City of Hammond
2020
Open Enrollment Benefits Guide

Benefits Overview

Enrollment

City of Hammond knows how important it is to provide quality employee benefits to our employees and their dependents. We always strive to provide a total benefits package that meets your needs as well as the needs of the organization.

Your Benefit Plan Options

The following plans will renew January 1, 2020:

	Medical Insurance
	HRA Funding
	Dental Insurance
	Vision Insurance
	Basic Life and AD&D Insurance
	Voluntary Life and AD&D Insurance
	Long Term Disability
	Short Term Disability
	Accident Insurance
	Critical Illness Insurance
	LegalShield and IDShield
	Employee Assistance Program

Benefits Overview Continued

During this Open Enrollment Period, you may request changes to the above plans subject to completion of the proper forms and approval by the insurance carriers. These changes will be effective Janauary 1, 2020 subject to carrier approval.

Please take the time to read the following benefit summaries carefully. This information along with your election documentation will help you in deciding the best benefit selections for you and your family. You will have until **Tuesday, November 26, 2019** to review all of the information provided and make your selections.

Deadline to make changes is November 26, 2019.

Changing Your Benefits During The Year

Due to IRS regulations, once you have made your elections for the plan year, you cannot change your benefits until the next annual open enrollment period. The only exception is if you experience a qualifying event, and election changes must be consistent with your life event.

To request a benefits change, notify the Human Resources office within 30 days of the qualifying life event. Change requests submitted after 30 days cannot be accepted. You may need to provide proof of the life event.

Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your child's eligibility for benefits
- Qualified Medical Child Support Order

- Employees are responsible for notifying Human Resources if a dependent is no longer eligible for coverage. Failure to notify HR will affect COBRA availability and premium refunds
- From time to time other coverage information and accident details may be requested by the carriers – please respond promptly to expedite processing of claims.

Medical Insurance

City of Hammond offers eligible employees one medical plan option through Blue Cross Blue Shield of Louisiana. The table below summarizes the key features of the medical plan. The coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

Benefits	BCBSLA Blue Saver 100/80 $3000	
	In-Network Benefit	**Out-of-Network Benefit**
Deductible Individual Family	 **$3,000** **$6,000**	 **$6,000** **$12,000**
Coinsurance	**100%**	**80%**
Out-of-Pocket Maximum Individual Family	 **$5,000** **$10,000**	 **$10,000** **$20,000**
Lifetime Maximum	Unlimited	Unlimited
Office Visit Primary Specialist	 **100%** After Deductible **100%** After Deductible	 **80%** After Deductible **80%** After Deductible
Wellness Preventive Care	100%	N/A
Emergency Room	**100%** After Deductible	**100%** After Deductible
Urgent Care	**100%** After Deductible	**80%** After Deductible
Inpatient Services	**100%** After Deductible	**80%** After Deductible
Outpatient Surgery	**100%** After Deductible	**80%** After Deductible
Prescription Drug Coverage	**100%** After Deductible for Generic **80%** After Deductible for Brand Name	

Medical Insurance Cost		
See chart below for 2020 payroll deductions.		
Elections		
	Employee Monthly Cost	**Cost Per Check (24)**
Employee Only	$0.00 (City pays $624.80)	$0.00 (City pays $312.40)
Employee / Spouse	$493.58	$246.79
Employee / Child(ren)	$306.13	$153.07
Family	$574.79	$287.40

Medical Insurance Continued

✳ Terms To Know:

Deductible: The amount that you must pay for medical services before the insurance plan will begin to pay. The only exception is preventative care, which is covered 100% by the plan.

Out-of-Pocket Maximum: The maximum amount of money you will pay for medical services during the plan year. The out-of-pocket maximum is the sum of your deductible and coinsurance payments.

Coinsurance: A form of cost-sharing where you and the insurance plan share expenses in a specified ratio after you meet the deductible (until you reach the out-of-pocket maximum).

Healthcare Marketplace Notice

Why am I receiving this notice? The Affordable Care Act requires us to inform you of the healthcare Marketplace that allows you to purchase health insurance online or over the phone. Marketplace open enrollment begins November 15 for enrollment on January 1.

Does this mean that City of Hammond will no longer offer health coverage? No. City of Hammond will continue to offer health plans with the same eligibility rules. Only full-time employees (those working 30 or more hours per week) and their dependents will be eligible.

Does the Marketplace offer anything besides a place to buy coverage? Yes, for some people, premium tax credits are available to pay for coverage depending upon whether a parent is eligible for affordable employer coverage, family size and household income.

Is it better for me to buy my coverage through the Marketplace? The decision to buy Marketplace coverage is personal and will be determined by your family's financial conditions. If you are eligible for a City of Hammond health plan, you are not likely to be eligible for a premium tax credit. If you purchase coverage through the Marketplace, you may need City of Hammond's EIN.

Can I use the City of Hammond subsidy in the Marketplace? No, if you choose to buy coverage through the Marketplace, the amount that City of Hammond pays for your coverage will be lost.

If I enroll in the City of Hammond health plan, will that coverage satisfy my obligation to have health insurance? Yes, you will not be subject to a tax for failure to maintain health coverage because the City of Hammond medical plan is intended to satisfy the minimum value standard.

What about my family? If your dependents do not have minimum value coverage through City of Hammond or some other source, there will be a tax due for them on the tax return of the person who claims them as dependents.

Why does it matter that the plan is minimum value? There are two reasons. If you have minimum value coverage, you won't have to pay a tax to the IRS as described above. The second reason is that if you are offered affordable, minimum value coverage, you are not eligible for a premium tax credit. This does not always mean that other members of your family are ineligible for a premium tax credit. That depends upon many factors, including marital status.

How do you know whether the plan is affordable to me? Affordability is determined on a person-by- person basis. In general, if the cost of coverage for you alone (not family or spousal coverage) exceeds 9.78% of your household income, the coverage is not affordable. We anticipate that our coverage will be affordable.

If I don't have coverage, what is the tax? The individual penalty was reduced to zero starting 2019.

How do I contact the Marketplace? Go to www.healthcare.gov or call 1-800-318-2596.

What is the Benny Card?

It is a credit card you use to pay for your prescriptions and doctor visits adding up to your total deductible. The card not only enables the City to pay for the majority of your deductible, but it also tracks the expenses. First present your Blue Cross Blue Shield card. Then use your Benny Card to pay.

How can I use the card?

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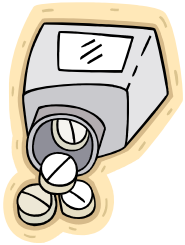
When you go to the doctor or pharmacy make sure to present your Blue Cross Blue Shield card. Then pay with your Benny Card.

INELIGIBLE Charges on Benny Card



- Over the counter drugs
  Ex.: Tylenol or sinus/
  allergy medications
- Medications such as:
  - smoking cessation
  - weight loss drugs, ED drugs and others
  (check with your pharmacist if you are unsure)
- Weight loss clinics, dentists and eye glasses
- Some physicals such as CDL
- **Charges from previous year(s)**
  (bills from previous years can be submitted to Empire Management or BancorpSouth Insurance for manual payment on or before March 31st of the next year)

Deductible Breakdown

	SINGLE	FAMILY
Initial Deductible Funding (City Pays)	$400	$800
Member Deductible Responsibility (Out of Pocket)	$700	$1400
Final Deductible Funding (City Pays)	$1900	$3800
Total BCBS Deductible	$3000	$6000
	Member may incur up to an additional $2000 if taking Brand Name RX	Member may incur up to an additional $4000 if taking Brand Name RX

All New Members Electing Coverage Will Need to Complete New HIPPA Forms for All Covered on Plan!!!!

HIPPA Form

Individual (person whose protected health information is being disclosed)

Group Name: _____Dept:_____ * REQUIRED TO SET UP BCBS ACCOUNT

Printed Name: _____ *Date of Birth: _____

Address: _____

Telephone: _____ *Email Address: _____

*Member Number: _____ *Group number: _____(may be obtained from Your BCBS card)

Authority to Release Protected Health Information

I hereby authorize ___Blue Cross Blue Shield_____ to release the protected health information identified in this authorization form to Empire Management Group.

Protected Health Information To Be Disclosed – Covering Dates of Service

From (date) _effective date of policy_____ to (date) __termination date of policy_____

Please check type of information to be released:

x All Claims Information
x Health Plan Benefit Information
x All Protected Health Information

☐ Other, (specify) _____

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the disclosure of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual"): ___substantiate claims related to Health Reimbursement account_____

Drug and/or Alcohol Abuse, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to __Empire Management Group 110 West Morris Avenue, Hammond, LA 70403 . Unless revoked, this authorization will expire on the following date, or after the following time period or event : _termination of above referenced policy_____.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. **I hereby hold Empire Management Group harmless for complying with this Authorization.**

Signature: _____ Date: _____

Description of relationship if Personal Representative of Individual:

Why do we need a HIPPA form?

This form allows Empire Management Group to access your online account with the insurance carrier. We match your Explanation of Benefits to your Benny Card charges. This process is called substantiation and is required by the IRS. If you do not wish to have Empire Management access your account, you can send the EOB for each Benny Card charge to Empire Management manually. Please contact Empire Management at 985-340-2880 and we can discuss this process.

For a charge to be eligible to be paid by the Benny Card, it must be:

1. A covered service, medication or medical equipment under your medical plan
2. Part of your deductible, co-pay or co-insurance under your medical plan
3. A charge for the employee or any covered dependent on the medical plan only
4. A medical expense incurred in the current calendar year

Dental Insurance

Sun Life

COMMONLY COVERED

- Exams and cleanings
- X-rays
- Fillings
- Tooth extractions
- Child braces

PROTECTS YOUR SMILE.
You can feel more confident with dental insurance that encourages routine cleanings and checkups. Dental insurance helps protect your teeth for a lifetime.

PREVENTS OTHER HEALTH ISSUES.
Just annual preventive care alone can help prevent other health issues such as heart disease and diabetes. Many plans cover preventive services at or near 100% to make it easy for you to use your dental benefits.

LOWERS OUT-OF-POCKET EXPENSES.
Seeing an in-network dentist can reduce your fees approximately 30% from their standard fees. Add the benefits of your coinsurance to that and things are looking good for your wallet.

DENTAL FAST FACTS

Periodontal disease can lead to receding gums, bone damage, loss of teeth, and can increase the risk of other health problems such as heart disease and diabetes.[1]

Treatment of gum disease in people with type 2 diabetes can lower blood sugar over time.[2]

CITY OF HAMMOND

All Eligible Employees

POLICY # 936668

Sun Life Assurance Company of Canada

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Good news! *Your plan covers routine services like cleanings and exams at* ***100%.***

CALENDAR YEAR MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	$1,500 per person	$1,500 per person
Types IV Ortho Service	$2,000 lifetime per child under age 26	$2,000 lifetime per child under age 26

CALENDAR YEAR DEDUCTIBLE

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	$50 individual/$150 family	$50 individual/$150 family
Type IV Ortho Services	N/A	N/A

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	100%	100%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%
Type IV Ortho Services	50%	50%

SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any 12 month period
- Routine dental cleanings – 2 in any 12 month period
- Fluoride treatment – 1 in any 6 month period. *Only for children under age 14*
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. *Only for children under age* 14
- Genetic test for susceptibility to oral diseases
- Bitewing x-rays – 1 in any 12 month period
- Intraoral complete series x-rays – 1 in any 60 month period
- **Type II Basic Dental Services, including:**
- New fillings
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- Minor gum disease (non-surgical periodontics)
- Scaling and root planing – 1 in any 36 month period per area
- Periodontal maintenance – 2 in any 12 consecutive months
- Localized delivery of antimicrobial agents
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 10 year replacement limit
- Stainless steel crowns– *only for children under age 19*
- Inlay, onlay, and crown restorations – 1 per tooth in any 10 year period
- General anesthesia/IV sedation – medically required

Type IV Ortho Services, including:

- Orthodontic treatment is limited to the dependent children or student age listed above

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive, basic or major services
- No waiting period for orthodontic services

Benefit adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care.

Late entrant

If you or a dependent apply for dental insurance more than 31 days after you become eligible, you or your dependent are a late entrant. The benefits for the first 12 months for late entrants will be limited as follows:

TIME INSURED CONTINUOUSLY UNDER THE POLICY	BENEFITS PROVIDED FOR ONLY THESE SERVICES
Less than 6 months	Preventive Services
At least 6 months but less than 12 months	Preventive Services and fillings under Basic Services
At least 12 months	Preventive, Basic, Major and Ortho Services

We will not pay for treatments subject to the late entrant limitation, and started or completed during the late entrant limitation period.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Dental

We will not pay a benefit for any Dental procedure, which is not listed as a covered dental expense. Any dental service incurred prior to the Effective date or after the termination date is not covered, unless specifically listed in the certificate. A member must be a covered dental member under the Plan to receive dental benefits. The Plan has frequency limitations on certain preventive and diagnostic services, restorations (fillings), periodontal services, endodontic services, and replacement of dentures, bridges and crowns. All services must be necessary and provided according to acceptable dental treatment standards. Treatment performed outside the United States is not covered, except for emergency dental treatment, subject to a maximum benefit. Dental procedures for Orthodontics; TMJ; replacing a tooth missing prior the effective date; implants and implant related services; or occlusal guards for bruxism are not covered unless coverage is elected or mandated by the state.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

This plan does not provide coverage for pediatric oral health services that satisfies the requirements for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act (PPACA).

Sun Life Financial companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, "Sun Life Financial" or "Sun Life").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 15-GP-01 and 16-DEN-C-01.

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Frequently asked questions

How does a PPO work?
PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?
Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance. The PPO network for your plan is the Sun Life Dental Network® with 130,000+ unique dentists.

Do I have to choose a dentist in the PPO network?
No. You can visit any licensed dentist for services. However, you could see lower out-of-pockets costs when you visit a dentist in the network.

Are my dependents eligible for coverage?
Yes. Your plan offers coverage for your spouse[3] and dependent children. An eligible child is defined as a child to age 26.[4]

What if I have already started dental work, like a root canal or braces, that requires several visits?
Your coverage with us may handle these procedures differently than your prior plan. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Do I have to file the claim?
Many dentists will file claims for you. If a dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life
P.O. Box 2940
Clinton, IA 52733

How can I get more information about my coverage or find my dental ID card?
After the effective date of your coverage, you can view benefit information online at your convenience through your Sun Life account. To create an account go to www.sunlife.com/account and register. You can also access this information from our mobile app—*Benefit Tools*, which is available for Apple and Android devices. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

What value added benefits does my plan include?
Your plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as brush biopsies for the early detection of oral cancer.

	Dental Rates	
Coverage	Employee Monthly Cost	Cost Per Paycheck (24)
Employee	$0.00 (City Pays $27.68)	$0.00 (City Pays $13.84)
Employee + Spouse	$28.12	$14.06
Employee + Child(ren)	$40.40	$20.20
Employee + Family	$68.74	$34.37

CONSIDER A PRE-DETERMINATION OF BENEFITS

They allow us to review your provider's treatment plan to let you know before treatment is started how much of the work should be covered by the plan, and how much you may need to cover. We recommend them for any dental treatment expected to exceed $300.

1. American Academy of Periodontology http://www.perio.org/consumer/love_the_gums_you%27re_with. (accessed on 06/06/19)
2. https://www.cdc.gov/diabetes/ndep/pdfs/150-Healthy-teeth-matter.pdf (accessed 06/06/19)
3. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
4. Please see your employer for more specific information.

Read the *Important information* section for more details including limitations and exclusions

Vision Insurance

Sun Life

COMMONLY COVERED

- Annual exams
- Lenses
- Frames
- Contact lenses
- Laser vision correction discount

PROTECTS YOUR EYES.

You can help protect your eyesight by visiting an eye doctor regularly. Vision insurance includes an annual comprehensive eye exam with an eye care doctor. Taking care of your eyes today can lead to a better quality of life later.

PREVENTS OTHER HEALTH ISSUES.

Just annual preventive care alone can help detect signs of chronic health conditions such as high blood pressure and diabetes. Early detection can be key before costly symptoms arise.[1]

LOWERS OUT-OF-POCKET EXPENSES.

Seeing an in-network eye care provider can reduce your expenses with savings on frames, lenses, contacts, eye exams and more.

VISION INSURANCE FAST FACTS

Roughly, 90% of diabetes-related blindness can be avoided by getting an annual eye exam.[2]	*59% of adults report experiencing symptoms of digital eye strain, such as blurred vision or headaches.[3]*

CITY OF HAMMOND

All Eligible Employees

POLICY # 936668

Sun Life Assurance Company of Canada

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BENEFIT	FREQUENCY	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Exam services WellVision exam®	1 per 12 months	$10 for exam	Up to $45
Routine retinal screening		No more than a $39 copay	
Laser vision correction discount	Once per eye per life-time.	Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.	N/A
Lenses			
Single lined	1 per 12 months	$25 (lenses and frame)	Up to $30
Bifocal lined			Up to $50
Trifocal			Up to $60
Lenticular			Up to $100
Necessary contacts			Up to $210
Lens enhancements			
Standard		$55 copay	N/A
Premium progressive		$95-$105 copay	N/A
Custom progressive		$150–$175 copay	N/A
Other		Average savings of 20-25%	N/A
Frames	1 per 24 months	$130 for the frame of your choice and 20% off the amount over your allowance $70 allowance at Costco®*	Up to $70
Elective contact lenses *Contact lenses are in place of lenses and frame.*	1 per 12 months	$60 for your contact lens exam (fitting and evaluation) $130 for contact lenses	Up to $105
Additional glasses and sunglasses discount	20% off complete pairs of prescription and non-prescription glasses, including sunglasses. Discounts are unlimited for 12 months following exam.		N/A
Coverage with retail providers	*Coverage with retail providers may be different. Check with Costco for VSP member pricing. Costco allowance is equivalent to the allowance at preferred providers and other retail providers.		

This chart outlines services for Plan 3.

Administrative services for the vision insurance plan are provided by Vision Service Plan (VSP).

Important information

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below conditions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Vision

We will not pay a benefit for any vision materials, services or options that are not shown in the Benefit Highlights section of the certificate. Any vision service incurred prior to the Effective date or after the termination date is not covered. A member must be a covered vision member under the Plan to receive vision benefits. In no event will benefits exceed the lesser of the actual cost of the examination or materials or the limits of coverage shown in the Benefit Highlights section of the certificate. The plan is designed to cover visually necessary materials rather than cosmetic materials; the member will be responsible for any additional costs above the basic cost.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

This vision plan does not provide coverage for pediatric vision health services that satisfies the requirement for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act ("PPACA").

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Frequently asked questions

How do I use my vision benefit?
Once enrolled, simply tell your VSP doctor you're a member and they will handle the rest. If you visit an in-network doctor for services and materials, you don't need an ID card or have forms to complete.

How do I locate an in-network VSP doctor?
You will have access to the largest national network[4] of private-practice eye care doctors in the industry through Vision Service Plan (VSP). There are three ways to find an in-network doctor:
1. Visit vsp.com and select the Choice network.
2. Call VSP at 800-877-7195.
3. Download our mobile app, Benefit Tools, and search for a doctor near you.

What happens if I use an out-of-network doctor?
You will be required to pay the full amount to the doctor at time of service. You can then submit a claim for reimbursement, which is a lesser benefit when compared to visiting a VSP doctor.

When will my coverage become effective?
Your coverage starts on the effective date specified in your group policy, provided you are actively at work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties.

Can I enroll as a late entrant?
If you elect coverage more than 31 days after your eligibility date, your effective date will be delayed to the next plan anniversary date.

Are my dependents eligible for coverage?
Yes. Your plan offers coverage for your spouse[5] and dependent children. An eligible child is defined as a child to age 26.[6]

How can I get more information about my coverage?
After the effective date of your coverage, you can visit www.sunlife.com/account to create a Sun Life account. Once you're logged in, you'll be able to see your plan details and more. Or you can call VSP Customer Service at 800-877-7195.

Can I use my benefits to buy glasses or contacts online?
Absolutely. Just visit www.eyeconic.com. Once you have linked your benefits you will be able to see how your coverage will be applied to different options that you are reviewing. Eyeconic features a virtual try-on tool so you can see how the glasses will look on you before you make your purchase.

	Vision Rates	
Coverage	Employee Monthly Cost	Cost Per Paycheck (24)
Employee	$6.18	$3.09
Employee + Spouse	$12.35	$6.18
Employee + Child(ren)	$13.59	$6.80
Employee + Family	$19.77	$9.89

1. https://vsp.com/eye-symptoms.html accessed 03/13/19.
2. https://www.vsp.com/diabetes.html accessed 03/13/19.
3. The Vision Council https://www.thevisioncouncil.org/content/digital-eye-strain accessed on 02/21/19.
4. Netminder as of December 2018.
5. If permitted by the Employer's benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
6. Please see your employer for more specific information.

Read the *Important information* section for more details including limitations and exclusions.

Standard Insurance Company
City of Hammond
Group Policy #758764
Effective Date January 1, 2020

Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by City of Hammond.

Eligibility

Definition of a Member	You are a member if you are an active employee of City of Hammond and regularly working at least 30 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows 30 consecutive days as a member.

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $30,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.
Life Age Reductions	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 65 and to 50 percent at age 70.

Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Group Basic Life and Accidental Death and Dismemberment Insurance

Other Basic AD&D Features

- Air Bag Benefit
- Expanded AD&D Package
- Family Benefits Package
- Line of Duty Benefit
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by City of Hammond. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and City of Hammond may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279-D-LA-758764 (11/19)
6248370-452604

Standard Insurance Company
City of Hammond
Group Policy #758764

Group Additional Life and AD&D Insurance

Help protect your loved ones from financial hardship.

Life insurance coverage is designed to help provide financial support and stability to your family should you pass away. Accidental Death & Dismemberment (AD&D) insurance provides an extra layer of protection if you die or become dismembered in an accident. You can also cover your eligible spouse and child(ren).

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits if you are dismembered, become terminally ill or die
- A special Guarantee Issue enrollment opportunity this year. See Open Enrollment section for additional details.

About This Coverage

If you take no action you'll be covered under Basic Life insurance provided you meet the eligibility requirements. Consider whether that would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund your children's education. If not, you may want to apply for additional coverage now.

Life Insurance		
How Much Can I Apply For? The coverage amount for your spouse cannot exceed 100 percent of your Additional Life coverage. The coverage amount for your child(ren) cannot exceed 100 percent of your Additional Life coverage.	For You:	**$10,000 – $500,000** in increments of **$10,000**
	For Your Spouse:	**$5,000 – $100,000** in increments of **$5,000**
	For Your Child(ren):	**$10,000**
What is the Guarantee Issue Maximum? Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.	For You:	Up to **$100,000**
	For Your Spouse:	Up to **$25,000**

Voluntary Life and AD&D Insurance

Group Additional Life and AD&D Insurance

AD&D Insurance The benefit is paid if you or your dependents are seriously injured or pass away as a result of a covered accident.		
What Does My AD&D Benefit Provide? Note: You cannot buy more coverage for your spouse or child(ren) than you buy for yourself.	For You:	The AD&D insurance coverage amount matches what you elect for Additional Life insurance.
	For Your Spouse:	The AD&D insurance coverage amount matches what you elect for Dependents Life insurance.
	For Your Child(ren):	The AD&D insurance coverage amount matches what you elect for Dependents Life insurance.
Keep in mind that the amount payable for certain losses is less than 100 percent of the AD&D insurance benefit.		

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Open Enrollment

During Open Enrollment From November 14, 2019 Through November 26, 2019

For You. If you are currently enrolled in Additional Life insurance for an amount less than $100,000, you may elect to increase your coverage up to, but not to exceed, the guarantee issue amount of $100,000 without having to answer health questions. If you are not currently enrolled in Additional Life insurance, you may elect up to $100,000 of coverage without having to answer health questions.

For Your Spouse. If your spouse is currently enrolled in Dependents Life insurance for an amount less than $25,000, you may elect to increase coverage up to, but not to exceed, the guarantee issue amount of $25,000 without having to answer health questions. If your Spouse is not currently enrolled in Dependents Life insurance, you may elect up to $25,000 of coverage without having to answer health questions.

Group Additional Life and AD&D Insurance

Additional Feature

	Life Insurance
Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

How Much Life Insurance Do You Need?

After a serious accident or death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Burial expenses
- Medical bills
- Your children's education
- Daily expenses

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/life/needs.**

Voluntary Life and AD&D Insurance

Group Additional Life and AD&D Insurance

How Much Your Coverage Costs

Your Basic Life insurance is paid for by City of Hammond. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

Use this formula to calculate your premium payment:

_____ ÷ 1000 = _____ x _____ = ➡

Enter the amount of coverage you are requesting (see benefit amounts in the About This Coverage section).

Enter your rate from the rate table.

This amount is an estimate of how much you would pay each month.

To get a sense of your semimonthly premium, divide your monthly premium amount by 2.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your age and your spouse's rate.

If you buy Dependents Life with AD&D coverage for your child(ren), your monthly rate is $0.26 per $1,000, no matter how many children you're covering. Your monthly AD&D rate of $0.054 per $1,000 is included.

Age (as of January 1)	Your Rate* (Per $1,000 of Total Coverage)	Your Spouse's Rate** (Per $1,000 of Total Coverage)
<30	$0.110	$0.110
30–34	$0.130	$0.130
35–39	$0.150	$0.150
40–44	$0.240	$0.240
45–49	$0.380	$0.380
50–54	$0.670	$0.670
55–59	$1.120	$1.120
60–64	$0.810	$0.810
65–69	$3.025	$3.025
70–74	$7.117	$7.117
75+	$7.277	$7.277

*Includes a monthly AD&D rate of $0.029 per $1,000 of AD&D benefit.
**Includes a monthly AD&D rate of $0.029 per $1,000 of AD&D benefit for your spouse.

Voluntary Life and AD&D Insurance

Employee Life with AD&D Semi-Monthly Premiums Group Additional Life and AD&D Insurance

Coverage Amount	Employee's Age as of January 1											
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75-79*	80+*
$10,000	0.55	0.65	0.75	1.20	1.90	3.35	5.60	4.05	15.13	23.13	18.19	12.73
$20,000	1.10	1.30	1.50	2.40	3.80	6.70	11.20	8.10	30.25	46.26	36.39	25.47
$30,000	1.65	1.95	2.25	3.60	5.70	10.05	16.80	12.15	45.38	69.39	54.58	38.20
$40,000	2.20	2.60	3.00	4.80	7.60	13.40	22.40	16.20	60.50	92.52	72.77	50.94
$50,000	2.75	3.25	3.75	6.00	9.50	16.75	28.00	20.25	75.63	115.65	90.96	63.67
$60,000	3.30	3.90	4.50	7.20	11.40	20.10	33.60	24.30	90.75	138.78	109.16	76.41
$70,000	3.85	4.55	5.25	8.40	13.30	23.45	39.20	28.35	105.88	161.91	127.35	89.14
$80,000	4.40	5.20	6.00	9.60	15.20	26.80	44.80	32.40	121.00	185.04	145.54	101.88
$90,000	4.95	5.85	6.75	10.80	17.10	30.15	50.40	36.45	136.13	208.17	163.73	114.61
$100,000	5.50	6.50	7.50	12.00	19.00	33.50	56.00	40.50	151.25	231.30	181.93	127.35
$110,000	6.05	7.15	8.25	13.20	20.90	36.85	61.60	44.55	166.38	254.43	200.12	140.08
$120,000	6.60	7.80	9.00	14.40	22.80	40.20	67.20	48.60	181.50	277.56	218.31	152.82
$130,000	7.15	8.45	9.75	15.60	24.70	43.55	72.80	52.65	196.63	300.69	236.50	165.55
$140,000	7.70	9.10	10.50	16.80	26.60	46.90	78.40	56.70	211.75	323.82	254.70	178.29
$150,000	8.25	9.75	11.25	18.00	28.50	50.25	84.00	60.75	226.88	346.95	272.89	191.02
$160,000	8.80	10.40	12.00	19.20	30.40	53.60	89.60	64.80	242.00	370.08	291.08	203.76
$170,000	9.35	11.05	12.75	20.40	32.30	56.95	95.20	68.85	257.13	393.21	309.27	216.49
$180,000	9.90	11.70	13.50	21.60	34.20	60.30	100.80	72.90	272.25	416.34	327.47	229.23
$190,000	10.45	12.35	14.25	22.80	36.10	63.65	106.40	76.95	287.38	439.47	345.66	241.96
$200,000	11.00	13.00	15.00	24.00	38.00	67.00	112.00	81.00	302.50	462.61	363.85	254.70
$210,000	11.55	13.65	15.75	25.20	39.90	70.35	117.60	85.05	317.63	485.74	382.04	267.43
$220,000	12.10	14.30	16.50	26.40	41.80	73.70	123.20	89.10	332.75	508.87	400.24	280.16
$230,000	12.65	14.95	17.25	27.60	43.70	77.05	128.80	93.15	347.88	532.00	418.43	292.90
$240,000	13.20	15.60	18.00	28.80	45.60	80.40	134.40	97.20	363.00	555.13	436.62	305.63
$250,000	13.75	16.25	18.75	30.00	47.50	83.75	140.00	101.25	378.13	578.26	454.81	318.37
$260,000	14.30	16.90	19.50	31.20	49.40	87.10	145.60	105.30	393.25	601.39	473.01	331.10
$270,000	14.85	17.55	20.25	32.40	51.30	90.45	151.20	109.35	408.38	624.52	491.20	343.84
$280,000	15.40	18.20	21.00	33.60	53.20	93.80	156.80	113.40	423.50	647.65	509.39	356.57
$290,000	15.95	18.85	21.75	34.80	55.10	97.15	162.40	117.45	438.63	670.78	527.58	369.31
$300,000	16.50	19.50	22.50	36.00	57.00	100.50	168.00	121.50	453.75	693.91	545.78	382.04
$310,000	17.05	20.15	23.25	37.20	58.90	103.85	173.60	125.55	468.88	717.04	563.97	394.78
$320,000	17.60	20.80	24.00	38.40	60.80	107.20	179.20	129.60	484.00	740.17	582.16	407.51
$330,000	18.15	21.45	24.75	39.60	62.70	110.55	184.80	133.65	499.13	763.30	600.35	420.25
$340,000	18.70	22.10	25.50	40.80	64.60	113.90	190.40	137.70	514.25	786.43	618.55	432.98
$350,000	19.25	22.75	26.25	42.00	66.50	117.25	196.00	141.75	529.38	809.56	636.74	445.72
$360,000	19.80	23.40	27.00	43.20	68.40	120.60	201.60	145.80	544.50	832.69	654.93	458.45
$370,000	20.35	24.05	27.75	44.40	70.30	123.95	207.20	149.85	559.63	855.82	673.12	471.19
$380,000	20.90	24.70	28.50	45.60	72.20	127.30	212.80	153.90	574.75	878.95	691.32	483.92
$390,000	21.45	25.35	29.25	46.80	74.10	130.65	218.40	157.95	589.88	902.08	709.51	496.66
$400,000	22.00	26.00	30.00	48.00	76.00	134.00	224.00	162.00	605.00	925.21	727.70	509.39
$410,000	22.55	26.65	30.75	49.20	77.90	137.35	229.60	166.05	620.13	948.34	745.89	522.12
$420,000	23.10	27.30	31.50	50.40	79.80	140.70	235.20	170.10	635.25	971.47	764.09	534.86
$430,000	23.65	27.95	32.25	51.60	81.70	144.05	240.80	174.15	650.38	994.60	782.28	547.59
$440,000	24.20	28.60	33.00	52.80	83.60	147.40	246.40	178.20	665.50	1,017.73	800.47	560.33
$450,000	24.75	29.25	33.75	54.00	85.50	150.75	252.00	182.25	680.63	1,040.86	818.66	573.06
$460,000	25.30	29.90	34.50	55.20	87.40	154.10	257.60	186.30	695.75	1,063.99	836.86	585.80
$470,000	25.85	30.55	35.25	56.40	89.30	157.45	263.20	190.35	710.88	1,087.12	855.05	598.53
$480,000	26.40	31.20	36.00	57.60	91.20	160.80	268.80	194.40	726.00	1,110.25	873.24	611.27
$490,000	26.95	31.85	36.75	58.80	93.10	164.15	274.40	198.45	741.13	1,133.38	891.43	624.00
$500,000	27.50	32.50	37.50	60.00	95.00	167.50	280.00	202.50	756.25	1,156.51	909.63	636.74

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Voluntary Life and AD&D Insurance

Spouse Life with AD&D Semi-Monthly Premiums

Group Additional Life and AD&D Insurance

Coverage Amount	Employee's Age as of January 1											
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75-79*	80+*
$5,000	0.28	0.33	0.38	0.60	0.95	1.68	2.80	2.03	7.56	11.57	9.10	6.37
$10,000	0.55	0.65	0.75	1.20	1.90	3.35	5.60	4.05	15.13	23.13	18.19	12.73
$15,000	0.83	0.98	1.13	1.80	2.85	5.03	8.40	6.08	22.69	34.70	27.29	19.10
$20,000	1.10	1.30	1.50	2.40	3.80	6.70	11.20	8.10	30.25	46.26	36.39	25.47
$25,000	1.38	1.63	1.88	3.00	4.75	8.38	14.00	10.13	37.81	57.83	45.48	31.84
$30,000	1.65	1.95	2.25	3.60	5.70	10.05	16.80	12.15	45.38	69.39	54.58	38.20
$35,000	1.93	2.28	2.63	4.20	6.65	11.73	19.60	14.18	52.94	80.96	63.67	44.57
$40,000	2.20	2.60	3.00	4.80	7.60	13.40	22.40	16.20	60.50	92.52	72.77	50.94
$45,000	2.48	2.93	3.38	5.40	8.55	15.08	25.20	18.23	68.06	104.09	81.87	57.31
$50,000	2.75	3.25	3.75	6.00	9.50	16.75	28.00	20.25	75.63	115.65	90.96	63.67
$55,000	3.03	3.58	4.13	6.60	10.45	18.43	30.80	22.28	83.19	127.22	100.06	70.04
$60,000	3.30	3.90	4.50	7.20	11.40	20.10	33.60	24.30	90.75	138.78	109.16	76.41
$65,000	3.58	4.23	4.88	7.80	12.35	21.78	36.40	26.33	98.31	150.35	118.25	82.78
$70,000	3.85	4.55	5.25	8.40	13.30	23.45	39.20	28.35	105.88	161.91	127.35	89.14
$75,000	4.13	4.88	5.63	9.00	14.25	25.13	42.00	30.38	113.44	173.48	136.44	95.51
$80,000	4.40	5.20	6.00	9.60	15.20	26.80	44.80	32.40	121.00	185.04	145.54	101.88
$85,000	4.68	5.53	6.38	10.20	16.15	28.48	47.60	34.43	128.56	196.61	154.64	108.25
$90,000	4.95	5.85	6.75	10.80	17.10	30.15	50.40	36.45	136.13	208.17	163.73	114.61
$95,000	5.23	6.18	7.13	11.40	18.05	31.83	53.20	38.48	143.69	219.74	172.83	120.98
$100,000	5.50	6.50	7.50	12.00	19.00	33.50	56.00	40.50	151.25	231.30	181.93	127.35

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Child Life with AD&D Semi-Monthly Premiums

Coverage Amount	Premium
$10,000	1.30

Group Additional Life and AD&D Insurance

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Life and AD&D Insurance Eligibility Requirements

To be eligible for coverage, you must be:

- An active employee of City of Hammond
- Regularly working at least 30 hours per week
- Insured for Basic Life insurance through The Standard

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

If you buy Additional Life and AD&D insurance for yourself, you may also buy Life and AD&D coverage for your eligible children and/or spouse. This is called Dependents Life and AD&D insurance. You can choose to cover your spouse, meaning a person to whom you are legally married, or your domestic partner as recognized by law. You may also choose to cover your child. Child means your child from live birth through age 25. Your child cannot be insured by more than one employee. Your spouse or child(ren) must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

Medical Underwriting Approval for Life Coverage

Required for:

- Coverage amounts higher than the guarantee issue maximum amount
- All late applications (applying 31 days after becoming eligible)
- Requests for coverage increases
- Reinstatements
- Eligible but not insured under the prior life insurance plan

Visit **www.standard.com/mhs** to submit a medical history statement online.

Coverage Effective Date for Life Coverage

To become insured, you must

- Meet the eligibility requirements listed in the previous sections,
- Serve an eligibility waiting period*,
- Receive medical underwriting approval (if applicable),
- Apply for coverage and agree to pay premium, and
- Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective.

If you are not actively at work on the day before the scheduled effective date of your insurance, including any optional coverages, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee. Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your coverage, including any optional coverages.

*Defined as first of the month that follows 30 consecutive days as a member

Life and AD&D Age Reductions

Under this plan, your coverage amount reduces to 65 percent at age 70, to 50 percent at age 75 and to 35 percent at age 80. Your spouse's coverage amount reduces by your age as follows: to 65 percent at age 70, to 50 percent at age 75 and to 35 percent at age 80. If you are age 70 or over, ask your human resources representative or plan administrator for the amount of coverage available.

Life Insurance Waiver of Premium

Your Life premiums may be waived if you:

- Become totally disabled while insured under this plan,
- Are under age 60, and
- Complete a waiting period of 180 days.

If these conditions are met, your Life insurance coverage may continue without cost until age 65, provided you give us satisfactory proof that you remain totally disabled.

Life and AD&D Insurance Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage from The Standard.

Life Insurance Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

Life Insurance Exclusions

Subject to state variations, you and your dependents are not covered for death resulting from suicide or other intentionally self-inflicted injury, while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

Voluntary Life and AD&D Insurance

Group Additional Life and AD&D Insurance

AD&D Benefits

The amount of the AD&D benefit is equal to the amount payable for your or your spouse's or child(ren)'s Life benefit on the date of the accident. For all other covered losses, the amount is shown as a percentage of the amount payable for the benefit on the date of the accident. No more than 100 percent of the AD&D benefit will be paid for all losses resulting from one accident.

Any loss must be caused solely and directly by an accident within 365 days of the accident. A certified copy of the death certificate is needed to prove loss of life.

All other losses must be certified by a physician in the appropriate specialty determined by The Standard.

Covered loss:	Percentage of AD&D benefit payable:
Life[1]	100%
One hand or one foot[2]	50%
Sight in one eye, speech or hearing in both ears	50%
Two or more of the losses listed above	100%
Thumb and index finger of the same hand[3]	25%
Quadriplegia	100%
Hemiplegia	50%
Paraplegia	50%

1 Includes loss of life caused by accidental exposure to adverse weather conditions or disappearance if disappearance is caused by an accident that reasonably could have resulted in your death.

2 Even if the severed part is surgically re-attached. This benefit is not payable if an AD&D benefit is payable for quadriplegia, hemiplegia, paraplegia, involving the same hand or foot.

3 This benefit is not payable if an AD&D benefit is payable for the loss of the entire hand.

AD&D Insurance Exclusions

You are not covered for death or dismemberment caused or contributed to by any of the following:

- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Suicide or other intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared), and any substantial armed conflict between organized forces of a military nature
- Voluntary consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy
- The date your Life coverage ends, your AD&D coverage will end as well

In addition to the above requirements, your Dependents Life and AD&D coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent.

For more details on when your insurance ends, contact your human resources representative or plan administrator.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

Group Additional Life and AD&D Insurance

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP190-LIFE/S399, GP399-LIFE/TRUST, GP899-LIFE, GP190-LIFE/A997/S399, GP411-LIFE

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204
www.standard.com

SI 12506-D-ALAA-LA-758764 (11/19)
6250427-455712

Standard Insurance Company
City of Hammond
Group Policy #758764
Effective Date January 1, 2020

Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by City of Hammond.

Eligibility

Definition of a Member	You are a member if you are a regular employee of City of Hammond, actively working at least 30 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows 30 consecutive days as a member.

Benefits

Monthly Benefit	60 percent of the first $10,000 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$6,000
Minimum Monthly Benefit	$100
Benefit Waiting Period	90 days

Long Term Disability Insurance

Group Long Term Disability Insurance

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longest. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Employee Assistance Program
- Family Care Expense Adjustment
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by City of Hammond. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and City of Hammond may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13271-D-LA-758764 (11/19)
6248370-452605

Standard Insurance Company
City of Hammond
Group Policy #758764

Group Short Term Disability Insurance

Protect your income and those who depend on it.

This coverage replaces a portion of your income when you can't work because of a qualifying disability. Even if you're healthy now, it's important to protect yourself and the people who count on your income. This insurance can help you pay the bills when you're unable to work.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits for a qualifying disability that is not work-related

About This Coverage

See the Important Details section for more information, including requirements, exclusions and definitions.

What Your Benefit Provides This is the benefit you'd receive if you were to suffer a qualifying disability. Eligible earnings are your weekly insured predisability earnings, as defined by the group policy. Your benefit amount will be reduced by deductible income; see the Important Details section for a list of deductible income sources.	**60%** of your eligible earnings, up to a maximum benefit of **$1,200** per week. Plan minimum **$15** per week.
Benefit Waiting Period If you suffer a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you can begin receiving your weekly benefit.	14 days for accidental injury 14 days for physical disease, pregnancy or mental disorder
Extended Benefit Waiting Period This applies if you do not apply for this coverage within 31 days of becoming eligible, were eligible for coverage under a prior plan for more than 31 days but were not insured, or if your insurance ends because you failed to pay your premium and is later reinstated.	60 days for any qualifying disability caused by physical disease, pregnancy or mental disorder occurring during the first 12 months of coverage.
How Long Your Benefits Last This is the maximum length of time you could be eligible to receive a weekly disability benefit.	90 days

Short Term Disability Insurance

Group Short Term Disability Insurance

Additional Features

Your coverage comes with some added features:

Return to Work Incentive	Your disability benefit will not be reduced by any work earnings you receive until the combined amount of the benefit, earnings and other sources of income exceeds 100 percent of your predisability earnings.
Help with Returning to Work	If a worksite modification would enable you to return to work, we can help your employer make approved modifications by covering some or all of the cost.

How Much Your Coverage Costs

Because this insurance is offered through City of Hammond, you'll have access to competitive group rates that may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and benefit amount.

Use this formula to calculate your premium payment:

_____	x 0.60 x	_____	÷ 10 =	_____	→	_____
Enter your weekly earnings (cannot be more than $2,000).		Enter your rate from the rate table.		This amount is an estimate of how much you'd pay each month.		To get a sense of your semimonthly premium, divide your monthly premium amount by 2.

Your Age (as of January 1)	Rate per $10 of weekly benefit
<30	$0.519
30–34	$0.566
35–39	$0.444
40–44	$0.417
45–49	$0.508
50–54	$0.600
55–59	$0.834
60+	$1.015

Not being able to work also means not being able to earn a paycheck. As you consider Short Term Disability insurance, think about the expenses you would need to cover if you were to become disabled:

- Mortgage or rent
- Utilities
- Groceries
- Medical bills
- Car insurance
- Childcare costs

To estimate your insurance needs, you'll need to consider your unique circumstances.
Use our online calculator at **www.standard.com/disability/needs**.

Group Short Term Disability Insurance

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Eligibility Requirements

To be eligible for coverage, you must be:

- A regular employee of City of Hammond
- Actively working at least 30 hours per week
- A citizen or resident of the United States or Canada

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

Employee Coverage Effective Date

To become insured, you must:

- Meet the eligibility requirements listed above
- Serve an eligibility waiting period*
- Apply for coverage and agree to pay premiums
- Be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

*Defined as first of the month that follows 30 consecutive days as a member

Definition of Disability

You will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent in your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

Exclusions

Subject to state variations, you are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- The loss of your professional or occupational license or certification
- An activity arising out of or in the course of any employment for wage or profit

Limitations

Short Term Disability benefits are not payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty, as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your disability prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20 percent of your predisability earnings in your own occupation but you elect not to
- Eligible to receive benefits for your disability under a workers' compensation law or similar law

When Your Benefits End

Your Short Term Disability benefits end automatically on the date any of the following occur:

- You are no longer disabled
- Your maximum benefit period ends
- Long term disability benefits become payable to you under a Long Term Disability plan
- Benefits become payable under any other disability insurance plan under which you become insured through employment during a period of temporary recovery
- You fail to provide proof of continued disability and entitlement to benefits
- You pass away

Deductible Income

Your benefits will be reduced if you have deductible income, which is income you receive or are eligible to

receive while receiving Short Term Disability benefits. Deductible income includes:

- Sick pay, annual or personal leave pay, severance pay or other forms of salary continuation (including donated amounts) paid
- Amounts under unemployment compensation law
- Amounts because of your disability from any other group insurance
- Any disability or retirement benefits received or you are eligible to receive from your employer's retirement plan
- Amounts under any state disability income benefit law or similar law
- Earnings from work activity while you are disabled, plus the earnings you could receive if you work as much as your disability allows
- Earnings or compensation included in your predisability earnings which you receive or are eligible to receive while Short Term Disability benefits are payable
- Amounts due from or on behalf of a third party because of your disability, whether by judgment, settlement or other method
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date the group policy (or your employer's coverage under the group policy) terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date City of Hammond ends participation in the group policy

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP399-STD, GP899-STD, GP309-STD, GP209-STD, GP399/ASSOC, GP399-STD/TRUST

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 12503-D-LA-758764 (11/19)
6248370-452607

Group Accident Coverage

Policy Series WPS-ACC 07/15

Designed for the employees of

City of Hammond

ELIGIBILITY AND KEY FEATURES

Coverage: 24 Hour Gold - Custom Plan

Eligibility: All employees ages 18 or above, working 20 hours per week for at least 90 days following the date of employment, and, and who are actively at work at time of enrollment are eligible for participation. An enrolled employee may also insure their spouse. Children under the age of 26 are eligible regardless of marital or dependency status. Grandchildren under age 26 for whom the employee is required by a court or administrative order to provide health coverage are also eligible. No medical questions are required.

Continuation of Coverage: This coverage may be continued in the event the insured is no longer an employee/member of the Policyholder. Coverage must have been in force for 1 month after the certificate date. Coverage will be continued at the same premium and coverage amounts then in force.

Effective Date of Coverage: Coverage becomes effective at 11:59 PM on the date of the signed enrollment form.

SEMI-MONTHLY PREMIUMS

Premiums are unisex, unismoke, are paid by the employee and are payroll deducted. Rates are based on the Certificate Effective Date

Employee	Employee & Spouse	Employee & Children	Employee, Spouse & Children
$5.84	$10.62	$13.16	$17.94

POLICY BENEFITS

All benefits are limited to one benefit per covered accident, per insured, and are paid independently of one another unless specifically noted otherwise.

HOSPITAL CARE

Hospital Admission: Within 6 months after the covered accident. Amount will be doubled if placed in a Hospital Intensive Care Unit within the first 24 hours of admission.	$2,000
Hospital Confinement: Per day up to 365 days. Within 6 months after the covered accident.	$500
Hospital Intensive Care Unit Confinement: Per day up to 30 days. Within 30 days after the covered accident.	$1,000
Lodging: Per day up to 30 days per covered accident for companion. Hospital must be more than 100 miles round trip from the residence of the insured.	$200
Rehabilitation Unit: Per day up to 30 days. When confined in a rehab unit following hospitalization.	$150
Transportation: Up to 3 round trips per covered accident. Insured must travel more than 100 miles round	$600

trip for treatment.

EMERGENCY CARE	
Ambulance	
• *Air: Within 48 hours after the covered accident.*	$1,000
• *Ground: Within 90 days after the covered accident.*	$200
Appliance: Within 90 days after the covered accident. For personal locomotion or mobility.	$100
Blood, Plasma, Platelets: Within 90 days after the covered accident.	$200
Physician Office/Urgent Care - Initial Visit: Within 60 days of a covered accident.	$50
Surgery	
• *Outpatient Surgery Facility Service: Torn Knee Cartilage, Ruptured Disc, Tendon/Ligament/Rotator Cuff.*	$200
• *Abdominal or Thoracic with repair: Within 72 hours of a covered accident.*	$1,000
• *Abdominal or Thoracic without repair: Within 72 hours of a covered accident.*	$100
• *Hernia: Diagnosed within 30 days and repaired within 90 days of the covered accident.*	$100
EMERGENCY ROOM	
Emergency Room Treatment: Within 72 hours after a covered accident.	$200
DIAGNOSTIC IMAGING	
Medical Imaging: For CT scan, MRI or EEG as the result of a covered accident.	$200
X-Rays: Payable for diagnosis and treatment of injuries received as the result of a covered accident.	$50
CONTINUING CARE	
Epidural Pain Management: Within 6 months after the covered accident. Payable once per 12 month period.	$100
Physician Follow-Up Care: Within 180 days of the covered accident. Payable twice per covered accident.	$100
Spinal Manipulation: Payable for 1 visit per day, up to a maximum of 5 visits per 12 month period, regardless of the number of covered accidents.	$30
Therapy Services – Occupational, Physical & Speech: Maximum of 10 visits per covered accident and completed within 2 years after the covered accident.	$30
SPECIFIC LOSS	
Burns: Treated by a physician within 72 hours after the covered accident.	
• *2nd degree burns which cover at least 36% of the body*	$1,500
• *3rd degree burns which cover at least 9 square inches of the body but less than 35 square inches*	$3,000
• *3rd degree burns which cover 35 or more square inches of the body*	$20,000
• *Skin Grafts: 25% of the applicable burn benefit*	
Concussion: Diagnosed by a physician within 72 hours after the covered accident.	$300
Emergency Dental Work	
• *Broken teeth repaired with crown(s)*	$300
• *Broken teeth resulting in extraction(s)*	$100
Eye Injury: Within 90 days after the covered accident.	$500

Accident Insurance

Gunshot Wound: Treated in a hospital or by a physician as the result of a covered accident.	$2,000
Laceration: Repaired by a physician within 72 hours after the covered accident.	
• *Treated without stitches, staples or glue*	$50
• *Total of all lacerations is not more than 3 inches long and repaired by stitches*	$100
• *Total of all lacerations is greater than 3 inches but not more than 5 inches and repaired by stitches*	$400
• *Total of all lacerations is over 5 inches and repaired by stitches*	$800
Organized Sports: Pays an additional 25% of the total benefit paid for the covered accident up to this amount. Payable once per 12 month period per insured.	$1,000
Prosthetic Device/Artificial Limb: Within 1 year of the covered accident.	
• *One*	$1,000
• *More than one*	$2,000
Ruptured Disc: Treated by a physician within 60 days and repaired through surgery within 1 year after the covered accident.	$1,000
Tendon, Ligament, Rotator Cuff: Within 1 year of the covered accident.	
• *Repair of one*	$1,200
• *Repair of more than one*	$1,800
• *Exploratory without repair*	$300
Torn Knee Cartilage: Treated by a physician within 60 days and repaired through surgery within 1 year after the covered accident.	
• *Surgery with Repair*	$1,500
• *Exploratory surgery*	$300

MAJOR INJURY

Accidental Death: Within 90 days from the date of a covered accident.	
• *Employee*	$100,000
• *Spouse*	$100,000
• *Children*	$20,000
Accidental Death / Common Carrier: Within 90 days after the covered accident.	
• *Employee*	$200,000
• *Spouse*	$200,000
• *Children*	$40,000
Coma: Unconscious for 30 consecutive days if as a result of a covered accident.	$10,000
Dismemberment: Within 90 days after the covered accident.	
• *Loss of both hands, or both feet or the sight of both eyes or any combination of two or more listed*	$20,000
• *Loss of one hand, or one foot or sight of one eye*	$10,000
• *Loss of two or more fingers or two or more toes or any combination of two or more fingers and toes*	$2,400
• *Loss of one finger or one toe*	$1,200
Catastrophic Accident: Payable after a 365 day elimination period.	
• *Employee (reduced by 50% at age 70)*	$100,000
• *Spouse (reduced by 50% at age 70)*	$100,000

Accident Insurance

• *Children*		$20,000
DISLOCATIONS: Diagnosed by a physician within 90 days after the covered accident.	Closed	Open
Dislocation (with Anesthesia)		
• *Hip*	$4,000	$8,000
• *Knee (except Patella)*	$2,000	$4,000
• *Ankle – Bones or Bones of Foot (not Toes)*	$1,600	$3,200
• *Collarbone (Sternoclavicular)*	$1,000	$2,000
• *Lower Jaw*	$600	$1,200
• *Shoulder (Glenohumeral)*	$600	$1,200
• *Elbow*	$600	$1,200
• *Wrist*	$600	$1,200
• *Bone or Bones of the Hand (not Fingers)*	$600	$1,200
• *Collarbone (Acromioclavicular and separation)*	$200	$400
• *One Toe or Finger*	$200	$400
• *Closed without Anesthesia: 25% of the closed with anesthesia benefit*		
FRACTURES: Diagnosed by a physician within 90 days after the covered accident.	Closed	Open
• *Skull - depressed fracture (except Bones of Face or Nose)*	$5,000	$10,000
• *Skull - simple non-depressed fracture (except Bones of Face or Nose)*	$2,000	$4,000
• *Hip, Thigh (Femur)*	$3,000	$6,000
• *Vertebrae, Body of (except Vertebral processes)*	$1,600	$3,200
• *Pelvis (includes Ilium, Ischium, Pubis, Acetabulum except Coccyx)*	$1,600	$3,200
• *Leg*	$1,600	$3,200
• *Bones of Face or Nose (except Mandible or Maxilla)*	$700	$1,400
• *Upper Jaw - Maxilla (except Alveolar process)*	$700	$1,400
• *Upper Arm between Elbow and Shoulder*	$700	$1,400
• *Lower Jaw - Mandible (except Alveolar process)*	$600	$1,200
• *Shoulder blade or Collarbone (Scapula, Clavicle, Sternum)*	$600	$1,200
• *Vertebral Processes*	$600	$1,200
• *Forearm, Hand, Wrist (except fingers)*	$600	$1,200
• *Kneecap (Patella)*	$600	$1,200
• *Foot (except toes)*	$600	$1,200
• *Ankle*	$600	$1,200
• *Rib*	$500	$1,000
• *Coccyx*	$400	$800
• *Finger, Toe*	$100	$200
• *Chips; 25% of closed benefit*		

HEALTH SCREENING BENEFIT RIDER (WPS-ACC HS Rider 07/15)

We will pay $50 for any one or more of the following health screening tests listed below performed by a Physician more than 30 days after the rider effective date. Benefit is payable once per calendar year per insured person.

1. Biopsy for Skin Cancer
2. Blood test for triglycerides
3. Bone marrow testing
4. CA 125 (blood test for ovarian cancer)
5. CA 15-3 (blood test for breast cancer)
6. CEA (blood test for colon cancer)
7. Chest X-ray
8. Colonoscopy
9. Electrocardiogram (EKG)
10. Fasting blood glucose test
11. Flexible sigmoidoscopy
12. Hemocult stool analysis
13. Lipid Panel (total cholesterol count)
14. Mammography/Breast Ultrasound
15. Oral Cancer screening using ViziLite, OraTest or other similar test
16. Pap smear (including ThinPrep Pap Test)
17. PSA (blood test for prostate cancer)
18. Serum Protein Electrophoresis (blood test for myeloma)
19. Stress test on a bicycle or treadmill
20. Thermography

POLICY EXCLUSIONS – WHAT WE WILL NOT PAY FOR

We will not pay benefits for losses that are caused or contributed to by, or are the result of:

1. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
2. any sickness or declining process caused by a sickness, including physical or mental infirmity. We also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any Injury. This exclusion does not apply to the Sickness Hospital Confinement Rider or the Health Screening Benefit Rider;
3. intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane;
4. war - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
5. active service in any of the armed forces, or units auxiliary thereto, including the National Guard or any Military Reserve;
6. repetitive stress or motion disorders caused by overuse or degenerative changes;
7. driving any taxi, limousine, bus or personal vehicle of any kind when used to transport fare-paying passengers;
8. mental or nervous disorders;
9. alcoholism or drug addiction;
10. ingestion or use of narcotic unless taken as prescribed by a Physician. This does not apply to accidental ingestion of substances by Children under the age of 5;
11. being under the influence of alcohol. Being under the influence of alcohol, for purposes of the Policy, means a blood alcohol level of 0.08 or more;
12. while incarcerated or detained in a penal institution of any kind, including house arrest and/or work furlough;
13. the commission of or an attempt to commit a felony or any loss to which a contributing cause was being engaged in an illegal activity.

DISCLAIMERS

Underwritten by Boston Mutual Life Insurance Company. The information provided here is a brief description of the important features of WPS-ACC 07/15 for the state of Louisiana. It is not a certificate of insurance or evidence of coverage. Any discrepancies between this proposal and the group policy will be resolved by the language issued in the Master Policy. Please refer to the Master Policy and individual Certificates of Coverage for a detailed description of the benefits, limitations, and exclusions.

If you have employees residing in Ohio who are eligible to enroll for this coverage, and the case is not sitused in their state of residence, the underwriting, rates and coverage will vary for these individuals. Please contact us if you need additional information for this state.

We believe this product is suitable for use in connection with a HSA (Health Savings Account) as permitted insurance. However, we do not give tax advice. You should consult with your tax advisor.

ECIP Employee Critical Illness plus

Employee Critical Illness Plus

Financial Protection for the Unexpected

- Includes Cancer Benefit
- Initial Occurrence
- Additional Occurrence
- Reoccurrence
- Spouse Coverage Available
- Child Coverage at No Additional Cost
- Health Screening Benefit

Protection for the Unexpected!

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

THIS IS A LIMITED BENEFIT POLICY

Approved for use in: AK, AL, AR, DC, DE, HI, IA, IN, KS, KY, LA, ME, MI, MO, MS, NE, NM, NV, OK, OR, SC, TN, VA, WI, WV.

BOSTON MUTUAL LIFE INSURANCE COMPANY – 120 Royall Street • Canton, MA 02021

Policy Series - WS–CI 4/12
TOBACCO / NO TOBACCO - Spouse up to 100% – Semi-Monthly
335-3619 2/17

Critical Illness Insurance

THE FACTS – According to Medical Statistics

- Over 1.6 million new cancer cases are expected to be diagnosed in 2015. [1]
- Cancer survival rates continue to improve. The 5-year survival rate for all cancers diagnosed between 2004 and 2010 is now 68%. However cancer is the second most common cause of death in the US, accounting for nearly 1 in every 4 deaths. [1]
- Each year, an estimated 600,000 Americans will have a new coronary attack and 305,000 will have a recurrent attack. [2]
- On average, someone in the US has a stroke every 40 seconds. [2]

[1] *Cancer Facts & Figures 2015 - American Cancer Society*
[2] *Heart Disease and Stroke Statistics - 2016 Update American Heart Association*

ELIGIBILITY

Individual Eligibility

All full-time employees, as defined by the master policy are eligible. If an employee is eligible, his/her spouse ages 18-69, is eligible for coverage.

Spouse Coverage Available

The employee may elect to apply for spouse coverage. Benefit amounts for the spouse are up to 100% of the employee amount. If the employee does not meet the underwriting requirements, the spouse may still be eligible for coverage. Spouse means a person of the opposite or same sex recognized as the insured's spouse/partner under the laws of the state. *(In Hawaii, the term also includes the insured's reciprocal beneficiary).*

Children Coverage at No Additional Charge

Each eligible child is covered at 25% of the primary insured amount at no additional charge. The definition of children may vary by state. Please review your certificate carefully.

Effective Date of Coverage

Coverage is effective on the date the application is signed, provided that the employee is actively at work and premiums for the coverage are paid.

Portability

The coverage is portable providing your coverage has been in force for 1 month after your certificate date and the group contract remains in force. Coverage will be continued at the same premium and coverage amounts then in force.

PLAN BENEFITS

Initial Occurrence Benefit

Lump Sum Benefits payable upon initial diagnosis of a covered illness or condition. Employee benefit amounts are available from $5,000 to $50,000.

Additional Occurrence Benefit

If an insured collects benefits for a Critical Illness under the plan and later has one of the remaining covered illnesses/procedures, then we will pay the benefit amount for each additional illness provided the occurrences are separated by at least 6 months. *(In Tennessee, the time period between different occurrences is 30 days).*

Re-Occurrence Benefit

If an insured collects benefits for a covered condition and is later diagnosed with the same condition, we will pay the benefit again provided that the two dates of diagnosis are separated by at least 6 months. *(12 months treatment free for Cancer/Carcinoma in situ).*

Covered Specified Critical Illnesses	Percent of Benefit Amount
Cancer	**100%**
Carcinoma in situ	**30%**
Skin Cancer	**$300 one-time *(lifetime)***
Heart Attack *(Myocardial Infarction)*	**100%**
Coronary Artery Bypass Surgery	**30%**
Angioplasty & Stent Insertion	**30%**
Stroke *(Apoplexy or Cerebral Vascular Accident)*	**100%**
Coma	**100%**
Paralysis	**100%**
Severe Burns	**100%**
Major Organ Transplant	**100%**
Alzheimer's Disease	**100%**
ALS *(Lou Gehrig's Disease)*	**100%**
Loss of Sight/Speech/Hearing	**100%**
End Stage Renal Disease	**100%**
Benign Brain Tumor	**100%**

Eligible Children are also covered for the following childhood Specified Critical Illnesses at 25% of the employee benefit amount:

- **Cerebral Palsy**
- **Cleft Lip or Palate**
- **Down Syndrome**
- **Cystic Fibrosis**
- **Spina Bifida**

All covered conditions are subject to the definitions found in the employee's certificate.

ECIP *Employee Critical Illness plus* Tobacco/No Tobacco Premium Rates

RATES INCLUDE THE FOLLOWING: Specified Critical Illness including Cancer, Pre-Existing Condition Exclusion, Age 70 Reduction and the $50 Health Screening Benefit Rider. Spouse is eligible to apply for up to 100% of the employee amount. Includes 25% benefit for eligible children.

Employee Non-Tobacco Rates

Face Purchase – *Semi-Monthly Premiums*

Issue Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.25	$3.60	$4.95	$6.30	$7.65	$9.00	$10.35	$11.70	$13.05	$14.40
30-39	$3.35	$5.80	$8.25	$10.70	$13.15	$15.60	$18.05	$20.50	$22.95	$25.40
40-49	$5.40	$9.90	$14.40	$18.90	$23.40	$27.90	$32.40	$36.90	$41.40	$45.90
50-59	$8.55	$16.20	$23.85	$31.50	$39.15	$46.80	$54.45	$62.10	$69.75	$77.40
60-69	$13.90	$26.90	$39.90	$52.90	$65.90	$78.90	$91.90	$104.90	$117.90	$130.90
* 70+	$26.90	$52.90	$78.90	$104.90	$130.90	NA	NA	NA	NA	NA

Employee Tobacco Rates

Face Purchase – *Semi-Monthly Premiums*

Issue Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.75	$4.60	$6.45	$8.30	$10.15	$12.00	$13.85	$15.70	$17.55	$19.40
30-39	$4.75	$8.60	$12.45	$16.30	$20.15	$24.00	$27.85	$31.70	$35.55	$39.40
40-49	$8.75	$16.60	$24.45	$32.30	$40.15	$48.00	$55.85	$63.70	$71.55	$79.40
50-59	$15.05	$29.20	$43.35	$57.50	$71.65	$85.80	$99.95	$114.10	$128.25	$142.40
60-69	$25.90	$50.90	$75.90	$100.90	$125.90	$150.90	$175.90	$200.90	$225.90	$250.89
* 70+	$50.90	$100.90	$150.90	$200.90	$250.89	NA	NA	NA	NA	NA

*** Benefit amounts for individuals who are age 70 and over and applying for coverage have already been reduced by 50%.**

Spouse Non-Tobacco Rates

Face Purchase – *Semi-Monthly Premiums*

Issue Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.25	$3.60	$4.95	$6.30	$7.65	$9.00	$10.35	$11.70	$13.05	$14.40
30-39	$3.35	$5.80	$8.25	$10.70	$13.15	$15.60	$18.05	$20.50	$22.95	$25.40
40-49	$5.40	$9.90	$14.40	$18.90	$23.40	$27.90	$32.40	$36.90	$41.40	$45.90
50-59	$8.55	$16.20	$23.85	$31.50	$39.15	$46.80	$54.45	$62.10	$69.75	$77.40
60-69	$13.90	$26.90	$39.90	$52.90	$65.90	$78.90	$91.90	$104.90	$117.90	$130.90

Spouse Tobacco Rates

Face Purchase – *Semi-Monthly Premiums*

Issue Ages	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.75	$4.60	$6.45	$8.30	$10.15	$12.00	$13.85	$15.70	$17.55	$19.40
30-39	$4.75	$8.60	$12.45	$16.30	$20.15	$24.00	$27.85	$31.70	$35.55	$39.40
40-49	$8.75	$16.60	$24.45	$32.30	$40.15	$48.00	$55.85	$63.70	$71.55	$79.40
50-59	$15.05	$29.20	$43.35	$57.50	$71.65	$85.80	$99.95	$114.10	$128.25	$142.40
60-69	$25.90	$50.90	$75.90	$100.90	$125.90	$150.90	$175.90	$200.90	$225.90	$250.89

Health Screening Benefits

We will pay a $50 benefit if an insured has any one of the covered screening tests after the 30 day waiting period. *(Waiting period does not apply in Kansas, Indiana and Missouri.)* This benefit is paid only once per calendar year, regardless of the number of tests. This benefit is paid regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the policy remains inforce. This benefit is payable for the covered employee *(and spouse if spouse coverage is included)*. This benefit is not paid for dependent children. The covered health screening tests include:

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill
2. Fasting blood glucose test
3. Blood test for triglycerides
4. Lipid Panel *(total cholesterol count)*
5. Bone marrow testing
6. CA 15-3 *(blood test for breast cancer)*
7. CA 125 *(blood test for ovarian cancer)*
8. CEA *(blood test for colon cancer)*
9. Chest X-ray
10. Electrocardiogram (EKG)
11. Colonoscopy
12. Flexible sigmoidoscopy
13. Hemocult stool analysis
14. Mammography/Breast Ultrasound
15. Pap smear *(including ThinPrep Pap Test)*
16. PSA *(blood test for prostate cancer)*
17. Serum Protein Electrophoresis *(blood test for myeloma)*
18. Thermography
19. Oral Cancer screening using ViziLite OraTest or other similar test
20. Biopsy for Skin Cancer

LIMITATIONS & EXCLUSIONS

BENEFIT REDUCTION

Specified Critical Illness benefits are reduced by 50% starting age 70.

WAITING PERIOD

This coverage contains a 30 day Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, you may elect to void the Certificate from the beginning and receive a full refund of premium. *(Waiting Period does not apply in Kansas, Indiana and Missouri.)*

PRIOR HISTORY OF CANCER

No benefits are payable for Cancer or Carcinoma in Situ if the Insured was previously diagnosed before this Certificate was in force and, after the previous diagnosis, the Insured has not gone 12 months without Treatment before a new diagnosis of Cancer/Carcinoma in situ is made.

PRE-EXISTING CONDITIONS LIMITATION *(Not applicable to Insureds with a Prior History of Cancer or Carcinoma in Situ – See* PRIOR HISTORY OF CANCER*)*

This certificate contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the first 180 days, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period. *(In Iowa and Kansas the pre-existing conditions limitation does not apply to newborn or adopted children.)*

EXCLUSIONS

We won't pay for a loss due to:

1. Intentionally self inflicted injury or action while sane or insane. *(In Missouri, insane does not apply.)*
2. Suicide or attempted suicide while sane or insane. *(In Missouri, insane does not apply.)*
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor. *(In Nevada, this exclusion does not apply.)*
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence. *(In Maine, civil commotion or state of belligerence do not apply.)*

(In Oklahoma, #4 is as follows and #5 is added:

4. War - declared or undeclared or military conflicts while serving in any armed forces or an auxiliary unit thereto.
5. Participation in an insurrection or riot, civil commotion or state of belligerence.)

(In South Carolina, #3 is as follows:

3. The Insured being drunk or under the influence of any narcotic unless taken on the advice of a Physician.)

To be eligible for benefits, the date of diagnosis must be after the 30 day waiting period and while this coverage is in force.

Underwritten by:

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 Royall Street • Canton, Massachusetts 02021 • *www.bostonmutual.com*
For Claims Call Toll Free: 1-877-212-2950 • For Customer Service Call Toll Free: 1-877-624-2249

This brochure provides a general description of the important features of the policy/certificate. This brochure is not the insurance contract and only the actual policy/certificate provisions will control.

See certificate for detail regarding exclusions.

LegalShield and IDShield

LegalShield® Worry Less. Live More.

IDShield℠

HAVE YOU EVER?

- ☐ Needed your Will prepared or updated
- ☐ Been overcharged for a repair or paid an unfair bill
- ☐ Had trouble with a warranty or defective product
- ☐ Signed a contract
- ☐ Received a moving traffic violation
- ☐ Had concerns regarding child support
- ☐ Worried about being a victim of Identity theft
- ☐ Been concerned about your child's identity
- ☐ Lost your wallet
- ☐ Worried about entering personal information on-line
- ☐ Feared the security of your medical information
- ☐ Been pursued by a collection agency

WHAT IS LEGALSHIELD?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1 million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

THE LEGALSHIELD® MEMBERSHIP INCLUDES:

- ✓ Personal Legal advice on unlimited issues
- ✓ Letters/ calls made on your behalf
- ✓ Contracts & documents reviewed (up to 15 pages)
- ✓ Residential Loan Document Assistance
- ✓ Lawyers prepare your Will, your Living Will and your Health Care Power of Attorney
- ✓ Moving Traffic Violations (available 15 days after enrollment)
- ✓ IRS Audit Assistance
- ✓ Trial Defense (if named defendant/ respondent in a covered civil action suit)
- ✓ Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
- ✓ 25% Preferred Member Discount (Bankruptcy, Criminal Charges, DUI, Other Matters, etc.)
- ✓ 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children. An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

THE IDSHIELD℠ MEMBERSHIP INCLUDES:

Privacy Monitoring
Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, and medical ID numbers (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.

Security Monitoring
SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle. With the family plan, Minor Identity Protection is included and provides monitoring for up to 8 children under the age of 18.

Consultation
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.

Full Service Restoration
Complete identity recovery services by Kroll Licensed Private Investigators and our $5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.

IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents up to the age of 18

Payroll Deduction Semi-Monthly	Individual	Family
LegalShield	$8.48	$9.48
IDShield	$4.48	$9.48
Combined	$12.95	$16.95

For more information, please call your independent associate:

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.

Employee Assistance Program (EAP)

Confidential: All information is strictly confidential between you and the EAP professional.
No Red Tape: A simple phone call starts the process.
Fees: The initial sessions are paid for by your employer, and are offered at no charge to you.

1-800-749-3277

What is an Employee Assistance Program (EAP)?
This program provides **free, confidential, professional assistance** to help employees and their families resolve problems / issues that affect their personal lives to job performance. Besides being confidential, the program is voluntary- it is designed to allow the employee or family to seek help on their own.

How does the EAP work?

It is an employer sponsored program. The request for help may be by the employee or the family simply calls you EAP at **800.749.3277** and an appointment will be arranged. Confidentiality is assured.
Any issues discussed are strictly between you and the counselor. Neither your employer nor your coworkers will have any knowledge of your request for help.

What kind of problems will the EAP deal with?

The program deals with human problems – the kinds that affect an employee's personal wellbeing and their ability to perform on the job. These problems may include martial difficulties, or problems caused by alcohol or drug abuse, but if doesn't have to be a serious problem to call your EAP. If it's a concern for you, it is a concern for us! EAP deals only with personal problems or issues which may affect work performance without interfering in your organization's existing policies and disciplinary procedures. EAP coaching service deals with "soft-skill" competencies to promote personal and professional success.

Some of the reasons to call EAP

- Parenting Skills
- Locate Resources
- Depression
- Anxiety
- Stress
- Grief
- Martial Relations
- Work/Life Issues
- Post-Trauma Issues
- Children/ Adolescents
- Anger
- Soft Skill Competencies
- Alcohol/ Drugs
- Gambling

Who will pay for the cost of counseling or other professional services that might be necessary?

The initial problem assessment and counseling services are free to the employee and their family members. If further assistance is necessary, the employee's regular health insurance benefits may be used. If services are not covered by the health insurance the counselor will try to help the employee minimize cost by making referrals to the most appropriate agency. This cost will be the employee's responsibility, but many times the services are available which are based on the individual's ability to pay.

Compliance Notices

Special Enrollment Rights

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

Newborns' Act Disclosure

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

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 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 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 **askebsa.dol.gov** or call 866-444-3272 (3272).

Compliance Notices

ALABAMA-Medicaid

myalhipp.com

(855)692-5447

ALASKA-Medicaid

Myakhipp.com

(866) 251-4861

ARKANSAS-Medicaid

Myarhipp.com

(855)692-7447

COLORADO

Health First Colorado & Child Health Plan Plus

Healthfirstcolorado.com

(800) 221-3943

FLORIDA-Medicaid

flmedicaidtplrecovery.com

(877) 357-3628

GEORGIA-Medicaid

Dch.georgia.gov/medicaid

(404) 656-4507

INDIANA-Medicaid

in.gov/fssa/hip/ or indianamedicaid.com

(877) 438-4479 or (800) 403-0864

IOWA-Medicaid

Dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

(888) 346-9562

KENTUCKY-Medicaid

chfs.ky.gov/dms/default.htm

(800) 635-2570

LOUISIANA-Medicaid

Dhh.louisiana.gov/index.cfm/subhome/1/n/331

(888) 695-2447

MAINE-Medicaid

maine.gov/dhhs/ofi/publicassistance/index.html

(800) 442-6003

MASSACHUSETTS-Medicaid and CHIP

mass.gov/eohhs/gov/depatments/masshealth/

(800) 462-1120

MINNESOTA-Medicaid and CHIP

Mn.gov/dhs/people-we-serve/seniors/healthcare/

(800) 657-3739

MISSOURI-Medicaid

dss.mo.gov/mhd/participants/pages/hipp.htm

(573) 751-2005

MONTANA-Medicaid

Dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

(800) 694-3084

NEBRASKA-Medicaid

Dhhs.ne.gov/Children_Family_Services/AccessNebraska

(855)632-7633

NEVADA-Medicaid

dwss.nv.gov

(800) 992-0900

NEW HAMPSHIRE-Medicaid

Dhhs.nh.gov/oii/documents/hippapp.pdf

(603) 271-5218

NEW JERSEY-Medicaid and CHIP

State.nj.us/humanservices/dmahs/clients/medicaid/

(609) 631-2392

Njfamilycare.org/index.html

(800) 701-0710

NEW YORK-Medicaid

Health.ny.gov/health_care/medicaid/

(800) 541-2831

NORTH CAROLINA-Medicaid

Dma.ncdhhs.gov/

(919) 855-4100

NORTH DAKOTA-Medicaid

Nd.gov/dhs/services/medicalserv/medicaid/

(844) 854-4825

OKLAHOMA-Medicaid and CHIP

insureoklahoma.org

(888) 365-3742

OREGON-Medicaid

Healthcare.oregon.gov/Pages/index.aspx

Oregonhealthcare.gov/index-es.html

(800) 699-9075

PENNSYLVANIA-Medicaid

Dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthip-pgprogram/index.htm

(800) 692-7462

RHODE ISLAND-Medicaid

Eohhs.gov

(888) 549-0820

SOUTH CAROLINA-Medicaid

Scdhhs.gov

(888) 549-0820

SOUTH DAKOTA-Medicaid

dss.sd.gov

(888) 828-0059

TEXAS-Medicaid

gethipptexas.com

(800) 440-0493

UTAH-Medicaid and CHIP

Medicaid.utah.gov/

Health.utah.gov/chip

(877) 543-7669

VERMONT-Medicaid

greenmountaincare.org

(800) 250-8427

Compliance Notices

VIRGINIA-Medicaid and CHIP

coverva.org/
programs_premium_assistance.cfm

Medicaid: (800) 432-5924

CHIP: (866) 242-8282

WASHINGTON-MEDICAID

Hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program

(800) 562-3022 ext. 15473

WEST VIRGINIA-Medicaid

Dhhr.wv.gov/bms/

(877) 598-5820, HMS Third Party Liability

WISCONSIN-Medicaid

Dhs.wisconsin.gov/publications/p1/p10095

(800) 362-3002

WYOMING-Medicaid

Wyequalitycare.acs-inc.com/

(307) 777-7531

To see if any other states have added a premium assistance program since Jan. 31, 2017, or for more information on special enrollment rights contact:

U.S. Department of Labor

Employee Benefits Security Administration

dol.gov/agencies/ebsa

(866) 444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

cms.hhs.gov

(877) 267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137

(expires 10/31/2019)

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes 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.

Written notice about the availability of these mastectomy-related benefits must be delivered to participants in a group health plan upon enrollment and then each year afterwards.

Does WHCRA apply to individuals who have not been diagnosed with cancer but who must undergo a mastectomy due to other medical reasons?

Despite the title, nothing in the law limits entitlement to WHCRA benefits to cancer patients. If an individual is receiving benefits in connection with a mastectomy and the group health plan covers mastectomies, then the individual is entitled to WHCRA benefits. Also, despite the title, nothing in the law limits WHCRA entitlements to women.

Does WHCRA mandate minimum hospital lengths of stay in connection with mastectomy or breast reconstruction?

No, but many State laws applicable to insured coverage provide more protections than WHCRA. Thus, if a plan provides coverage through an insurance company, covered individuals may be entitled to minimum hospital stays under State law. If your plan is insured, check with your State insurance department for more information.

May group health plans impose deductibles or coinsurance requirements on the coverage specified in WHCRA?

Yes, but only if the deductibles and coinsurance are consistent with those established for other medical/surgical benefits under the plan or coverage.

Can my plan refuse to cover reconstructive surgery benefits because the mastectomy was performed when the participant was covered under a different insurance company?

If the plan provides coverage for mastectomies and the participant is receiving benefits under the plan that is related to a mastectomy, then the plan generally is required to cover reconstructive surgery upon request. In addition, the plan generally is required to cover the other benefits specified in WHCRA. It does not matter that the participant was not enrolled in the current plan and/or was not covered by the same insurance company at the time of the mastectomy.

Compliance Notices

The Women's Health and Cancer Rights Act Continued

There are additional related protections under the Affordable Care Act. For plan years beginning on or after January 1, 2014, a group health plan generally cannot limit or deny benefits relating to a health condition that was present before enrollment in the plan (a preexisting condition). For more information see the Affordable Care Act section of this publication at page 9 or visit the Affordable Care Act Web page of the Department of Labor's Employee Benefits Security Administration (EBSA) at **dol.gov/ebsa/healthreform/** or the Department of Health and Human Services' Website at HealthCare.gov.

Is my plan required to provide preventive services related to the detection of breast cancer?

Under the Affordable Care Act, plans must provide certain preventive services, such as breast cancer mammography screenings for women 40 years of age and older, with no copayment, coinsurance or deductible (or other cost-sharing). For more information, visit HealthCare.gov/what-are-my-preventive-care-benefits/.

WHCRA does not require coverage for preventive services related to the detection of breast cancer.

What information should be included in the notice provided when participants enroll in the plan?

The enrollment notice must state that, for an individual who is 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.

The enrollment notice must also describe any deductibles and coinsurance limitations applicable to such coverage. Under WHCRA, coverage of breast reconstruction and other benefits specified in WHCRA may be subject only to deductibles and coinsurance limits consistent with those established for other medical/surgical benefits under the plan or coverage. A copy of a model enrollment notice is included on page 141.

What information should be included in the annual notice to participants in the plan?

The annual notice should describe the four categories of coverage required and should contain information on how to obtain a detailed description of the mastectomy-related benefits available under the plan. To satisfy this annual notice requirement, the plan may provide the same notice it provided to individuals upon enrollment in the plan if it contains the appropriate information as described above.

A model annual notice is included on page 142.

How must the plan provide these notices to participants?

These notices must be delivered in accordance with the Department of Labor's disclosure rules applicable to furnishing Summary Plan Descriptions. For example, the notices may be provided by first class mail or any other means of delivery prescribed in the regulation. A separate notice must be furnished to a group health plan beneficiary where the last known address of the beneficiary is different than the last known address of the covered participant.

To avoid duplication of notices, a group health plan can satisfy the WHCRA notice requirements by contracting with another party that provides the required notice. For example, in the case of an insured group health plan, the plan will satisfy the notice requirements with respect to a particular participant if the issuer timely provides the notice including the information required by WHCRA.

Where can I find more information about the requirements under WHCRA?

WHCRA is administered by the U.S. Departments of Labor and Health and Human Services.

For more information regarding an employer-sponsored group health plan's responsibilities under WHCRA, visit the Website of the Department of Labor's Employee Benefits Security Administration at dol.gov/ebsa/ healthlawschecksheets.html.

For more information on WHCRA, visit the Website of the Department of Health and Human Services' Centers for Medicare & Medicaid Services at cms.gov/CCIIO/ Programs-and-Initiatives/Other-Insurance-Protections/whcra_ factsheet.html.

Compliance Notices

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Why is the Plan providing me with this Privacy Notice?

This Notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (the "HIPAA Privacy Rules"). The HIPAA Privacy rules are federal laws that seek to ensure the privacy and confidentiality of your health information. The HIPAA Privacy Rules require the Plan to take certain actions to protect the privacy of your health information. This Notice has been prepared to advise you of the uses and disclosures of your Protected Health Information (as defined below) that may be made by the Plan and to advise you of your rights and the Plan's legal duties relating to the privacy of your Protected Health Information.

What is Protected Health Information?

Protected Health Information generally is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, health care clearinghouse, a health plan or your employer on behalf of a group health plan, that relates to:

1) Your past, present or future physical or mental health or condition;
2) The provision of health care to you; or
3) The past, present or future payment for the provision of health care to you.

For example, the information included in an explanation of benefits ("EOB") from the Plan is Protected Health Information. In addition, Protected Health Information includes genetic information which includes information about your genetic tests or the genetic tests of your family members or the manifestation of a disease in one of your family members. For example, the fact that your spouse is diagnosed with Type II diabetes is genetic information.

Will the Plan have access to my Protected Health Information?

Yes. As an individual enrolled in the Plan, you should be aware that the Plan may have access to your Protected Health Information from time to time. The Plan may receive your Protected Health Information in a variety of ways. An example of how the Plan may receive this information is when your health care provider, such as your doctor or your hospital, submits bills for services rendered to you to be paid by the Plan.

When may the Plan use or disclose my Protected Health Information?

The law permits the Plan to use or disclose Protected Health Information to carry out "treatment," "payment" and other "health care operations". When the Plan makes uses or disclosures of your Protected Health Information for treatment, payment or health care operations purposes, the Plan is not required to notify you or obtain your Authorization (discussed further below).

Treatment: Treatment means the provision, coordination, or management of health care and related services by health care providers, including the coordination or management of health care by a health care provider with a third party (such as an insurer of the Plan), consultation between providers with respect to a patient, and the referral of a patient for health care from one provider to another. The Plan itself does not engage directly in "treatment" under the HIPAA Privacy Rules. However, the Plan may interact with a health care provider in treatment transactions.

Payment: Payment means activities undertaken by the Plan to determine eligibility for benefits or fulfill its responsibility for coverage and provision of benefits under the Plan. Examples of when the Plan might use or disclose Protected Health Information for payment purposes include disclosures to facilitate the payment of claims made on the Plan by health care providers, the Plan's activities to obtain or provide reimbursement for the provision of health care, or the Plan's activities in obtaining premiums. When the Plan discloses information for payment purposes, the Plan will attempt only to disclose that Protected Health Information which is minimally necessary to ensure proper and timely payment of claims.

Health Care Operations: The term "health care operations" means those other functions and activities that the Plan performs in connection with providing health care benefits. Examples of what constitute health care operations during which the Plan might use or disclose your Protected Health Information include activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, business planning and development relating to the Plan, and compliance with the HIPAA Privacy Rules. Another example would include the Plan's use or disclosure of Protected Health Information to better manage its operations, such as when the Plan discloses information with a vendor or consultant (commonly referred to as a "Business Associate") to ensure proper accounting and record-keeping relating to the Plan's provision of health care benefits. Under contractual agreements with the Plan, Business Associates can receive, create, maintain, use, and disclose your Protected Health Information, without your consent, but only to assist the Plan with its payment, operations, and other limited purposes.

Compliance Notices

HIPAA Privacy Notice Continued

May the Plan use or disclose my Protected Health Information for other purposes?

Yes. For uses or disclosures of Protected Health Information that are not made for treatment, payment, or health care operations purposes and for which no exception regarding Authorization applies, the law requires the Plan to obtain your Authorization. An Authorization is your approval for the Plan's disclosure of your Protected Health Information to a particular person or entity for a particular purpose. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes. You may revoke an Authorization at any time, but a revocation is not effective if the Plan has already reasonably relied on your Authorization to make a particular use or disclosure. Examples of when an Authorization would be required include when the uses or disclosures are made to your employer for disability, fitness for duty or drug testing purposes. Additionally, if you request that the Plan use or disclose your Protected Health Information, the Plan may require that you sign an Authorization that permits the Plan to honor your request.

When might the Plan make a use or disclosure of my Protected Health Information without my Authorization?

As discussed above, the Plan is not required to obtain your Authorization to use or disclose your Protected Health Information for treatment, payment or health care operations purposes. Additionally, there are some limited exceptions in which the law allows the Plan to use or disclose your Protected Health Information for purposes other than treatment, payment, or health care operations without your Authorization. Most of these uses or disclosures are permitted to promote the government's need to ensure a safe and healthy society. In some cases, you may be given an opportunity to agree or object before the use or disclosure is made; in other cases, you may not be given this opportunity. Whenever the Plan makes these types of uses and disclosures, the Plan will ensure that it meets any necessary prerequisites and will limit the use or disclosure of your Protected Health Information to the minimum necessary to accomplish its purpose.

The types of uses or disclosures of Protected Health Information that may be made without your Authorization and without giving you the opportunity to object include those made: to avert communicable or spreading diseases; for public health activities; for federal intelligence, counter-intelligence and national security purposes; to properly assist law enforcement to carry out their duties; when a judge or administrative tribunal orders the release of such Protected Health Information; for cadaveric organ, eye and tissue donations (where appropriate); to help apprehend criminals; to assist armed forces personnel and operations; for military service, veterans affairs separation/discharge matters; for coroner/medical examiner purposes; for health oversight purposes (such as when the government requests certain information from the Plan to determine its compliance with applicable laws); to assist victims of abuse, neglect or domestic violence; to address work-related illness/workplace injuries and for workers' compensation purposes; to carry out clinical research that involves treatment where the proper body has determined the importance for doing so; for FDA-related purposes; for certain health and safety purposes; for funeral/funeral director purposes; to help determine veterans eligibility status; to protect Presidential and other high-ranking officials; and for reporting to correctional institutions/law enforcement officials acting in a custodian capacity.

There are also several types of uses or disclosures of Protected Health Information that the Plan may make without your Authorization as long as, whenever possible, you are given an opportunity to agree or object before the Plan makes the use or disclosure. These exceptions are very limited and generally involve the release of a limited amount of Protected Health Information to aid your family members, close personal friends, or disaster relief personnel in locating you in the event of an emergency or in case of your incapacity.

Will the Plan disclose my Protected Health Information to my employer?

The Plan has the right to disclose your Protected Health Information to the Plan Sponsor, which is usually your employer, subject to certain limitations. The Plan may generally disclose to the Plan Sponsor information regarding whether you are enrolled in the Plan and "summary health information," which means information that summarizes the claims history and experiences of the individuals enrolled in the plan without specifically identifying you or other plan participants. The Plan may disclose this information without your Authorization, and the Plan Sponsor may only use the information for its activities relating to its sponsorship of the Plan. For example, the Plan Sponsor may use this information to seek bids from health insurers or to analyze its health plan expenses. If the Plan Sponsor needs more than "summary health information" or enrollment information to carry out its responsibilities, then documents that govern the Plan will determine the extent to which Protected Health Information may be used or disclosed, except that in no case may the Plan Sponsor use or disclose your Protected Health Information for employment-related decisions or for any other purposes other than as permitted by the Plan documents or by law. Additionally, Plan Sponsors that receive Protected Health Information from the Plan must make certain certifications to the Plan regarding the uses and disclosures of the information and must ensure that any agents or subcontractors of the Plan Sponsor agree to the same restrictions and conditions that apply to the Plan Sponsor.

Will the Plan use or disclose my Protected Health Information for marketing, fundraising or other similar purposes?

While the Plan does not anticipate using or disclosing your Protected Health Information for marketing, fundraising or other similar purposes, under the HIPAA Privacy Rules, the Plan may only make such uses or disclosures with your Authorization, unless the Plan communicates with you face-to-face or provides you with some promotional gift of nominal value, in which case your Authorization would not be required.

Is the Plan Subject to Other Restrictions Regarding the Use and Disclosure of my Protected Health Information?

The Plan will not:

1) Use your genetic information for underwriting purposes, which includes determining whether you are eligible for benefits; or
2) Directly or indirectly receive payment in exchange for your Protected Health Information unless the Plan obtains a valid authorization from you.

Do I have the right to request additional restrictions on the uses or disclosures of my Protected Health Information?

Yes. You have the right to request additional restrictions relating to the Plan's use or disclosure of your Protected Health Information beyond those otherwise required under the HIPAA Privacy Rules. You also have the right to limit disclosures to family members or friends who are involved in your care or payment for your care. For example, you could ask that the Plan not use or disclose information about a surgery that you had. Although the Plan is not legally required to grant these requests, it is your right to make such a request. If the Plan agrees to the restriction, it can stop complying with the restriction after providing notice to you. For additional information or to obtain the proper form for making such a request, please contact the Plan's Privacy Officer.

Compliance Notices

HIPAA Privacy Notice Continued.

May I request that certain communications of my Protected Health Information be made to me at alternate locations?

Yes. The Plan may communicate your Protected Health Information to you in a variety of ways, including by mail or telephone. If you believe that the Plan's communications to you by the usual means will endanger you or your health care and you would like the Plan to make its communications that involve Protected Health Information to you at an alternate location, you may contact the Plan's Privacy Officer to obtain the appropriate request form. The Plan will only accommodate reasonable requests and may require information as to how payment, if any, will be handled.

Do I have the right to obtain access to my Protected Health Information?

Generally yes. You have the right to request and obtain access to your Protected Health Information maintained by the Plan unless an exception applies. The Plan may deny you access to your Protected Health Information if the information is not required to be accessible under the HIPAA Privacy Rules or other applicable law. For example, you do not have a right to access information compiled by the Plan in anticipation of or for use in a civil, criminal or administrative proceeding.

If the information you request is maintained electronically, and you request an electronic copy, the Plan will provide a copy in the electronic form and format you request, provided the information may be readily produced in that manner. If not, the Plan will work with you to come to an agreement on form and format. If you and the Plan cannot agree on an electronic form and format, the Plan will provide you with a paper copy.

The Plan may charge you a reasonable, cost-based fee for copying (including the cost of supplies and labor) any Protected Health Information required to be copied to adequately respond to your access request, as well as any postage costs and costs associated with preparing an explanation or summary of the Protected Health Information necessary to adequately respond to your access request (unless otherwise precluded by applicable State or other law). If you would like to request access to your Protected Health Information, please notify the Plan's Privacy Officer so that you can complete the appropriate forms.

Do I have the right to request an amendment to my Protected Health Information?

Yes. You have the right to request that the Plan amend your Protected Health Information. The Plan reserves the right to deny or partially deny requests for amendments that are not required to be granted under the HIPAA Privacy Rules. For example, the Plan may deny a request for amendment when the Protected Health Information at issue is accurate and complete. If you would like to request an amendment of your Protected Health Information, please notify the Plan's Privacy Officer so that you can complete the appropriate forms.

Do I have the right to an accounting of disclosures of my Protected Health Information made by the Plan?

Yes. You have the right to request and obtain a proper accounting of disclosures the Plan has made of your Protected Health Information. The Plan is not required to account for all uses and disclosures of Protected Health Information that the Plan makes. For example, the Plan is not required to provide an accounting for disclosures made for treatment, payment, or health care operations purposes or for disclosures made with your Authorization. Additionally, the Plan reserves the right to limit its accountings to disclosures made after the compliance date of the HIPAA Privacy Rules.

The Plan will provide you with your first accounting at no charge to you. If you request any additional accountings within a 12-month period, the Plan may charge you a reasonable, cost-based fee. At the time that you request a subsequent accounting, the Plan will provide you with information regarding the fees, and you will have the opportunity to withdraw or modify your request if you wish to do so. If you would like to request an accounting of your Protected Health Information, please notify the Plan's Privacy Officer so that you can complete the appropriate forms.

Do I have the right to receive notice if the privacy or security of my Protected Health Information is compromised?

Yes. In certain circumstances, you have the right to receive notice from the Plan if the privacy or security of your Protected Health Information is compromised. The notice will describe what occurred, the date of the occurrence (or if later, the date on which the Plan learned of the occurrence), the type of information Involved, actions you should take to protect your information, and actions the Plan is taking to mitigate the harm and reduce the likelihood of recurrence.

May the Plan amend this Notice?

Yes. The Plan is required to abide by the Notice that is currently in effect; however, the Plan reserves the right to change the terms of this Notice at any time and to make the new Notice effective for all Protected Health Information maintained by the Plan. If this Notice is amended, you will be provided with a copy of the new Notice through regular mail, electronic mail, posting at work site, posting on Intranet sites, or by some other reliable method intended to reach all Plan participants.

If I have an objection to the way my Protected Health Information is being handled, may I file a complaint?

Yes. The Plan has procedures in place for receiving and resolving complaints. If you believe that the Plan has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules, you may file a complaint by contacting the Plan's Privacy Officer. You may send a letter outlining your complaint to the Privacy Officer or you may call the Privacy Officer and request a complaint form. The Plan requests that you attempt to resolve your complaint with the Plan via these complaint procedures since the Plan is in the best position to respond to your complaint. However, if you believe the Plan has violated your privacy rights, you may also file a complaint with the Office of Civil Rights ("OCR") at the United States Department of Health and Human Services ("HHS"). You may contact the HHS OCR at: Medical Privacy, Complaint Division, Office of Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, Voice Hotline Number (800) 368-1019, Internet Address www.hhs.gov/ocr.

It is against the policies and procedures of the Plan to retaliate against any person who has filed a privacy complaint, either with us or with HHS OCR. Should you believe that you are being retaliated against in any way upon your filing a complaint with us or the HHS OCR, please immediately contact the Plan's Privacy Officer, so that the Plan may properly address the issue.

May I obtain a paper copy of this Notice?

Yes. If you received this Notice via the Internet or electronic mail, you have the right to request and receive a paper copy of this Notice. If you would like to receive a paper copy of this Notice, please contact the Plan's Privacy Officer.

Compliance Notices

HIPAA Privacy Notice Continued.

What if I have additional questions that are not answered in this Notice?

If you have any questions, concerns or issues relating to the privacy of your Protected Health Information that is not covered in this Notice, please contact the Plan's Privacy Officer.

Important Notice from your Employer About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Your employer has determined that the prescription drug coverage offered by the insurance carrier is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from **October 15th to December 7th** however, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current coverage may or may not be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact your Human Resources Department for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov; Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Compliance Notices

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

The parent-employee dies;
The parent-employee's hours of employment are reduced;
The parent-employee's employment ends for any reason other than his or her gross misconduct;
The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
The parents become divorced or legally separated; or
The child stops being eligible for coverage under the Plan as a "dependent child."

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

Compliance Notices

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

OMB 0938-0990

MEDICARE PART D

Important Notice from City of Hammond About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of Hammond has determined that the prescription drug coverage offered by your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC

What Happens to Your Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage could be affected. See the Summary Plan Description for additional information.

If you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) to Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days after your current coverage ends, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

CMS Form 10182-CC

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE DRUG PLANS, YOU MAY BE REQUIRED TO PROVIDE A COPY OF THIS NOTICE WHEN YOU JOIN TO SHOW WHETHER OR NOT YOU HAVE MAINTAINED CREDITABLE COVERAGE AND, THEREFORE, WHETHER OR NOT YOU ARE REQUIRED TO PAY A HIGHER PREMIUM (A PENALTY).

Name of Entity/Sender:	City of Hammond
Contact—Person/Office:	Loretta Severan
Address:	310 East Charles Street Hammond, LA 70401
Phone Number:	985-277-5626

When Will You Pay A Higher Premium (Penalty) to Join A Medicare Drug Plan?

If the coverage under your employer is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

CMS Form 10182-CC

Important Contacts

BXS Insurance	
Account Manager:	*Mickie Thompson*
Phone Number:	*888-240-5899*
Email:	*mickie.thompson@bxsi.com*
Empire Management	
Contact:	*Wende Powell*
Phone Number:	*985-340-2880*
Email:	*empmgt@bellsouth.net*
City of Hammond Human Resources	
Contact:	*Loretta Severan*
Phone Number:	*985-277-5626*
Email:	*severan_ls@hammond.org*
Medical Insurance (Blue Cross Blue Shield)	
Phone Number:	*800-495-2583*
Website:	*www.bcbsla.com*
HRA Card (Consumer Choice Plans)	
Phone Number:	*985-340-2880*
Website	*http://www.consumerchoiceplans.com*
Dental and Vision Insurance (SunLife)	
Phone Number:	*800-786-5433*
Website:	*www.sunlife.com*
Life, Vol Life, STD, and LTD (Standard)	
Phone Number:	*888-937-4783*
Website	*www.standard.com*
Whole Life, Accident, and Critical Illness (Boston Mutual)	
Provider Name:	*Boston Mutual*
Contact and Phone Number:	*Frances Clements 225-755-1288*
Email:	*francis@clementsinsgroup.com*
Legal Shield	
Contact Name:	*Austin Powell*
Phone Number:	*985-386-8542*
Email:	*apowell@powellins.net*