Medical / Pharmacy (R_x) / HSA / Wellness **Page 11**	Cigna 1-800-997-1654 **www.cigna.com** or **www.mycigna.com**	
Dental – Patient Direct **Page 17**	Beta Health 1-800-807-0706 **www.betadental.com**	
Dental – PPO Plan **Page 18**	Delta Dental 1-800-610-0201 **www.deltadentalco.com**	
Vision **Page 19**	EyeMed 1-866-939-3633 **www.eyemedvisioncare.com**	
Flexible Spending Account (FSA / LPFSA) **Page 20**	Rocky Mountain Reserve 1-888-722-1223 www.rockymountainreserve.com	
Short-Term (STD) & Long-Term (VLTD) Disability **Page 23**	Cigna Life & Disability Please Contact HR for Life Questions **www.cigna.com**	
Basic & Supplemental (Voluntary) Life **Page 26**	Cigna Life & Disability Please Contact HR for Life Questions **www.cigna.com**	
Voluntary Benefits – Accident / Hospital / Critical Illness: Page 29	Aflac 1-800-433-3036 **www.aflac.com**	
Laws & Policies **Page 33**		

WHAT'S HAPPENING IN 2021?

- **<u>Premiums for medical coverage are increasing</u>**, but if you enroll in the medical plan and "engage" with your PeakMed Direct Primary Care (DPC) doctor (or a PeakMed affiliate), **<u>then you will be given a wellness credit of $69 per month</u>** (see the "Wellness Program" page for details).

- **No Changes to the Core Medical / Dental / Vision Plans for 2021!**

  Medical: Cigna remains the carrier for the Medical and Pharmacy plan. Their network of providers (physicians, hospitals, and ancillary services) will fulfill all of your healthcare needs. These are in-network medical plans only:

  - Value ($5,500) Medical Plan
  - Premier ($2,500) Medical Plan
  - HSA ($4,000) Medical Plan

  Dental:

  - Patient Direct Discount Plan (Beta Health)
  - Delta Dental PPO Plus Premier Plan

  Vision: EyeMed

  - EyeMed Vision Plan

- For those enrolled in the Qualified High Deductible Health Pan (QHDHP), the HSA $4,000 Plan, have the option of a **Health Savings Account (HSA)** to which you can contribute on a pre-tax basis.

- **PeakMed Direct Primary Care (DPC)** – Automatically available to all employees enroll in a medical plan and is a voluntary option for those employees not enrolled in the medical plan.

- **Member Navigator** – **HealthAdvocate** services, your one-stop for all benefit needs – medical, dental, vision, wellness, FSA, HSA, disability, life insurance questions – are being expanded so they'll be better equipped than ever to assist you.

- **Flexible Spending Account (FSA) and Health Savings Account (HSA)** – Our FSA and HSA vendor is Rocky Mountain Reserve. Services include both a Health Care Flexible Spending Account (HCFSA) as well as the Dependent Care Flexible Spending Account (DCFSA). For those enrolled in the high deductible health plan, a Health Savings Account (HSA) option is also available.

  <u>You must still make a new FSA election for the 2021 plan year in order to continue this benefit.</u>

  Based upon which medical plan elected at the time of initial enrollment, new hires are eligible to participate in the FSA / HSA / LPFSA as of the first of the month 60-days after their date of hire.

- **Voluntary Benefit Plans** – Aflac offers coverage under popular voluntary benefit programs – accident, hospital indemnity, and critical illness – all with the convenience of pre-tax deduction every pay period.

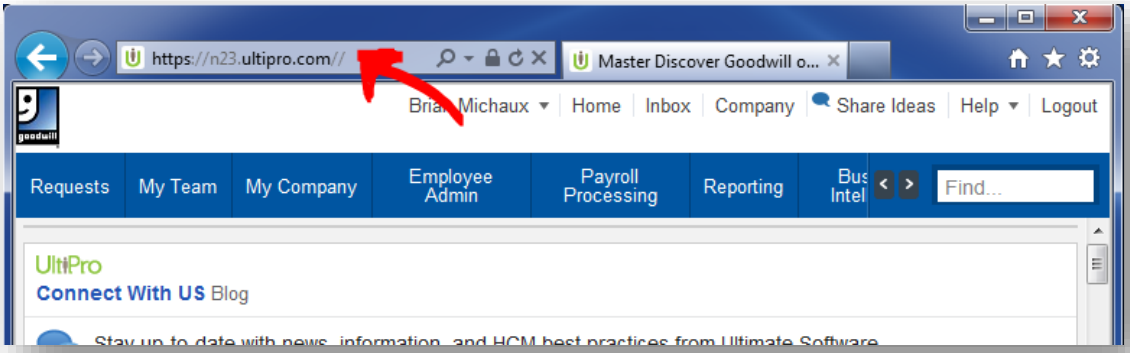
- **Life & Disability** – Cigna Life and Disability is our insurance carrier for Basic Life / AD&D, Supplemental and Dependent Life, Short-Term Disability (STD), and Voluntary Long-Term Disability (VLTD) policies. <u>STD is an employer-paid benefit and Long-Term Disability is only available if paid for by the employee.</u>

HOW TO ENROLL

How to Access the System to Complete your 2021 Open Enrollment Employee Benefit Elections

Type this address into your web browser*: **https://n23.ultipro.com**

* *The term "web browser" refers to a program on your computer (Some versions of Internet Explorer have difficulty so if you are having trouble you might try one of the others)*



Current Active Employees:

- If you need assistance logging in to UltiPro Employee Self Service, please contact your supervisor or Human Resources via the HRHelpdesk@discovermygoodwill.org email.
- Information about benefits is available on UltiPro – Go to "Myself" → "Company Info"
- Review benefit programs you are currently enrolled in – Go to "Myself" → "Current Benefits."
- Review your employee demographic information and update as necessary (including dependent data) – Go to "Change Name, Address, or Telephone" on the right-hand side of the "Myself" → "Employee Summary" page.
- Add any new dependent information – you must have a social security number and birthdate for each dependent. Go to "Myself" → "Personal" → "Contacts."
- Select, review, or waive medical, dental and vision benefits.
- Review voluntary insurance benefits and indicate interest in receiving more information. If you're not interested, then you are required to waive coverage.
- Provide and/or update your beneficiary information for the Basic Life and AD&D Insurance and Supplemental Life Insurance. To add or change your beneficiary information – Go to "Myself" → "Personal" → "Contacts."

BENEFIT PROGRAM INFORMATION

ELIGIBILITY

Coverage begins for enrolled eligible employees on the first of the month following sixty (60) days of employment.

Full-Time (FT) –

You are eligible for Medical, Dental, Vision, FSA, HSA, Basic Group Life and AD&D, Supplemental Life, Short-Term Disability (STD), Voluntary Long-Term Disability (LTD) and Aflac voluntary benefits:

- Employees identified by their manager as Full-Time (FT) scheduled to work a minimum of 30+ hours per week, or who become Full-Time (FT) due to ACA rules, are eligible to participate in our benefit plans beginning the first of the month following sixty (60) days from when they become a Full-Time employee.

Part-Time (PT) –

- Employees identified by their manager as Part-Time (PT) scheduled to work 29 hours or less per week, are eligible to voluntarily participate in the PeakMed Direct Primary Care (DPC), Employee Assistance Program (EAP), the Health Care Flexible Spending Account (HCFSA) and/or the Dependent Care Flexible Spending Account (DCFSA), and Aflac voluntary benefits.

ELIGIBLE DEPENDENTS

- Legally married spouse
- Children until they turn 26 regardless of student marital, or employment status. This includes natural children, stepchildren, adopted (or placed for adoption), and children for whom you are the legal guardian.

OPEN ENROLLMENT

The benefits plan year is from January 1st through December 31st, 2021. This year's annual open enrollment period will be held during November and will end on or around November 20th.

Annual deductibles and/or out-of-pocket maximums cycle on a calendar year basis (January through December). If you elect to participate in the Flexible Spending Account (FSA), it also cycles on a calendar year basis.

During open enrollment, you may enroll in or make changes to your benefit programs. Open enrollment is the only time you may add or change benefits during the year unless you have a qualifying life event.

Make sure you understand the offerings and enroll yourself and your eligible dependents in the benefit programs you would like for the upcoming plan year.

QUALIFYING LIFE EVENTS

The following Qualifying Life Events (QLEs) allow you a **30-day** special enrollment period to complete and submit a request to change and update your benefits outside of the open enrollment period:

- You get married, divorced or legally separated;
- You add a child through birth, adoption or change in custody;
- Your spouse or child dies; and/or
- Your spouse and/or child(ren) lose eligibility for coverage

The following events allow you a **60-day** special enrollment period to complete and submit a request to change and update your benefits outside the open enrollment period:

- You, your spouse or child loses coverage under either a Medicaid plan under Title XIX or under a state child health plan (CHIP) under Title XXI of the Social Security Act due to a loss of eligibility for that program's coverage
- You, your spouse, or child becomes eligible for premium assistance with respect to the cost of coverage under our group health plan through either a Medicaid plan under Title XIX (such as Utah's Premium Partnership) or under a state child health plan (CHIP) under Title XXI of the Social Security Act (see enclosed disclosure).

MEMBER NAVIGATOR

HealthAdvocate™
Always at your side

HealthAdvocate is a service provided by Goodwill at **no cost to you**. Their experts connect you to ALL of your Full-Time (FT) benefits and help to resolve health-care and insurance-related issues — all through the convenience of a single, toll-free number: 866-799-2731.

They Make Healthcare Easier By:

- Answering questions about your entire benefits package;
- Connecting you to the right benefit at the right time, such as medical, dental, pharmacy and more;
- Supporting medical issues, from common to complex;
- Clarifying and answering questions about diagnoses and treatments;
- Researching the latest treatment options;
- Finding the right in-network doctors, hospitals and other facilities;
- Scheduling tests and appointments, even with hard-to-reach specialists;
- Researching and arranging expert second opinions;
- Explaining and resolving insurance claims, billing issues and your share of costs; and
- Facilitating pre-authorizations and coordinating benefits.

Help Is Only a Phone Call Away

- Connect to All of Your Benefits
- Get Expert Healthcare Help

24/7 support
866.799.2731
Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members

With **HealthAdvocate**, you have **unlimited access** to a team of experienced "Personal Health Advocates," typically Registered Nurses (RNs), supported by medical directors, benefits and claims specialists.

These advocacy services are available to eligible Full-Time (FT) employees, their spouses or domestic partners, and dependent children, parents and parents-in-law.

***IMPORTANT INFORMATION** – Health Advocate is not health Insurance, it is a health advocacy and support service not affiliated with any insurance carrier or third-party provider. As such, it is not subject to COBRA continuation should you leave the Company.*

MEMBER NAVIGATOR

HealthAdvocate connects you to ALL of your Full-Time (FT) employee benefits, and helps you resolve health-care and insurance-related issues — all through a single, toll-free number.

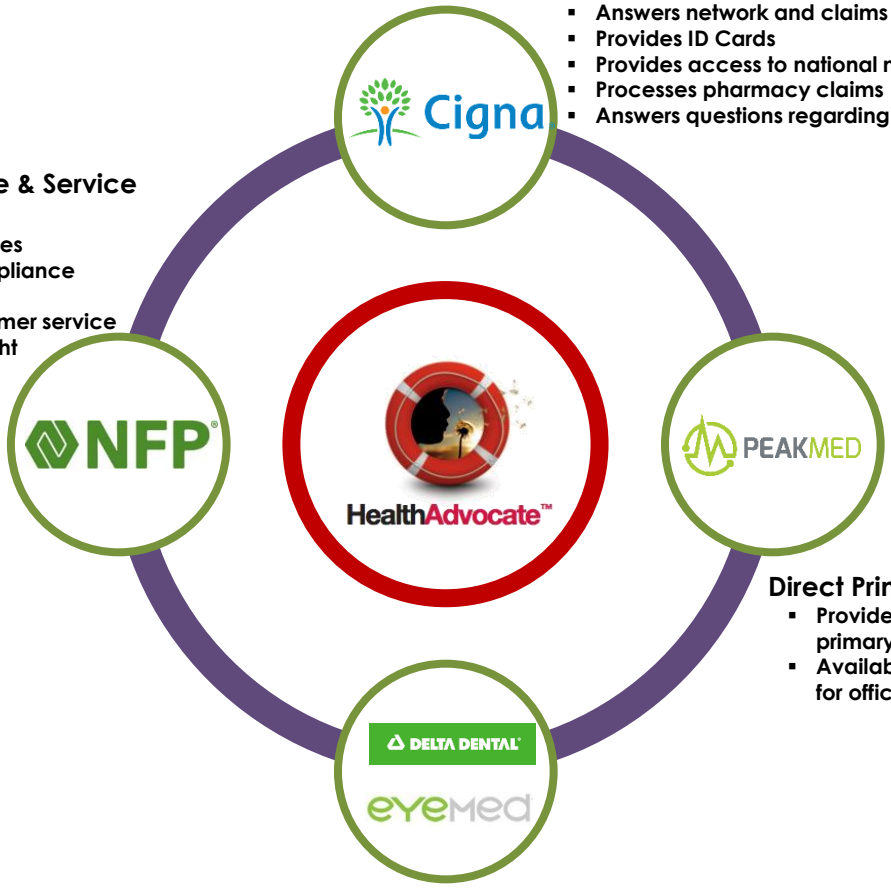
- Available for All Benefits
- Assist with Finding Providers
- Benefit Coverage, Claims Status, and Billing Questions

HealthAdvocate™
Always at your side

24/7 support
866.799.2731
Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members

Network / Pharmacy Benefit Manager (PBM)
- Processes your medical claims
- Answers network and claims questions
- Provides ID Cards
- Provides access to national network of providers
- Processes pharmacy claims
- Answers questions regarding claims and pharmacies

Account Expertise & Service Excellence
- Consulting services
- Technical / Compliance
- Actuarial
- Dedicated customer service
- Wellness Oversight



Direct Primary Care (DPC)
- Provides convenient access to primary care
- Available to members at NO cost for office visits

Dental & Vision
Available for all benefits
- PPO Dental Plan
- Patient Direct (Beta Health) Discount Dental Plan
- Comprehensive Vision Coverage Provides access to network of providers and discounted network rates

DIRECT PRIMARY CARE (DPC)

As your direct primary care provider, use PeakMed for ALL your primary care needs!

Goodwill provides PeakMed Direct Primary Care (DPC) services to all Full-Time (FT) employees enrolled in the Medical / R_x plans.

PeakMed services are also being offered as a stand-alone option, on a post-tax basis, to those who are not enrolled or are not eligible to participate in the core medical plan.

At PeakMed, we believe in both helping people and changing their lives for the better. In addition to primary and urgent care needs, members have access to laboratory services, on-site pharmacy, pediatric care, physicals, wellness and more!

- **$0 Copay for Office and Urgent Care Visits**
- Access to Your Provider via Email, Text or Phone
- Lab Services
- Pediatric Care
- Pharmacy
- Routine Physicals
- Proactive Care
- Savings on Medications, Labs and X-rays

PeakMed® Isn't Health Insurance. It's Health CARE.

Convenience

Visit
https://www.peakmed.com/,
call **1-844-673-2563,**
or refer to the
PeakMed Locations Flyer
for a complete list of Colorado
locations available to you.

IMPORTANT INFORMATION *– COBRA continuation applies to PeakMed Direct Primary Care (DPC) services as this is a health care provider whose cost is included in your monthly premiums. Should you leave Goodwill's employment but elect not to continue coverage under COBRA, then you will also be offered a separate opportunity to continue DPC services directly from the provider should you choose to do so.*

DIRECT PRIMARY CARE (DPC)

CONVENIENT ACCESS TO PRIMARY CARE

IT'S SIMPLE, AFFORDABLE, AND CONVENIENT

Goodwill is offering PeakMed to **all Full-Time (FT) employees currently enrolled in our Medical/R_X plans and can be purchased on a stand-alone basis by Part Time (PT) employees and by those who do not participate in our core medical plans.** You have unlimited access to board-certified doctors and mid-levels. As your primary care physician, they can diagnose, treat, and prescribe medication.

Get the care you need, when you need it, in person, via online video, phone or secure e-mail. The service is secure, confidential and compliant with all medical privacy regulations.

When should I use PeakMed?

- ✓ For **ALL** your primary care needs
- ✓ Your primary care physician is not available
- ✓ If you're considering the ER or urgent care for a non-emergency medical issue
- ✓ At home, traveling, or at work
- ✓ 24/7/365 M.D. access (including holidays)

What can be treated?

- ✓ Hypertension
- ✓ Diabetes
- ✓ Cholesterol
- ✓ Allergies
- ✓ Asthma
- ✓ Bronchitis
- ✓ Cold and flu
- ✓ Ear infections
- ✓ Joint aches and pain
- ✓ Respiratory infection
- ✓ Sinus problems
- ✓ And more!

PeakMed can treat conditions related to:

- ✓ Chronic conditions (e.g., high blood pressure, diabetes, etc.)
- ✓ Adult physicals
- ✓ School physicals
- ✓ Sleep disorders
- ✓ Smoking addiction
- ✓ Other personal challenges
- ✓ And more!

Who are PeakMed's providers?

Our providers practice primary care, pediatrics, family, and urgent care.

We incorporate technology and longer appointment times into our practices to provide convenient access to quality care.

Who is eligible?

If you are an eligible Goodwill employee, you can elect to have access to PeakMed for your dependents (subject to payroll deductions). However, if you want a child seen, a parent or guardian must be present during registration and any consults involving minors.

Your Copay Cost Is

$0 per visit

Subject to eligibility

IMPORTANT INFORMATION *– COBRA continuation applies to PeakMed Direct Primary Care (DPC) services as this is a health care provider whose cost is included in your monthly premiums. Should you leave Goodwill's employment but elect not to continue coverage under COBRA, then you will also be offered a separate opportunity to continue DPC services directly from the provider should you choose to do so.*

DIRECT PRIMARY CARE (DPC)

Direct Primary Care (DPC) Standalone Rates –

IMPORTANT NOTE:

If you are a Full-Time (FT) employee enrolled for any Medical Plan, then PeakMed Direct Primary Care (DPC) services are already included as part of your monthly medical coverage and premiums!

Standalone Employee Contributions Per Pay Period (24 Deductions)

PEAKMED-ONLY PREMIUMS PER PAY PERIOD		
RATE TIER	**PER EACH EMPLOYEE & COVERED ADULT**	**PER EACH DEPENDENT *(up to 18 years of age)***
Per Pay Period Rates	$34.50	$22.50
PeakMed Direct Primary Care (DPC) standalone services are available as a post-tax benefit only to those employees not otherwise eligible to participate in any of our core medical plans.		

Affordable
No co-pays, no deductibles and wholesale/cash pay pricing for medications, labs, and imaging.

On-Site Pharmacy
Wholesale prices on prescription medications.

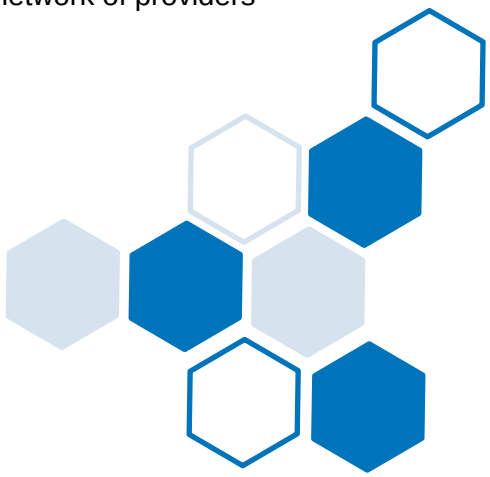
Whole Body Care
Real time to discuss your health with 30-60 minute doctor appointments.

IMPORTANT INFORMATION *– COBRA continuation applies to PeakMed Direct Primary Care (DPC) services as this is a health care provider whose cost is included in your monthly premiums. Should you leave Goodwill's employment but elect not to continue coverage under COBRA, then you will also be offered a separate opportunity to continue DPC services directly from the provider should you choose to do so.*

MEDICAL / R_x

As an employee of Goodwill, you have:

- Three (3) options to select from for medical coverage:
  - ✓ **Value ($5,500) Medical Plan** – In-network only based on Cigna's network of providers
  - ✓ **Premier ($2,500) Medical Plan** – In-network only based on Cigna's network of providers
  - ✓ **HSA ($4,000) Medical Plan** – In-network only based on Cigna's network of providers
- **You do not need to select a Primary Care Physician (PCP) under any Cigna medical plan.** If you so choose, you may utilize PeakMed to be your PCP.
- Call Cigna at 855-799-1974 to speak with a representative to get personalized guidance.
- **Referrals are required** for members or covered dependents to receive care from a specialist.
- Medical / pharmacy benefits and comprehensive network provider directories can be located online via at **www.cigna.com**. Click on the "Find a Doctor, Dentist or Facility" link and follow the on-screen prompts. Be sure to select the Cigna network.



SPECIAL NOTE FOR RURAL MEMBERS

If you reside in a location other than along the Front Range or within easy access to a major metro-politan area, then you will be assigned to Cigna's Open Access Plus (OAP) network. The medical plan benefits are exactly the same, only a different network; however, per pay period premium costs will be slightly higher. You will be advised after your enrollment if this applies to you and/or any covered dependents. Refer to the individual medical plans shown on the next few pages to see the OAP rates.

Medical / R_x Plan Rates – LocalPlus & SureFit Networks ONLY

You can save $69 per month on Medical Premiums by doing one simple thing!

If you enroll in any Goodwill medical plan you are automatically enrolled in Direct Primary Care (DPC) with PeakMed (or a PeakMed affiliate). **If you "engage" with your Direct Primary Care doctor, you will be given a wellness credit of $69 per month. See the "Wellness Program" on Page 15 for more details.**

Effective January 1, 2021 through December 31, 2021

Full-Time Employee Contributions Per Pay Period (24 Deductions)

MEDICAL PLAN PREMIUMS PER PAY PERIOD (24)			
RATE TIER	**VALUE ($5,500) PLAN WITH / WITHOUT WELLNESS**	**PREMIER ($2,500) PLAN WITH / WITHOUT WELLNESS**	**HSA ($4,000) PLAN WITH / WITHOUT WELLNESS**
Employee Only	$31.42 / $65.92	$58.42 / $92.92	$34.10 / $68.60
EE & Spouse	$157.45 / $191.95	$184.53 / $219.03	$157.93 / $192.43
EE & Child(ren)	$164.90 / $199.40	$192.91 / $227.41	$165.35 / $199.85
EE & Family	$255.77 / $290.27	$298.66 / $333.16	$256.52 / $291.02

MEDICAL / R_x

Cigna – Value ($5,500) Medical Plan	In-Network Only
Calendar Year Deductible (January 1 – December 31, 2021)	
Individual	$5,500
Family	$11,000
Coinsurance (Amount Plan Pays / Amount YOU pay)	70% / 30%
Out-of-Pocket Annual Maximum (Includes Copays, Deductibles, & Coinsurance)	
Individual	$7,500
Family	$15,000
Lifetime Benefit Maximum	Unlimited
Office Visits	
PeakMed Direct Primary Care (DPC)	$0 Copay / No Deductible
Primary Care Physician (PCP)	Deductible then 30%
Specialist	Deductible then 30%
Preventive Care	Covered at 100%, No Deductible
Diagnostic Laboratory / X-Rays	Deductible then 100% *(independent lab facility only);* Otherwise, Deductible then 30%
MRI / CT / PET Scans	Deductible then 30%
Emergency Medical Care	
Emergency Room	$300 Copay, waived if admitted
Ambulance	Deductible then 30%
Urgent Care	$100 Copay
Hospital Services	
Inpatient Services	Deductible then 30%
Outpatient Services	Deductible then 30%
Prescription Plan	
Tier 1 (Generic)	$15 Copay
Tier 2 (Brand Formulary)	$45 Copay
Tier 3 (Brand Non-Formulary)	$60 Copay
Tier 4 (Specialty)	20% Copay
Mail Order (90-Day Supply)	3x Retail Copay
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Summary Plan Description (SPD), the SPD will prevail.	

	EMPLOYEE COST– Value ($5,500) Medical Plan		
Medical Plan Network	**Employee Cost LocalPlus & SureFit Networks WITH WELLNESS** ***Per Pay Period (24)***	**Employee Cost LocalPlus & SureFit Networks WITHOUT WELLNESS** ***Per Pay Period (24)***	**Employee Cost* OAP Network Only WITH / WITHOUT WELLNESS** ***Per Pay Period (24)***
Employee Only	$31.42	$65.92	$33.82 / $68.32
Employee + Spouse	$157.45	$191.95	$170.68 / $205.18
Employee + Child(ren)	$164.90	$199.40	$178.90 / $213.40
Family	$255.77	$290.27	$278.19 / $312.69

* ***Rates shown for the OAP Network (outside the front range) are both with and without wellness. If someone needs to be on the OAP plan due to network access issues, per period rates are slightly higher.***

MEDICAL / R_x

Cigna – Premier ($2,500) Medical Plan	In-Network Only
Calendar Year Deductible (January 1 – December 31, 2021)	
Individual	$2,500
Family	$5,000
Coinsurance (Amount Plan Pays / Amount YOU pay)	80% / 20%
Out-of-Pocket Annual Maximum (Includes Copays, Deductibles, & Coinsurance)	
Individual	$5,500
Family	$11,000
Lifetime Benefit Maximum	Unlimited
Office Visits	
PeakMed Direct Primary Care (DPC)	$0 Copay / No Deductible
Primary Care Physician (PCP)	Deductible then 20%
Specialist	Deductible then 20%
Preventive Care	Covered at 100%, No Deductible
Diagnostic Laboratory / X-Rays	Deductible then 100% *(independent lab facility only);* Otherwise, Deductible then 20%
MRI / CT / PET Scans	Deductible then 20%
Emergency Medical Care	
Emergency Room	$300 Copay, waived if admitted
Ambulance	Deductible then 20%
Urgent Care	$100 Copay
Hospital Services	
Inpatient Services	Deductible then 20%
Outpatient Services	Deductible then 20%
Prescription Plan	
Tier 1 (Generic)	$15 Copay
Tier 2 (Brand Formulary)	$45 Copay
Tier 3 (Brand Non-Formulary)	$60 Copay
Tier 4 (Specialty)	20% Copay
Mail Order (90-Day Supply)	3x Retail Copay
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Summary Plan Description (SPD), the SPD will prevail.	

	EMPLOYEE COST – Premier ($2,500) Medical Plan		
Medical Plan Network	**Employee Cost LocalPlus & SureFit Networks WITH WELLNESS** ***Per Pay Period (24)***	**Employee Cost LocalPlus & SureFit Networks WITHOUT WELLNESS** ***Per Pay Period (24)***	**Employee Cost* OAP Network Only WITH / WITHOUT WELLNESS** ***Per Pay Period (24)***
Employee Only	$58.42	$92.92	$63.50 / $98.00
Employee + Spouse	$184.53	$219.03	$212.55 / $247.05
Employee + Child(ren)	$192.91	$227.41	$223.22 / $257.72
Family	$298.66	$333.16	$346.97 / 381.47

* ***Rates shown for the OAP Network (outside the front range) are both with and without wellness. If someone needs to be on the OAP plan due to network access issues, per period rates are slightly higher.***

MEDICAL / R_x

Cigna – HSA ($4,000) Medical Plan	In-Network Only
Calendar Year Deductible (January 1 – December 31, 2021)	
Individual	$4,000
Family	$8,000
Coinsurance (Amount Plan Pays / Amount YOU pay)	80% / 20%
Out-of-Pocket Annual Maximum (Includes Copays, Deductibles, & Coinsurance)	
Individual	$6,500
Family	$13,000
Lifetime Benefit Maximum	Unlimited
Office Visits	
PeakMed Direct Primary Care (DPC)	$0 Copay / No Deductible
Primary Care Physician (PCP)	Deductible then 20%
Specialist	Deductible then 20%
Preventive Care	Covered at 100%, No Deductible
Diagnostic Laboratory / X-Rays	Deductible then 100% *(independent lab facility only);* Otherwise, Deductible then 20%
MRI / CT / PET Scans	Deductible then 20%
Emergency Medical Care	
Emergency Room	Deductible then 20%
Ambulance	Deductible then 20%
Urgent Care	Deductible then 20%
Hospital Services	
Inpatient Services	Deductible then 20%
Outpatient Services	Deductible then 20%
Prescription Plan	
Tier 1 (Generic)	Deductible then 20%
Tier 2 (Brand Formulary)	Deductible then 20%
Tier 3 (Brand Non-Formulary)	Deductible then 20%
Tier 4 (Specialty)	Deductible then 20%
Mail Order (90-Day Supply)	3x Retail Cost
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Summary Plan Description (SPD), the SPD will prevail.	

	EMPLOYEE COST – HSA ($4,000) Medical Plan		
Medical Plan Network	**Employee Cost LocalPlus & SureFit Networks WITH WELLNESS** ***Per Pay Period (24)***	**Employee Cost LocalPlus & SureFit Networks WITHOUT WELLNESS** ***Per Pay Period (24)***	**Employee Cost* OAP Network Only WITH / WITHOUT WELLNESS** ***Per Pay Period (24)***
Employee Only	$34.10	$68.60	$34.07 / $68.57
Employee + Spouse	$157.93	$192.43	$171.47 / $205.97
Employee + Child(ren)	$165.35	$199.85	$179.73 / $214.23
Family	$256.52	$291.02	$279.53 / $314.03

* ***Rates shown for the OAP Network (outside the front range) are both with and without wellness. If someone needs to be on the OAP plan due to network access issues, per period rates are slightly higher.***

HEALTH SAVINGS ACCOUNT (HSA)

What is a Health Savings Account (HSA)?

A Qualified High Deductible Health Plan (QHDHP) with a Health Savings Account (HSA) is an alternative to traditional health insurance plans. The HSA is a savings product that offers a different way for consumers to pay for their health care costs. HSAs enable you to pay for current qualified expenses and save for future medical and retiree health expenses on a tax-free basis.

You must be covered by a Qualified High Deductible Health Plan (QHDHP), such as the HSA ($4,000) Medical Plan, to be able to contribute to an HSA. You own and control the money in your HSA. As your account balances grow, you may also decide what types of investments to make with your HSA money.

You may contribute to your HSA, up to the legal maximum. **In 2020, the maximum annual contribution for a single enrollee set by the IRS is $3,550, while the maximum family contribution is set at $7,100. In 2021, the maximum annual contribution for single enrollee set by the IRS is $3,600, and the maximum family contribution is $7,200.**

With the HSA, you can make changes to the amount of your contribution throughout the year.

A catch-up contribution, up to an additional $1,000, is allowed for individuals who are 55 years or older..

What you can do with your HSA

- Pay qualified health care expenses: Use the Rocky Mountain Reserve debit card or submit claims to www.rockymountainreserve.com to pay for qualified health care expenses.

You can use your debit card, request a check by phone or online, or transfer funds online

- Save money for future medical expenses: You may not have significant health care expenses every year, but saving the maximum amount every year helps you build a sizeable savings for when you are faced with larger medical expenses
- Save for post-retirement expenses: Once you reach age 65, you can use your HSA funds to pay for anything you wish. Qualified medical expenses are still not taxed; any other expenses are subject to tax but not penalties

Your HSA is *your* money. Whatever you do not spend in a given year rolls over to the next. If you change jobs or retire, your HSA balance goes with you.

ROCKY MOUNTAIN reserve

QHDHP* / HSA Annual Limits			
	Employee Only Coverage	**Two-Party Coverage**	**Family Coverage**
2021 Maximum Contribution to HSA	$3,600	$7,200	$7,200
2020 Maximum Contribution to HSA	$3,550	$7,100	$7,100
Catch-up Contribution *(age 55 and older)*	$1,000	$1,000	$1,000

** QHDHP = Qualified High Deductible Health Plan*

WELLNESS PROGRAM

PARTICIPATION in a wellness program is good, but **ENGAGEMENT** is better.

Visit Your Primary Care Physician

The first step to encouraging a healthy lifestyle is to establish or engage in a preventive care office visit (i.e. annual physical) with your primary care physician. Your annual physicals will be covered 100% when conducted by an in-network physician within the provider network.

ATTENTION

You can save $69 per month on Medical Premiums simply by being proactive in managing your health!

- If you are enrolled in a Goodwill medical plan you are automatically enrolled in Direct Primary Care with PeakMed (or a PeakMed affiliate). **If you "engage" with your Direct Primary Care doctor, you will be given a credit of $69 per month.**

- What do we mean by "engage?" This is the simple part. All you need to do is **participate and establish care by scheduling an appointment, either in-person or virtually, with a PeakMed provider,** so they can get to know you and understand your health history and goals.

- Once you are engaged with this doctor, they will be available to help you, for a **$0 office visit copay**, in many cases, by phone or online, in situations where you might otherwise need to seek urgent care or an in-person doctor's office visit. Just think about how much you can save with **$0 copay!**

- So, to be clear, **in order to save $69 per month**, all you need to do is participate in an established care appointment with a PeakMed (or affiliate) provider. That's it, it's just that simple.

- We assume all employees will take advantage of this opportunity to receive the **$69 / month wellness credit**. An employee who chooses to not engage with a PeakMed / Affiliate doctor by the required deadline will pay the full monthly premium beginning in the month following the deadline.

DENTAL

Beta Health Patient Direct Discount Plan –

The Beta Health Patient Direct Discount Plan, utilizes only network providers. Individuals enrolling in the Patient Direct Plan must select one general dentist for themselves and their family. All general services must be obtained from the selected dentist to receive network discounts. Specialty services are available from any Patient Direct Participating Specialist without a referral.

Beta Health – Patient Direct Discount Plan	In-Network *(Beta Health Patient Direct)*
Calendar Year Deductible & Annual Maximums *(Individual, Family and Annual)*	None
Preventive Care *(Exams, Cleanings, X-Rays, Fluoride Treatment)*	Varies by Service *(please refer to fee schedule)*
Basic Services *(Fillings, Palliative Treatment, Simple Extractions)*	Varies by Service *(please refer to fee schedule)*
Major Services *(Gum Disease, Root Canals)*	Varies by Service *(please refer to fee schedule)*
Major Services *(Bridges, Dentures, Crowns, Inlays, Outlays, Repairs, Adjustments)*	Varies by Service *(please refer to fee schedule)*
Orthodontics	Varies by Service *(please refer to fee schedule)*
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Summary Plan Description (SPD), the SPD will prevail.	

Always refer to Beta Health's Patient Direct Network Only Fee Schedule for further information. In particular, please note:

- Beta Health's Patient Direct discount dental programs **do not constitute dental insurance and are considered discount, fee-for-service dental plans only.**
- Network-only fees are for General Dentists only. A participating specialist is available by calling Beta Health at 1-800-807-0706.
- You'll need to review the provider directory and select a primary dental office. For a provider listing, go to www.betadental.com and select "Dental Providers" — "Dentist Locator" using the "Alpha Plan" or call 1-800-807-0706. If you do not select a primary dentist, then one will be automatically selected for you.
- Any procedure not listed on the fee schedule will be discounted 20% off the participating General Dentists normal fee.
- To print your I.D. card, go to **www.betadental.com.**

EMPLOYEE COST	
Dental Plan	**Employee Cost Per Pay Period (24)**
Employee Only	$3.44
Employee + Spouse	$6.75
Employee + Child(ren)	$9.13
Family	$10.91

***IMPORTANT INFORMATION** – The above illustrates the employee's expected out-of-pocket costs for copays, deductibles and coinsurance when accessing medical services. Any remaining costs are covered by your employer and the employer-sponsored plan.*

DENTAL

Delta Dental PPO Plus Premier –

Under the Dental PPO network program, members have the ability to select any licensed dentist for treatment; however, if a member selects either a PPO or Premier dentist, the member's Out-of-Pocket costs are reduced as participating dentists agree to accept Delta Dental's contracted rate as payment in full for covered services and collect only applicable deductible and/or coinsurance amounts from the member.

Delta Dental –Preferred Provider Organization (DPPO)	In-Network *(Delta PPO)*	Out-of-Network *(Delta Premier & Non-Network)*
Annual Maximum (Applies for Class II and III Expenses)	$2,000 per Member	
Calendar Year Annual Deductible – Individual; / Family	$50 / $150	
Reimbursement Levels		
Class I – Diagnostic & Preventive Services	**Amount YOU Pay:**	
Oral Exams Routine Cleanings and X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic) Emergency Care to Relieve Pain	0%, No Deductible	20%, No Deductible
Class II – Basic Services Fillings Oral Surgery Simple Extractions General Anesthesia Relines, Rebases and Adjustments	20% after Deductible	20% after Deductible
Class III – Major Services Minor and Major Periodontics Root Canal Therapy / Endodontics Bridges / Crowns / Dentures / Repairs / Adjustments	50% after Deductible	50% after Deductible
Class IV – Orthodontia - Dependent children to age 19 Diagnostic, Active, Retention Treatment	50% Covered, No Deductible $1,000 Lifetime Maximum per Child 12-Month Waiting Period on Orthodontia Services	
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Summary Plan Description (SPD), the SPD will prevail.		

In addition, participating dentists file claims on behalf of the member. Pre-treatment authorization for any amount over $250 is highly recommended. Have your dentist contact Delta Dental to obtain a pre-treatment authorization before any services are performed.

Find your network provider and print your I.D. card at **www.deltadentalco.com.**

EMPLOYEE COST	
Dental Plan	**Employee Cost Per Pay Period (24)**
Employee Only	$7.76
Employee + Spouse	$16.21
Employee + Child(ren)	$18.64
Family	$29.63

***IMPORTANT INFORMATION** – The above illustrates the employee's expected out-of-pocket costs for copays, deductibles and coinsurance when accessing medical services. Any remaining costs are covered by your employer and the employer-sponsored plan.*

VISION

Your vision is very important to your overall health. Whether your vision is 20/20 or less than perfect, everyone should receive regular vision care.

Did you know that regular comprehensive eye exams can spot symptoms of many underlying health problems, such as diabetes, hypertension, high cholesterol, glaucoma, and cataracts? We partner with a network of providers where members receive comprehensive vision care.

Our providers deliver a complete vision examination, arriving at both a diagnosis and treatment plan (if needed). Don't take chances with your most precious possession – the gift of sight. Use your vision plan today!

Find your network provider and print your I.D. card at **www.eyemedvisioncare.com**.

EyeMed Vision – Covered Services	In-Network *(Select Network)*	Out-of-Network
Frequencies		
Exam	Once Every 12 Months	
Lenses	Once Every 12 Months	
Frames	Once Every 24 Months	
Routine Vision Examination	$10 Copay	Reimbursement up to $30
Frames	$150 Allowance, 20% discount on balance over $150	Reimbursement up to $75
Lenses		
Single Vision	$25 Copay	Reimbursement up to $25
Bifocal Vision	$25 Copay	Reimbursement up to $40
Trifocal Vision	$25 Copay	Reimbursement up to $55
Lenticular Vision	$25 Copay	Reimbursement up to $55
Lens Options	Copays Vary by Type of Option	Reimbursement up to $5 for Standard Plastic Scratch Coating
Elective Contact Lenses	$150 allowance, 15% discount on balance over $150	Reimbursement up to $120
Medically Necessary Contact Lenses	$0 Copay, Paid-in-Full	Reimbursement up to $210
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Summary Plan Description (SPD), the SPD will prevail.		

** This plan may offer in-network and out-of-network-benefits; however, to receive the maximum benefit, you should always use participating providers. To find a provider, use the respective contact information shown in the beginning of this guide.*

EMPLOYEE COST

Vision Plan	Employee Cost Per Pay Period (24)
Employee Only	$2.77
Employee + Spouse	$5.25
Employee + Child(ren)	$5.53
Family	$8.12

FLEXIBLE SPENDING ACCOUNT (FSA)

You have the option to participate in an employee benefit that may increase your spendable income and lower your taxes.

A Flexible Spending Account (FSA) allows you to pay for your portion of unreimbursed health care expenses and dependent or childcare services with **pre-tax dollars**. With an FSA, contributions are deducted from your pay-check before state and federal taxes. By making these contributions with pre-tax dollars, you will reduce your taxable income **and take home a larger portion of your paycheck.**

Three Components of an FSA:

1. **Group Benefit Premiums:** An FSA allows your portion of group medical, dental, vision and most supplemental plan premiums to be deducted from your paycheck on a pre-tax basis.
2. **Health Care FSA (HCFSA; includes dental and vision):** Each year, you may set aside up to $1,500 pre-tax dollars to pay for qualifying out-of-pocket medical, dental, vision, and some over the counter expenses.
3. **Dependent Care FSA (DCFSA):** Each year, you may set aside up to $5,000 pre-tax dollars (or $2,500 if married and filing individually) to pay for eligible dependent care expenses. This may include childcare, elder care or other eligible dependent care. Dependent care funds are only available for reimbursement as they are deducted from your pay-check.

Available Accounts:

- **Flexible Spending Account (FSA) –** To be used without participation in a Qualified High Deductible Health Plan (QHDHP) and a Health Savings Account (HSA).
- **Limited Purpose Flexible Spending Account (LPFSA) –** May be used in conjunction with participation in a Qualified High Deductible Health Plan (QHDHP) and a Health Savings Account (HSA) and may only be used for eligible dental and vision expenses.

FSA Facts You Should Know:

- Participation is voluntary
- Participation in the plan simply allows you to pay for qualified expenses with pre-tax dollars.
- Over-the-counter medications and other items will not be eligible without a prescription. See IRS list for eligible expenses
- Flexible Spending Accounts are subject to the "use it or lose it" rule, although you are allowed to carry over up to $550 of unused funds into the next benefit plan year.
- Participants should carefully monitor their health care spending throughout the year to avoid any unused balance being forfeited.

Example of Savings Using a Flexible Spending Account (FSA)

	Without an FSA	With an FSA
Gross Income	$40,000	$40,000
Pre-Tax Expenses for Health/Dependent Care	$0	$1,500
Taxable Income	$40,000	$38,500
Less Taxes	$10,279	$10,010
After-Tax Expenses for Health	$2,500	$0
Spendable Income	$27,221	$28,490
Your Savings With Flexible Spending	—	**$1,269**

LIMITED PURPOSE FSA

For those employees enrolled in the Qualified High Deductible Health Plan (QHDHP) with a Health Savings Account (HSA), the HSA $4,000 Plan, you cannot also enroll in a normal Flexible Spending Account (FSA); however, you do have an option to enroll in what is called a Limited Purpose Flexible Spending

A Limited Purpose Flexible Spending Account (LPFSA) offers you an easy way to further reduce your taxes while paying for out-of-pocket dental and vision expenses. An LPFSA provides you valuable benefits and tax savings in that it allows you to set aside some of your compensation on a tax-free basis and as you incur expenses during the plan year, you are reimbursed from these accounts.

The Limited Purpose FSA option Goodwill offers is:

- Dental and Vision – Maximum Annual Contribution: $1,500

Rocky Mountain Reserve (RMR) Debit Card

For the 2021 plan year, employees will have access to a debit card provided by Rocky Mountain Reserve (RMR). Your FSA elections will be available via the debit card and eliminates the need for submitting a claim for reimbursement; however, you may still be asked to provide documentation (receipts) to RMR to validate your FSA debit card claim.

Whether you've enrolled in the traditional FSA or opted for the Limited Purpose FSA, the debit card from Rocky Mountain Reserve (RMR) allows participants to pay for eligible products and services at approved vendors and service providers, such as medical, dental and vision providers. Without the convenience of the RMR debit card, you must pay out-of-pocket expenses with your own funds and then apply for a reimbursement by completing a claim form.

With the RMR Benefits Card, you can present it at the point of purchase and charge those expenses to your flexible spending account rather than paying for the expense first and then being reimbursed.

Your personal debit card transactions are available online at https://www.rockymountainreserve.com. Once you have received your RMR debit card, be sure to register at this site to access your account online.

Do I still need to keep and submit my receipts?

Yes, It is an IRS requirement that you keep all of your receipts! If required by Rocky Mountain Reserve (RMR), submit copies of your receipts to them unless the charge equals the exact amount of one of your provider's copayment amounts, is a pre-approved repetitive expense, or the merchant has an IRS-compliant inventory approval system in place. RMR will notify you in writing when a receipt is required to be submitted.

FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Account (FSA) Contributions –

ROCKY MOUNTAIN reserve

Flexible Spending Account (FSA) Contribution Example –

Bob elects $1,080 annually to his Health Care Flexible Spending Account (HCFSA) starting on January 1st. Per the plan design, his contribution would be $45 per pay period ($1,080 divided by 24 pay periods equals $45).

Health Care Flexible Spending Account (HCFSA) Contribution Calculation*

Full-Time (FT) Employee Contributions Are Based Upon 24 Pay Period Deductions

Cannot Exceed $1,500 for the Year

$ _____ ÷ by # of Contributing Pay Periods* Remaining in the Year = $ _____

Your HCFSA Annual Amount — *Per Pay Period Contribution*

You will have full access to any HCFSA funds on the first day you're eligible and have elected this benefit!

Dependent Care Flexible Spending Account (DCFSA) Contribution Calculation*

Full-Time (FT) Employee Contributions Are Based Upon 24 Deductions

Cannot exceed $5,000 for the Year

$ _____ ÷ by # of Contributing Pay Periods* Remaining in the Year = $ _____

Your DCFSA Annual Amount — *Per Pay Period Contribution*

You will not have access to any DCFSA funds until you actually have money in your account.

Limited Purpose Flexible Spending Account (LPFSA) Contribution Calculation*

HSA $4,000 Plan Participants Only

Full-Time (FT) Employee Contributions Are Based Upon 24 Deductions

Cannot exceed $1,500 for the Year

$ _____ ÷ by # of Contributing Pay Periods* Remaining in the Year = $ _____

Your LPFSA Annual Amount — *Per Pay Period Contribution*

You will have full access to any LPFSA funds on the first day you're eligible and have elected this benefit!

* *Contributions are only taken from the first two (2) pay periods each month.*

LIFE & DISABILITY

All active employees meeting minimum eligibility requirements will be eligible for **employer-paid** Short-Term Disability (STD) protection, designed to replace a portion of the disabled employee's income while they are unable to work and to encourage their timely return-to-work.

Employer-Paid Short-Term Disability (STD) –

The STD plan provides covered employees with weekly benefits for disability due to sickness and off-the-job accidents. Coverage is not provided for on-the-job accidents (refer to Goodwill's workers' compensation policies for additional information regarding work-related accidents).

The Short-Term Disability (STD) benefit is provided at no cost to eligible Full-Time (FT) employees.

SHORT-TERM DISABILITY (STD) INSURANCE			
CLASS DESCRIPTION	**BENEFIT PERCENT**	**MINIMUM AMOUNT**	**MAXIMUM AMOUNT**
All Other Employees	60% of Pre-Disability Salary	$25 / Week	$1,500 / week
Elimination Period	Fourteen (14) Consecutive Days for Accident or Sickness; **Use of Goodwill Sick Leave is required;** Benefits Begin on the 15th Day		
Maximum Duration	11 Weeks		
Non-Occupational	Provides benefits for non-work related illnesses/injuries only		
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail.			

LIFE & DISABILITY

All active employees meeting the minimum eligibility requirements are eligible for voluntary employee-paid Long-Term Disability (LTD) protection, designed to replace a portion of the disabled employee's income while they are unable to work and to encourage their timely return-to-work.

Voluntary Long-Term Disability (VLTD) –

The voluntary Long-Term Disability (LTD) plan provides covered employees with monthly benefits for disability due to sickness and off-the-job accidents. LTD helps replace your income if you are sick or injured and cannot work. It is designed to begin after you have been disabled for a predetermined waiting period.

The voluntary Long-Term Disability (LTD) benefit is paid for by eligible Full-Time (FT) employees.

Elimination Period	90 Days
Monthly Benefit Percentage	60% of your monthly covered earnings
Monthly Maximum Benefit Amount	$6,000 per month
Maximum Benefit Duration	Social Security Normal Retirement Age (SSNRA)
Definition of Disability	Employees are considered disabled, due to injury or sickness, if they are unable to perform the material duties of their regular occupation for a specified period; And, solely due to injury or sickness, they are unable to earn more than 80% of their Indexed Covered Earnings
Pre-Existing Condition Limitation	Three (3) Months Prior / Twelve (12) Months Insured
Mental Nervous / Substance Abuse	Twenty-Four (24) Months (Lifetime)
Subjective Conditions Limitation	None
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail.	

Voluntary Long-Term Disability (VLTD) Rates and Premium Calculation

Full-Time Employee Contributions Are On A Per Pay Period Basis (24 Deductions)

Your cost may change when you move into a new age category.

AGE	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74+
RATE	$0.16	$0.205	$0.395	$0.615	$0.920	$1.240	$1.715	$1.820	$1.920	$2.000	$2.050

To calculate your per pay period cost, please use the following formula:

$____ (*Your Annual Salary*) ÷ 12 = $____ (*Your Monthly Salary*) ÷ 100 = $____ x $____ (*Rate*) = $____ (*Monthly Cost*)

x 12 (months) ÷ 24 (pay periods) = $____ (*Per Pay Period Cost*)

LIFE & DISABILITY

Group Employee Basic Life / AD&D Insurance –

We believe we should offer our employees the opportunity to provide for their family's future rather than leaving it to chance. Life insurance can provide your dependents with a lifetime of financial security and upon your death, can be used to pay off your debts – such as credit cards and your mortgage – or other expenses that could burden your family.

As an eligible employee, you are automatically covered by a Basic Life and Accidental Death & Dismemberment (AD&D) Insurance benefit **AT NO COST TO YOU** of **one times** your annual salary (up to a maximum of $500,000).

You do not have to enroll for Group Basic Life and AD&D; however, you must designate a beneficiary.

SUMMARY OF GROUP BASIC LIFE AND AD&D BENEFITS	
CIGNA	**Benefit Amount**
Life Benefit Amount	1x Annual Salary
AD&D Benefit Amount	1x Annual Salary
Coverage Reduction Schedule	Benefit reduces to 65% at age 65; 50% at age 70
Accelerated Death Benefit	Included, not to exceed 80% of Employee's Amount or $400,000
Waiver of Premium	Yes, prior to age 60
Portability Conversion	Yes
This summary is provided for informational purposes only. Details may differ from state-to-state. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail.	

LIFE & DISABILITY

Supplemental (Voluntary) Employee Life / AD&D Insurance –

If you want additional financial protection for you and your family, then employees may purchase Supplemental Term Life Insurance and Accidental Death and Dismemberment (AD&D) coverage for themselves as well as Supplemental Dependent Life Insurance Coverage.

Supplemental Life Insurance is coverage you pay for, in addition to the basic coverage already provided by Goodwill. Life insurance pays your beneficiary, a benefit to them if you die while you are covered under the policy.

SUMMARY OF SUPPLEMENTAL (VOLUNTARY0) EMPLOYEE LIFE / AD&D BENEFITS	
CIGNA	**Benefit Amount**
Life Benefit Amount	Employee: Increments of $10,000, not to exceed $500,000 Spouse: Increments of $5,000, not to exceed $250,000 Child(ren): Increments of $5,000, not to exceed $20,000
AD&D Benefit Amount	Up to $500,000 Employee Coverage Up to $250,000 Spouse Coverage
Guaranteed Issued Amount	Employee: $200,000 Spouse: $30,000 Child(ren): $20,000
Coverage Reduction Schedule	Benefit reduces to 65% at age 65; 50% at age 70
Accelerated Death Benefit	Included, not to exceed 80% of Employee's Amount or $400,000
Waiver of Premium	Yes, prior to age 60
Portability Conversion	Yes
This summary is provided for informational purposes only. Details may differ from state-to-state. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail.	

If you elect an amount which exceeds the guaranteed issue amount of $200,000, you will need to provide evidence of good health, called an Evidence of Insurability (EOI), that is satisfactory to Cigna before the amount over $200,000 can become effective. If you don't elect coverage when you are initially eligible for the plan, you will also be required to submit evidence of good health before any additional life insurance becomes effective. Goodwill will bill you on the guaranteed issue amount until the Evidence of Insurability (EOI) is approved by Cigna.

Employee Supplemental (Voluntary) Life / AD&D Insurance Rates

Full-Time Employee Contributions Per Pay Period (24 Deductions)

AGE	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
RATE	$0.085	$0.095	$0.100	$0.130	$0.180	$0.280	$0.390	$0.610	$0.800	$1.620	$2.820	$4.970

LIFE & DISABILITY

Spouse Supplemental (Voluntary) Life Insurance –

If you purchase Supplemental Life Insurance for yourself, you may also purchase Supplemental Life Insurance for your legal Spouse in increments of $5,000. The maximum amount you can purchase cannot be more than the lesser of $250,000 or 50% of your Employee Voluntary / Supplemental Life Insurance coverage.

If you elect an amount which exceeds the guaranteed issue amount of $30,000, your Spouse will need to provide evidence of good health, called an Evidence of Insurability (EOI), that is satisfactory to Cigna before the amount over $30,000 becomes effective. Costs are based on the employee's age.

Goodwill will only bill you on the guaranteed issue amount until the Evidence of Insurability (EOI) is approved by Cigna.

Spouse Supplemental (Voluntary) Life / AD&D Insurance Rates

Full-Time Employee Contributions Per Pay Period (24 Deductions)

AGE	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
RATE	$0.085	$0.095	$0.100	$0.130	$0.180	$0.280	$0.390	$0.610	$0.800	$1.620	$2.820	$4.970

Child(ren) Supplemental (Voluntary) Life Insurance –

If you purchase Supplemental Life Insurance for yourself, you may also purchase Supplemental Life Insurance for your Dependent Child(ren), up to age 26, in the amount(s) of $5,000 to $20,000. Child(ren) between the ages of live birth and 6 months are limited to coverage in the amount of $1,000. Child life coverage is at a **monthly cost of $0.20 per $1,000 of coverage** (cost is for all covered children whether it be one or five).

Beneficiary Designation –

You must select a beneficiary – A person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. This beneficiary designation will be for ALL group life and/or accidental death insurance coverage issued by Cigna for you, unless specifically named otherwise. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each.

Log in to the UltiPro HR/Payroll system to update your beneficiaries or ask the benefits team to direct you to a printable form.

Make sure that the designated beneficiary for your life insurance is up-to-date!

LIFE & DISABILITY

Supplemental Life Insurance Premium Calculation Example –

Bob is between 25 to 29 years of age.

- He elects $200,000 of Life / AD&D insurance coverage for himself, which is the guaranteed issue amount.
- His rate is $0.095 per $1,000 of life benefit.

According to the plan design:

- His monthly premium is $19.00 ($200,000 divided by $1,000 times $0.075)
- His per pay period cost is $9.50 ($19.00 times 12 months divided by 24 pay periods).

Refer below to make your own life insurance premium calculations for both you and your spouse.

Employee Supplemental (Voluntary) Life / AD&D Premium Calculation

Full-Time Employee Contributions Based Upon Per Pay Period (24 Deductions)

Cost may change when you move into a new age category.

AGE	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
RATE	$0.085	$0.095	$0.100	$0.130	$0.180	$0.280	$0.390	$0.610	$0.800	$1.620	$2.820	$4.970

To calculate your per pay period cost, please use the following formula(s):

$_____ ÷ $1,000 = $_____ x $_____ X 12(months) ÷ 24 (pay periods) = $_____

Your Life Benefit Amount — *Rate* — *Per Pay Period Cost*

Spouse Supplemental (Voluntary) Life / AD&D Premium Calculation

Full-Time Employee Contributions Based Upon Per Pay Period (24 Deductions)

Cost may change when your spouse moves into a new age category.

AGE	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
RATE	$0.085	$0.095	$0.100	$0.130	$0.180	$0.280	$0.390	$0.610	$0.800	$1.620	$2.820	$4.970

To calculate your spouse's per pay period cost, please use the following formula(s):

$_____ ÷ $1,000 = $_____ x $_____ X 12(months) ÷ 24 (pay periods) = $_____

Spouse Life Benefit Amount — *Rate* — *Per Pay Period Cost*

VOLUNTARY BENEFITS

Aflac Group Voluntary Benefits –

Aflac offers group products for voluntary accident, hospital indemnity and critical illness benefits. You can choose one or choose them all.

Backed by decades of plan design and claims experience, the Aflac voluntary benefit plans feature commonly-used accident, hospital indemnity and critical illness coverage to help better protect employees against out-of-pocket costs due to injuries and illnesses. Voluntary benefits are a simple way employers can provide employees with multiple benefit options that strike a balance between their coverage needs and budgets.

Aflac Features & Plan Provisions	
Benefit Amounts	**See Benefit Schedule for Available Options**
Coverage	**Non-Occupational**
Covered Insureds	**Available for All Family Members** ***(spouse and child-only coverage is not available)***
Guaranteed-Issue	• **Accident is always offered on a Guaranteed-Issue basis;** • **Critical Illness up to $30,000 for Employee and $15,000 for Spouse;** • **Hospital Indemnity is offered to all eligible new hires.**
Payment Method	**Payroll Deducted on a Pre-Tax Basis**
Pre-Existing Condition Limitation	**None**
Waiting Period	**1st of the Month 60-Days After Your Date of Hire (DOH)**
Benefit Reductions	**No Reduction at Any Age**
Portability / Continuation	**Yes**
Eligibility	**Employees must be actively-at-work on the application date and the effective date. They must work at least 20 hours per week.** ***(seasonal and temporary employees are not eligible)***
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail.	

VOLUNTARY BENEFITS

Voluntary Accident –

The table below only shows part of the voluntary accident plan coverage available from Aflac.

Initial Accident Treatment Category - High-LT	Employee	Spouse	Child
Initial Treatment - once per accident, within 7 days of the accident			
ER/Urgent Care	$175	$175	$175
ER/Urgent Care with X-Ray	$225	$225	$225
Doctor's Office	$100	$100	$100
Doctor's Office with X-Ray	$150	$150	$150
Ambulance - within 90 days of the accident			
Maximum number of payments per covered accident: No Maximum			
Ground	$400	$400	$400
Air	$1,200	$1,200	$1,200
Major Diagnostic Testing - within six months of the accident Maximum number of diagnostic tests per covered accident: 1	$200	$200	$200
Pain Management - within six months of the accident Maximum number of payments per covered accident: 1	$100	$100	$100
Blood/Plasma/Platelets - within six months of the accident Maximum number of days per covered accident: 3	$200	$200	$200
Concussion - once per accident, within six months of the accident	$500	$500	$500
Coma - once per accident We will pay the amount shown if the insured is in a coma lasting 30 days or more as a result of a covered accident	$7,500	$7,500	$7,500
Burns - once per accident, within six months of the accident			
Second Degree Burns			
Less than 10%	$75	$75	$75
At least 10%, but less than 25%	$150	$150	$150
At least 25%, but less than 35%	$375	$375	$375
35% or more	$750	$750	$750
Third Degree Burns			
Less than 10%	$750	$750	$750
At least 10%, but less than 25%	$3,750	$3,750	$3,750
At least 25%, but less than 35%	$7,500	$7,500	$7,500
35% or more	$15,000	$15,000	$15,000
Emergency Dental Work - once per accident, within six months of the accident			
Repair with Crown	$200	$200	$200
Extraction	$50	$50	$50
Eye Injury - removal of a foreign body	$250	$250	$250
Dislocations - once per accident, within 90 days of the accident			

AFLAC VOLUNTARY ACCIDENT MONTHLY PREMIUMS	
Employee Only	$8.47
EE & Spouse	$14.41
EE & Child(ren)	$17.09
EE & Family	$23.03

Accident Premium Calculation

Full-Time Employee Contributions Based Upon Per Pay Period (24 Deductions).

$_____ x 12 (months) = $_____ ÷ 24 (pay periods) $_____

Your Accident Monthly Premium Amount — *Per Pay Period Cost*

Remember – AFLAC pays you in the event of an accident while covered under this plan.

Please request a sample policy for full benefit provisions and descriptions

VOLUNTARY BENEFITS

Critical Illness –

The table below shows the voluntary critical illness coverage available to you from Aflac.

Base Benefits	
Heart Attack (Myocardial Infarction)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	25%
Major Organ Transplant*	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%

*25% of this benefit is payable for Insureds placed on a transplant list for a major organ transplant

Cancer Benefits	
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Skin Cancer	$250 per calendar year

Health Screening Benefit	
Health Screening (payable for employee and spouse only)	$50 per calendar year

EMPLOYEE UNI-TOBACCO MONTHLY PREMIUMS		
AGE	$15,000	$30,000
18-25	$4.77	$8.31
26-30	$6.32	$11.41
31-35	$7.47	$13.70
36-40	$9.79	$18.36
41-45	$11.79	$22.34
46-50	$14.06	$26.89
51-55	$21.91	$42.59
56-60	$21.60	$41.96
61-65	$44.18	$87.13
66+	$77.59	$153.95

SPOUSE UNI-TOBACCO MONTHLY PREMIUMS		
AGE	$7,500	$15,000
18-25	$3.00	$4.77
26-30	$3.78	$6.32
31-35	$4.35	$7.47
36-40	$5.51	$9.79
41-45	$6.51	$11.79
46-50	$7.64	$14.06
51-55	$11.57	$21.91
56-60	$11.41	$21.60
61-65	$22.70	$44.18
66+	$39.41	$77.59

Critical Illness Premium Calculation

Full-Time (FT) Employee Contributions Based Upon Per Pay Period (24 Deductions)

Your cost may change when you move into a new age category.

$_____ = $_____ X 12 (months) = $_____ ÷ 24 (pay periods) = $_____

Your Critical Illness Benefit Amount ($15,000 or $30,000) = *Age –Banded Rate per Month from Table Above* X 12 (months) = ÷ 24 (pay periods) = *Per Pay Period Cost*

Remember – AFLAC pays you in the event of a covered critical illness or hospitalization while covered under these plans.

Please request a sample policy for full benefit provisions and descriptions

VOLUNTARY BENEFITS

Hospital Indemnity –

The table below shows the voluntary hospital coverage available to you from Aflac.

Hospitalization Benefits - Mid	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	**$1,000**
Hospital Confinement (per day) Maximum confinement period: 31 days per covered sickness or covered accident	**$150**
Hospital Intensive Care (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$150**
Intermediate Intensive Care Step-Down Unit (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$75**

Health Screening Benefit	
Health Screening Benefit Payable once per calendar year per insured.	**$50**

AFLAC VOLUNTARY HOSPITAL INDEMNITY MONTHLY PREMIUMS	
Employee Only	$15.68
EE & Spouse	$31.52
EE & Child(ren)	$25.02
EE & Family	$40.86

Hospital Indemnity Premium Calculation

Full-Time Employee Contributions Based Upon Per Pay Period (24 Deductions).

$_____ x 12 (months) = $_____ ÷ 24 (pay periods) $_____

Your Hospital Indemnity Monthly Premium Amount

Per Pay Period Cost

Remember – AFLAC pays you in the event of a covered critical illness or hospitalization while covered under these plans.

Please request a sample policy for full benefit provisions and descriptions

Additional Information

NFP®

LAWS & POLICIES

HIPAA

Your information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**.

Your Rights

You have the right to:

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

Your Choices

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

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Get an electronic or paper copy of your medical record

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

Ask us to correct health and claims records

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

For certain health information, you can tell us your choices about what we share.

- If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

- Include your information in a hospital directory

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

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

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- *Example: We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

HIPAA Notice of Special Enrollment Rights

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 towards your or your dependents' other coverage). However, you must request enrollment within 30 days (or any longer period that applies under the plan) after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 30 days (or any longer period that applies under the plan) after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, use the contact information in the front of this guide.

Women's Health and Cancer Rights Act Enrollment Notice

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

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

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

If you would like more information on WHCRA benefits, call your Plan Administrator.

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 January 31, 2020. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

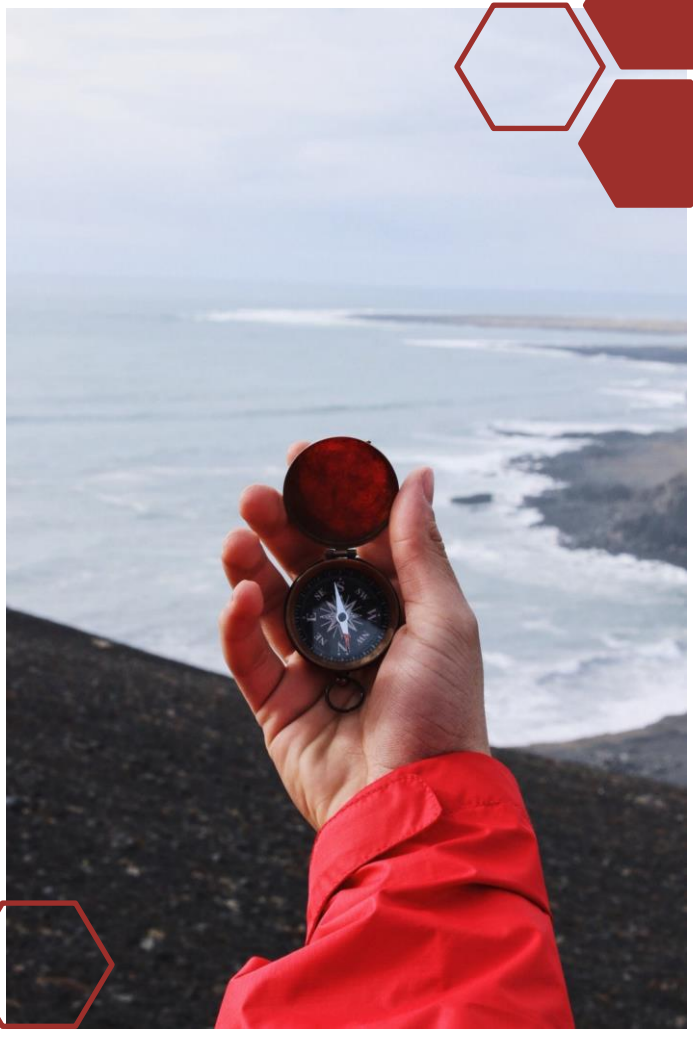
U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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



Employee Rights Under the Family and Medical Leave Act

Leave Entitlement

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid, job-protected leave in a 12 month period for one or more of the following reasons :

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

Employer Responsibilities

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint: 1-866-4-USWAGE or www.dol.gov/whd

Employee Rights Under the Family and Medical Leave Act

Leave Entitlement

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid, job-protected leave in a 12 month period for one or more of the following reasons :

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

Employer Responsibilities

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint: 1-866-4-USWAGE or www.dol.gov/whd

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

State	Website & Phone
Colorado	http://www.healthfirstcolorado.com 1-800-221-3943

About NFP

NFP is a leading insurance broker and consultant that provides employee benefits, property and casualty, retirement and individual private client solutions through our licensed subsidiaries and affiliates. Our expertise is matched by our commitment to each client's goals and is enhanced by our investments in innovative technologies in the insurance brokerage and consulting space.

NFP has more than 5,600 employees and global capabilities. Our expansive reach gives us access to highly rated insurers, vendors and financial institutions in the industry, while our locally based employees tailor each solution to meet our clients' needs. We've become one of the largest insurance brokerage, consulting and wealth management firms by building enduring relationships with our clients and helping them realize their goals.

For more information, visit [www.nfp.com.](http://www.nfp.com)