2020 Employee Benefits Guide

CenterLight™
Health System

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Your Benefits, Your Choice

What's New Starting in 2020?

CenterLight Health System is pleased to provide you with our employee benefits plan offerings, designed specifically to benefit you.

This guide provides an overview of the benefits available to you as a CenterLight Health System employee.

CenterLight Health System is dedicated to providing its employees with a comprehensive benefits program offering the flexibility to customize benefits to meet your needs both now and in the future.

In an effort to enhance your benefits package, CenterLight Health System is happy to announce the following:

- **Access to our Alliant Advocates to help with benefits questions and information**
- **We are happy to announce that we will be remaining with Aetna**
- **No Change to employee contributions per pay period**

Eligibility and Enrollment

WHO IS ELIGIBLE?

All non-union Employees must work 17.5 standard hours weekly to be eligible for Medical, Dental and Vision. All non-union employees must work at least 26 standard hours weekly to be eligible for Life and Long Term Disability.

You can enroll the following family members in our medical plans.

- Your spouse or domestic partner (including same-sex spouse or domestic partner)
- Your children:
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.
    - Termination for dependents age 26 is the end of the month of their 26th birthday

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of CenterLight Health System cannot also be covered as a dependent.

WHEN CAN I ENROLL?

Coverage for new full-time employees begins on the 1st of the month following 30 days of hire.

Open enrollment for current full-time employees is generally held in November. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 30 days to make your change (60 days for birth/adoption).

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

FIND A PRIMARY CARE PROVIDER (PCP)

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor's visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor
- If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

EAT WELL

Eating healthier really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

USE URGENT CARE CLINICS

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

Finding a Doctor, Hospital, or Health Care Provider

Find a Doctor Online using DocFind

Utilize DocFind via Aetna.com to search for doctors before or after you are a member

- **Supports searches for In-Network Providers:**
  - Primary Care Physicians, Specialists
  - Hospitals, Facilities and Pharmacies
  - Provider data is refreshed six times per week

If you are not yet enrolled:

- **Step 1:** Go to: **www.aetna.com**
- **Step 2:** Click on "Find a doctor" on the right hand side of the screen;
- **Step 3:** Under "Not a Member Yet?" Click on "Plan from an Employer", type your home zip code, and select one of our two offered plans:

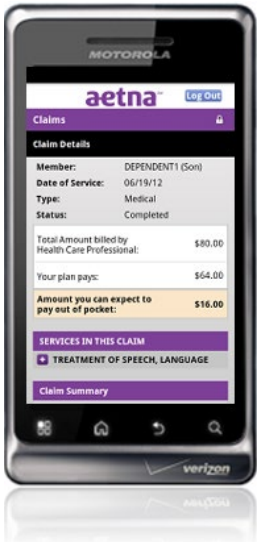
  EPO: OPEN ACCESS ELECT CHOICE EPO
  PPO: OPEN ACCESS MANAGED CHOICE POS

- **Step 4**: At this point you have the option to search by name, specialty, procedure or condition; go below under "Find what you need by category" and click on "Medical Doctors & Specialists", "Hospitals and Facilities", "Behavioral Heath", "Urgent Care" or "Alternative Medicine"

Aetna Navigator

As an Aetna Member locate your benefits information online via your Aetna Navigator Account. Log into Aetna Navigator to:

- Request a new ID card or print a temporary ID card
- Search for doctors, facilities and prescriptions
- Check claim status
- View online Explanation of Benefits
- E-mail Aetna Member Services
- Access Aetna wherever you are using their mobile app!



Getting the Care You Need Now

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

When Can I Use Teladoc?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a nonemergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Get The Care You Need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

Talk to a doctor anytime!

1.855.Teladoc (1.855.835.2362)

www.Teladoc.com/Aetna

www.Teladoc.com/mobile

Meet Our Doctors

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standard

Reach For Your Fitness Goals and Get some Cash Back

Gym Reimbursement Program

With the New York fitness reimbursement program you get cash back for certain exercise facility fees or membership fees.

- You can turn in your receipts anytime during the plan year. You get reimbursed quarterly.
- You can get reimbursed up to $200 and your eligible spouse/domestic partner can get reimbursed up to $100 per six-month period for eligible expenses.
- Members need to complete 50 visits within the 6 month period to earn up to $100 (spouse) or $200 (employee) credit. Members can submit proof of 50 visits and payment on aetna.com.

Save on home exercise equipment

Build your home gym with discounts on elliptical trainers, treadmills and strength equipment.

More healthy perks

Getting fit is just the start to a healthier you. You can also try out an at-home weight-loss program. Or get one-on-one health coaching to help you quit smoking, lower stress, lose weight and more.

Medical EPO Plan with Difference Card

This medical plan includes the Difference Card which helps pay for a portion of your out-of-pocket medical costs. Detailed instructions on how to use the Difference Card can be found on pages 10-11.

WHO IS ELIGIBLE? All non-union Employees must work 17.5 standard hours weekly to be eligible for Medical Benefits.

	AETNA PLAN	DIFFERENCE CARD PAYS	YOU PAY
PRIMARY CARE VISIT COPAY	$50 copay	$20 copay	$30 copay
SPECIALIST VISIT COPAY	$70 copay	$20 copay	$50 copay
EMERGENCY ROOM	$200 copay	$50 copay	$150 copay
URGENT CARE	$50 copay	$20 copay	$30 copay
IN-NETWORK DEDUCTIBLE	$4,500 Individual $9,000 Family	$4,000 Individual $8,000 Family	$500 Individual $1,000 Family
IN-NETWORK COINSURANCE	$2,850 Individual $5,700 Family	$2,850 Individual $5,700 Family	$0 Individual $0 Family
IN-NETWORK HOSPITAL Facility Fee	Deductible & Coinsurance	Remaining Deductible & Coinsurance	$250
PHARMACY Generic Preferred Brand Non-Preferred Brand Supply Limit	 $10 copay $25 copay $50 copay 30 Days	N/A	 $10 copay $25 copay $50 copay 30 Days
MAIL ORDER Generic Preferred Brand Non-preferred Brand Supply Limit	 $20 copay $50 copay $100 copay 90 Days	N/A	 $20 copay $50 copay $100 copay 90 Days

2020 BI-WEEKLY COST	
Employee	$81.97
Employee/Spouse	$118.61
Employee/Child(ren)	$109.12
Family	$145.41

Questions? Call the Alliant Benefit Advocates at 877-819-9413

Medical PPO Plan with Difference Card

The PPO option allows for the use of doctors who are both in AND out of the Aetna Network of physicians.

WHO IS ELIGIBLE? All non-union Employees must work 17.5 standard hours weekly to be eligible for Medical Benefits.

	AETNA PLAN	DIFFERENCE CARD PAYS	YOU PAY
PRIMARY CARE VISIT COPAY	$50 copay	$20 copay	$30 copay
SPECIALIST VISIT COPAY	$70 copay	$20 copay	$50 copay
EMERGENCY ROOM	$200 copay	$50 copay	$150 copay
URGENT CARE	$50 copay	$20 copay	$30 copay
IN-NETWORK DEDUCTIBLE	$4,500 Individual $9,000 Family	$4,250 Individual $8,500 Family	$250 Individual $500 Family
IN-NETWORK COINSURANCE	$2,850 Individual $5,700 Family	$2,850 Individual $5,700 Family	$0 Individual $0 Family
IN-NETWORK HOSPITAL Facility fee	Deductible & Coinsurance	Remaining Deductible & Coinsurance	$250
OUT-OF-NETWORK DEDUCTIBLE	$5,500 Individual $11,000 Family	$4,500 Individual $9,000 Family	$1,000 Individual $2,000 Family
OUT-OF-NETWORK COINSURANCE	$9,500 Individual $26,500 Family	$0	$9,500 Individual $26,500 Family
PHARMACY Generic Preferred Brand Non-Preferred Brand Supply Limit	 $10 copay $25 copay $50 copay 30 Days	N/A	 $10 copay $25 copay $50 copay 30 Days
MAIL ORDER Generic Preferred Brand Non-preferred Brand Supply Limit	 $20 copay $50 copay $100 copay 90 Days	N/A	 $20 copay $50 copay $100 copay 90 Days

2020 BI-WEEKLY COST	
Employee	$126.99
Employee/Spouse	$213.19
Employee/Child(ren)	$192.36
Family	$224.69

The Difference Card

Your Medical plans includes two components for your medical benefits. Aetna is your insurance company and processes your claims submitted by your doctors. The Difference Card helps you pay for, or obtain reimbursement for, out-of-pocket expenses you may incur under your Aetna plan, such as copays, deductibles and coinsurance amounts.
In order to obtain reimbursement from the Difference Card for your deductible, and coinsurance, we will collect your EOBs (Explanation of Benefits) from Aetna.

A word about the Difference Card

CenterLight Health System uses the Difference Card for one reason only – **to save you money.** The copay amount on your medical plan is higher for a reason. By using the Difference Card to offset the copay amount, we can purchase a less expensive health benefit and pass along out of pocket savings to you. **CenterLight Health System chooses to manage its health benefit plans in this fashion because we believe that the dollars saved belong in your pocket**.

How to use your Difference Card

Step 1:

If your doctor accepts MasterCard, simply give your Difference Card to the cashier and s/he will swipe it for payment. CenterLight Health System via the Difference Card, pays $20 towards your copay at your Primary Care Physician.

Step 2:

If you are visiting a Specialist's office, you will be asked to pay the remaining copay of $50 (copay amount of $70 is listed on your Aetna Card) using your own credit card, check, cash, or FSA.

If your doctor does not accept credit cards

You will need to pay out-of-pocket using cash or check and then submit your receipt for reimbursement. Reimbursement forms can be obtained from the Difference Card website www.differencecard.com .

Access your Difference Card account online

- Log on to www.differencecard.com
- Your initial Username is you Social Security Number
- Your initial Password is you 8-digit birthday (MMDDYYYY)
- Enter the "scrambled" code and then click on the purple "**Enter**" button
- You'll know you've logged on properly when you see the
- "**Welcome**" prompt at the top right of your screen
- Once you're logged on, click on the "**Participant Portal**" tab on the top of the screen

Detailed Instructions for Using the Difference Card

In-Network Primary Care Physician / Specialist Office Visit / Urgent Care Copays

1. The employee pays his/her portion of the copay to the physician.
2. The employee then presents the Difference Card for the remaining copay amount.
3. If the employee did not bring s/he Difference Card to the physician and/or the physician does not accept credit cards, s/he pays the entire copay and submits the receipt, along with a reimbursement form, to the Difference Card to get the additional copay amount back.

In-Network Deductible / Coinsurance

1. The employee presents his/her insurance card to the hospital/facility.
2. The hospital/facility sends a bill to the insurance carrier.
3. The insurance carrier pays the hospital based on their pre-negotiated rates and contract terms.
4. The insurance carrier sends the employee and the hospital an "Explanation of Benefits" (EOB) statement.
5. The EOB is collected by the Difference Card from Aetna automatically. In the event that the EOB must be submitted manually, the employee submits the EOB, along with a reimbursement form, to the Difference Card. The Difference Card calculates the reimbursement due to the employee.
6. The Difference Card issues a check or direct deposit to the employee for the amount shown on the Difference Card Summary of Benefits.
7. Once the employee receives the check from the Difference Card, the employee pays the balance due to the hospital/facility.

Dental Benefits High Option

CenterLight Health System gives you a choice between two dental plans, a High Option and Low Option PPO utilizing **the PDP Plus Network of Metlife**

WHO IS ELIGIBLE? All non-union Employees must work 17.5 standard hours weekly to be eligible for Dental Benefits.

HIGH OPTION	Metlife PDP Plus Network	
	In-Network	Out-Of-Network
Annual Deductible Individual Family	 $25 $75	 $25 $75
Benefit Maximum Individual (Annual) Orthodontia (Lifetime)	$2,000 $2,000	$2,000 $2,000
Preventative Services Includes: Routine exams & cleanings—two per calendar year X-rays	100% Deductible Waived	100% Deductible Waived
Basic Services Include: Fillings and stainless steel crowns Simple Oral Surgery Endodontics (Root Canal) Denture Repair Periodontal Prophylaxis- if three months have lapsed after active surgical periodontal treatment – Subject to routine cleaning frequency	80% After Deductible	80% After Deductible
Major Services Includes: Complex Oral Surgical procedures General Anesthesia Periodontal Surgical Procedures—once every 36 months per quadrant Crowns Bridges Dentures	50% After Deductible	50% After Deductible
Orthodontic Services Includes: **(child(ren) to age 19)** Orthodontic procedures, including x-rays, diagnostic procedures, fixed & removable Appliances	50% Deductible Waived	50% Deductible Waived

2020 Bi-Weekly Cost	
Single	$22.00
Family	$35.00

Dental Benefits Low Option

The Low PPO Plan also utilizes the **PDP Plus Network of Metlife**

WHO IS ELIGIBLE? All non-union Employees must work 17.5 standard hours weekly to be eligible for Dental Benefits.

LOW OPTION	Metlife PDP Plus Network	
	In-Network	Out-of-Network
Annual Deductible Individual Family	 $50 $150	 $50 $150
Benefit Maximum Individual (Annual) Orthodontia (Lifetime)	$1,500 $1,500	$1,500 $1,500
Preventative Services Includes: Routine exams & cleanings—two per calendar year X-rays	100% Deductible Waived	60% Deductible Waived
Basic Services Include: Fillings and stainless steel crowns Simple Oral Surgery Endodontics (Root Canal) Denture Repair Periodontal Prophylaxis- if three months have lapsed after active surgical periodontal treatment – Subject to routine cleaning frequency	90% After Deductible	60% After Deductible
Major Services Includes: Complex Oral Surgical procedures General Anesthesia Periodontal Surgical Procedures—once every 36 months per quadrant Crowns Bridges Dentures	60% After Deductible	40% After Deductible
Orthodontic Services Includes: **(child(ren) to age 19)** Orthodontic procedures, including x-rays, diagnostic procedures, fixed & removable Appliances	60% Deductible Waived	50% Deductible Waived

2020 Bi-Weekly Cost	
Single	$12.00
Family	$20.00

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. We offer you a vision plan through VSP Life Insurance Company.

WHO IS ELIGIBLE? All non-union Employees must work 17.5 standard hours weekly to be eligible for Vision Benefits.

	VSP Vision Plan	
	In-Network	Out-Of-Network
Examination		
Benefit	$10 copay then plan pays 100%	Reimbursed up to $50
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Prescription Glasses	$25 copay then plan pays 100%	$25 copay then plan pays 100%
Eyeglass Lenses		
Single Vision Lens	$25 copay then plan pays 100%	Reimbursed up to $50
Bifocal Lens	$25 copay then plan pays 100%	Reimbursed up to $75
Trifocal Lens	$25 copay then plan pays 100%	Reimbursed up to $100
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Frames	Up to $120 for a wide selection of frames Up to $140 for featured frame brands	Reimbursed up to $70
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Contacts (Elective)		
Benefit	Reimbursed up to $120	Reimbursed up to $105
Frequency	1 x every 12 months from last date of service	In-network limitations apply

2020 Bi-Weekly Cost	
Single	$5.47
Family	$11.76

MetLaw Legal Care Assistance

MetLaw - Hyatt Legal Plan provides you with access to experienced attorneys and eliminates effort on your end. It's a smart, simple, affordable way to get the legal help you need.

1 Easy to find an attorney

Go to **members.legalplans.com**, or call **800-821-6400** to speak with an experienced service team that can match you with the right attorney and give you a case number.

2 Easy to make an appointment

Call the attorney you select, provide your case number and schedule a time to talk or meet.

3 Easy from start to finish

That's it! There are no copays, deductibles or claims forms when you use a Network Attorney for a covered matter.

When life calls for legal help, MetLaw is there for you.

$7.62 bi-weekly covers you, your spouse and dependents. Telephone and office consultations are available for an unlimited number of personal legal matters with an attorney of your choice.

Money Matters	- Debt Collection Defense - Identity Theft Defense - Negotiations with Creditors	- Personal Bankruptcy - Promissory Notes	- Tax Audit Representation - Tax Collection Defense
Home & Real Estate	- Boundary & Title Disputes - Deeds - Eviction Defense - Foreclosure - Mortgages	- Property Tax Assessment - Refinancing & Home Equity Loans of Primary, Second or Vacation Home	- Sale or Purchase of Primary, Second or Vacation Home - Security Deposit Assistance - Tenant Negotiations - Zoning Applications
Estate Planning	- Codicils - Complex Wills - Healthcare Proxies - Living Wills	- Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	- Revocable & Irrevocable Trusts - Simple Wills
Family & Personal	- Adoption - Affidavits - Conservatorship - Demand Letters - Garnishment Defense - Guardianship	- Immigration Assistance - Juvenile Court Defense, Including Criminal Matters - Name Change - Parental Responsibility Matters - Personal Property Protection	- Prenuptial Agreement - Protection from Domestic Violence - Review of ANY Personal Legal Document - School Hearings
Civil Lawsuits	- Administrative Hearings - Civil Litigation Defense - Incompetency Defense	- Disputes Over Consumer Goods & Services	- Pet Liabilities - Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your Parents: - Deeds - Leases	- Medicaid - Medicare - Notes - Nursing Home Agreements	- Powers of Attorney - Prescription Plans - Wills
Vehicle & Driving	- Defense of Traffic Tickets[1] - Driving Privilege Restoration	- License Suspension Due to DUI	- Repossession
E-Services	- Attorney Locator - Financial Planning	- Insurance Resources - Law Firm E-Panel	- Self-Help Legal Documents - Work/Life Resources

To learn more, visit **info.legalplans.com** and enter access code: **GETLAW**
or call our Client Service Center at **1.800.821.6400** Monday-Friday, 8am-8pm (EST Time).

Ancillary Benefits

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

WHO IS ELIGIBLE? All non-union employees must work at least 26 standard hours weekly to be eligible for Life and Long Term Disability.

Basic Life Insurance

Basic Life Insurance coverage provides important financial protection for your family in the event of your death. CenterLight Health System provides eligible employees with Basic Life Insurance at no cost to you. Coverage is provided by Prudential.

Basic Life Amount	3 x salary up to a Max. of **$1,000,000** for Directors and Above and 1.5 x basic annual earnings rounded to the next higher $1,000, up to a maximum benefit of $500,000 for all others.

Benefit Reduction at age 65: If you have reached age 65, your amount of life insurance will be reduced to 65%, 45% at age 70, 30% at age 75 & 20% at age 80.

Supplemental Life Insurance

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Prudential. You must select Supplemental Life in order to elect coverage for your dependents.

Employee Voluntary Life Amount	You can purchase up to 1x's your annual salary to a maximum of $500,000
Spouse Voluntary Life Amount	You can purchase either $10,000 OR $20,000
Child(ren) Voluntary Life Amount	Up to age 25, if full time student– You can purchase either $2,000 or $10,000

Payroll Deductions: You pay 100% of the cost for coverage, which will be deducted from your paycheck on a post-tax basis.

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Evidence of Insurability: Any amount requested above $150,000 requires proof of good health. Evidence of Insurability (EOI) is also required for all elections and changes during annual open enrollment. An Evidence of Insurability form involves providing the insurance company with additional information about your health.

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck.

Ancillary Benefits Continued

Short-Term Disability Insurance

Short-Term Disability coverage pays you a certain percentage of your income if you can't work because a non-work related injury, illness, or maternity leave. Benefits begin on the 8th day of a sickness or accident. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition.

CenterLight provides this benefit to employees at no cost. Accordingly, any benefits received will be considered taxable to you. ***Employees must exhaust all sick balances**

Short Term Disability Benefits:

Monthly Benefit Amount	Plan pays 66 2/3% of gross weekly base earnings
Maximum Weekly Benefit	$1,000 (Coverage varies for Director and above)
Benefits Begin After:	7 Days
New Hire Eligibility	After 30 day waiting period

Long-Term Disability Insurance

Basic Long Term Disability (LTD) provides income replacement if you become disabled and are unable to work. LTD benefits begin after you have been disabled for 180 days due to injury/sickness. The LTD plan works together with other sources of disability income (for example, Social Security) to replace a portion of your earnings.

CenterLight provides this benefit to all eligible employees at no cost. Accordingly, any benefits received will be considered taxable income to you. **Note, you may elect to pay the cost of the Basic LTD, which will result in a tax free benefit.**

Long-Term Disability Continued

Long Term Disability Benefits:

Monthly Benefit Amount	Plan pays 60% of gross monthly base earnings (may be reduced by other income)
Maximum Monthly Benefit	$7,000
Benefits Begin After:	
Accident	180 days of disability
Sickness	180 days of disability

In addition, if you make $140,000 or more, you have the option to purchase Supplemental Long Term Disability Coverage. By Electing LTD you can increase your monthly benefit to a maximum of $15,000. You will pay 100% of the cost for the benefit above basic coverage offered by CenterLight Health System. Accordingly, any benefits received in addition to the basic benefits will be tax free income to you.

Maximum LTD Benefit Period

Age At Disability	Benefit Period
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69	12 months

Cost of Supplemental Life & Disability

Voluntary Life Step Rates

AGE	2020 MONTHLY COST (EMPLOYEE)	AGE	2020 MONTHLY COST (EMPLOYEE)
<20 - 34	$0.0540	55 - 59	$0.6030
35 - 39	$0.0810	60 - 64	$0.9360
40 - 44	$0.1350	65 - 69	$1.6830
45 - 49	$0.2340	70 - 74	$3.0060
50- 54	$0.3870		

- Voluntary Life Rates are 100% employee paid.
- Rates are based on per $1,000 of insurance coverage.
- You MUST elect Supplemental Employee Life Coverage in order to elect coverage for your dependents.

Voluntary Dependent Life

	FAMILY OPTIONS	MONTHLY COST
Option 1	Spouse/Dependent Child $10,000/$2,000	$2.241
Option 2	Spouse/Dependent Child $10,000/$10,000	$4.041
Option 3	Spouse/Dependent Child $20,000/$2,000	$4.500
Option 4	Spouse/Dependent Child $20,000/$10,000	$6.300
Option 5	Child(ren) $5,000	$0.900
Option 6	Child(ren) $10,000	$1.800

Long Term Disability Rates

	2020 MONTHLY COST
Core	$0.353 per $100
Buy-Up	$0.353 per $100

- LTD is provided at no cost to you, however, the benefit will be taxed.
- If you elect to pay for LTD, your disability payment will be tax free.
- The LTD benefit maxes out at a salary of $140,000
- **You must have an annual salary of at least $140,000 to be eligible for Supplemental LTD Insurance.**

Flexible Spending Account

CenterLight Health System Flexible Spending Accounts program is an Internal Revenue Code (IRC), Section 125 plan. This program allows for the dollars you spend on certain expenses incurred throughout the year to be exempt from taxes. The program is comprised of two separate benefits Health Care FSA and Dependent Care FSA.

Health Care FSA

This option allows the member to use pre-tax earnings to pay for certain incurred medical, dental, and vision expenses allowed by the IRS but not reimbursed by an insurance provider. Insurance premiums are not reimbursable expenses in an FSA.

Eligible Medical Services

Medical Services for which you can use your Health Care FSA include:

Acupuncture	Body Scans	Fertility Treatment	Nursing Services
Alcoholism Treatment	Breastfeeding Classes	Immunizations	Optometrist/Eye Exam
Ambulance	Chiropractic Care	Lasik	Primary/Specialist copay
Anesthesia	Drug Addiction Treatment	Mastectomy Bras	Psychiatric Care

You can view a more comprehensive list on www.fsafeds.com Attached in the appendix (pg. 29) is a copy of the claim form.

Dependent Care FSA

This option allows the member to use pretax earnings to pay for work related child care or adult care expenses. (Children must be under the age of 13 for child care expenses.)

Eligible Expenses for Dependent Care FSA

Expense for which you can use your Dependent Care FSA include:

Adult Day Care	Child Care	Elder Care	Preschool
After School Program	Custodial Elder Care	Extended Care	Senior Day Care
Au pair	Day Camp	Nanny	Sick Child Care

You can view a more comprehensive list on www.fsafeds.com Attached in the Appendix (pg. 31) is a copy of the claim form.

Eligible & Ineligible OTC Expenses

It can be confusing to figure out which are eligible and ineligible FSA expenses. When it comes to **Over the Counter (OTC) Medical Supplies** you can use your FSA to purchases items such as:

Birth Control Products	Contact Lens Solutions	Hearing Aid Batteries	Pre-Natal Vitamins
Breast Pumps	First Aid Supplies	Heating Pads	Sunscreen
Lactation Supplies	Health Monitors	Insulin & Diabetic Supplies	Supports/Braces

You are allowed to expense certain **OTC Medications** as long as you have a prescription. Some of the medications that you can expense are:

Acne Medication	Cough, Cold & Flu remedies	Motion Sickness Pills	Smoking Cessation
Allergy & Sinus Medication	Diaper Rash Ointments	Nasal Sprays for Congestion	Wart Removers
Anti-Fungal Medication	First Aid Creams	Pain relievers (Tylenol, Advil)	Yeast Infection Creams

Flexible Spending Account Continued

Ineligible OTC FSA expenses that are commonly thought of being eligible are:

Baby Diapers	Hair Removal Products	Mouthwashes	Teeth Whitening Product
Cosmetics	Insect Repellants	Sport Energy Liquids, bars	Toothpaste
Deodorants, Shampoos	Lip Balms	Stay Awake Aids	Wrinkle Reducers

You can see the complete list with this link from the fsastore.com

Other Reimbursements

You can also use your Medical FSA to pay for transportation expenses required for eligible medical care. You can expense mileage, tolls and parking fees as long as they're accompanied by a receipt showing the provider, date of service and amount of the expense. The actual mileage incurred is reimbursed at 20 cents per mile. Attached in the Appendix (pg. 32) is a copy of the claim form.

Tax Savings

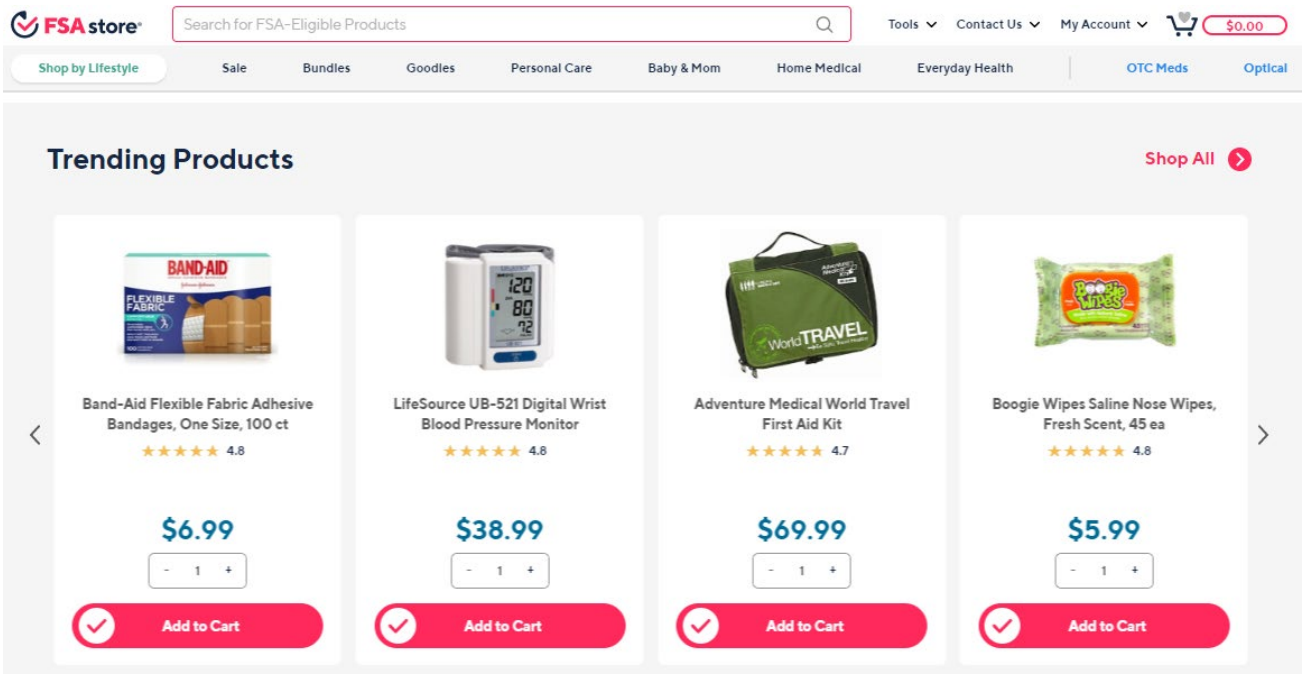
Payment on a pretax basis means that you reduce your taxable income by the amounts elected for either of the flexible spending accounts. This means that you do not pay federal, state income taxes or social security taxes on these amounts.

This saves you:

- 15% - 30% on Federal taxes
- 2% - 8% on State taxes
- 7.65% on FICA (Social Security) taxes

FSA Store

You can also purchase FSA eligible OTC medication and items online with www.fsastore.com
You can create an account and use your FSA account to purchase items that eligible and prescribed OTC medication.



Flexible Spending Account Continued

Grace Period

The grace period is an extension of time for active participants to spend down any money they have in their FSA that they haven't used during the plan year. During the grace period participants may incur qualified expenses and be reimbursed from the previous year's unused FSA funds. Participants have a two and a half month grace period at the end of the plan year to incur health and dependent claims (until March 15, 2021). After the two and a half months, participants have until March 31st to submit a paper claim for reimbursement of eligible expenses. **You will not be eligible to use your card during the grace period for prior year funds**. Claims submitted during the grace period must be done through submission of claim forms.

Debit Card

As an added convenience, employee participants may choose to have access to the funds in their **Health Care FSA** by using the Beniversal Debit Card. The flex card is not just another credit card. It's a card that provides instant access to the pre-tax funds available in your FSA. This allows employee participants to avoid paying cash for services (in addition to your payroll deduction), completing and submitting a claim form, and waiting for a reimbursement check. Employee Participants can use the debit card to pay for eligible expenses wherever MasterCard ® is accepted – from physician and dental offices to pharmacies and vision service locations. The use of the card is subject to IRS rules. Be sure to save your receipts! Independent Health Administrators or the IRS could request documentation for any claim to be substantiated. An enrollment agreement must be submitted to Human Resources for processing.

Dependent Care Reimbursement Account is managed through a paper process. Claims reimbursement for the Dependent Care Account will be through submission of claim forms, with receipts, directly to the Administrator of our Flexible Spending Plans, Benefit Resources Inc. (BRI). BRI will process reimbursements on a weekly basis via paper checks mailed to your home or via direct deposit according to your instructions.

All claims must be submitted by March 31, 2021.

CONTRIBUTION LIMITS	
ANNUAL CONTRIBUTIONS PROGRAM	MAXIMUM
Health Care FSA	$2,750
Dependent Care FSA	$5,000

Qualified Transit Program

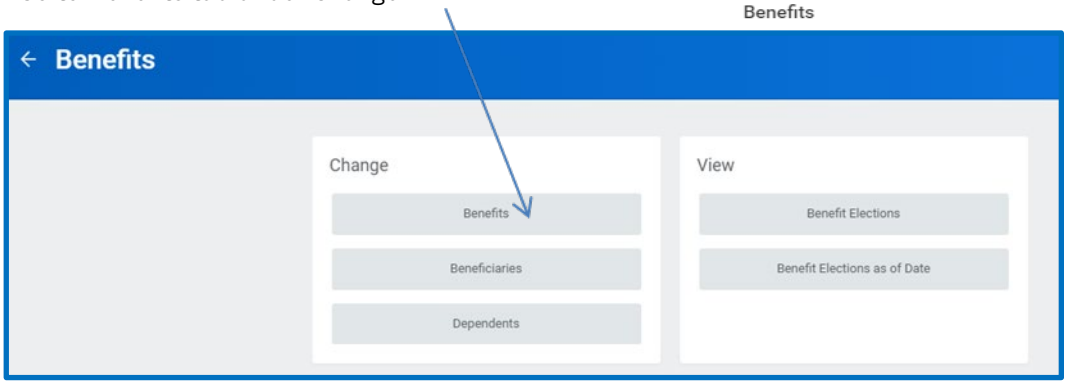
CenterLight will continue to offer "Qualified Transit Program" Plan through BRI. This plan allows an employee to use payroll deductions taken on a pre-tax basis to pay for qualified workplace mass transit expenses.

Benefit Resource will administer your Qualified Transit Program, which offers:

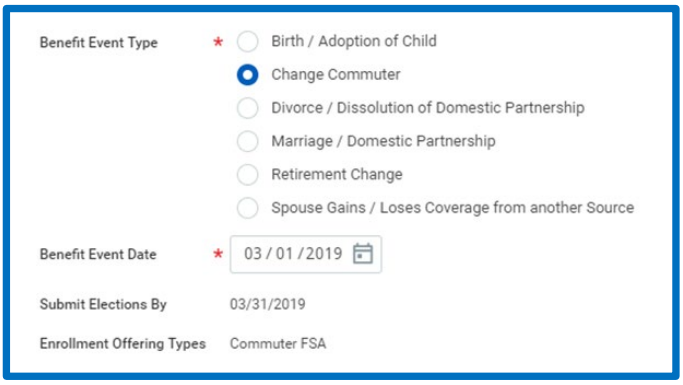
- Flexibility for on-line changes to monthly transit amounts in your Workday account
- Use of a e-TRAC® MasterCard for transit programs
- Continued use of paper reimbursement for transit expenses when necessary
- The monthly tax-free maximum amount is limited by the IRS. You can set aside up to $135 Biweekly election, up to a maximum of $270 tax-free for mass transit. These amounts do change from time to time

Employees will need to enroll in your Qualified Transit Program online. Follow the steps below to complete your web enrollment:

1. Find the Benefits icon on your homepage in Workday
2. Go to Benefits tab under Change



3. Select "Change Commuter" and "Start Date"
4. Select "Submit" at the bottom
5. Follow the instructions on the screen then select "Continue"
6. Review Coverage Begin Date and Employee Cost
7. Read Legal Notice and select "I agree"
8. Select "Submit" to complete elections
9. You may print a copy for your records



Additional Benefits

Guidance Resource Program

No matter what's going on in your life, GuidanceResources® is here to help. Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a no-cost, company-sponsored benefit that is available to you and your dependents to provide confidential support, resources and information to get through life's challenges.

Employee Assistance Program (EAP)

An Employee Assistance Program (EAP) is a confidential counseling service to help address the personal issues you are facing. This service, staffed by experienced clinicians, is available by calling a toll-free phone line 24 hours a day, seven days a week. A Guidance Consultant is available to listen to your concerns and refer you to a local provider for in person counseling or to resources in your community. Call any time with personal concerns, including, but not limited to:

- Depression
- Alcohol & Substance Abuse
- Grief & Loss

Financial Information, Resources and Tools

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Getting out of debt
- Tax Pressures
- Retirement planning

Call GuidanceResource at
1-800-311-4327
Or go to www.guidanceresources.com
And enter your company Web ID: GEN311
Let our experts work for you!

Metlife Auto & Home Insurance

MetLife Auto & Home is a New Benefit which is here to provide the personal touch you expect when addressing your insurance needs. You will have generous discounts and unique features available on personal insurance products, including but not limited to:

- Automobile
- Renters
- Personal Excess Liability
- Homeowners

Look out for additional announcements and information which will be mailed directly to your home address.

Customer Service
1-800-438-6388
MetLife Auto & Home mobile app now available in the App Store

Your Benefit Advocate Team

Who are the Benefit Advocates at Alliant Employee Benefits?
Benefit Advocates are highly-trained professionals with extensive insurance industry experience who are available to assist you with your benefit needs.

Benefit Advocates can assist with:
- Insurance claims questions
- Denied claim appeals
- Benefit questions or clarifications
- Prescription problems
- Flexible Spending Account and Dependent Care Flexible Spending Account questions
- COBRA inquiries

When you contact your Benefit Advocate for assistance, please provide the following information:
- Member ID Number or Social Security Number
- Date of Birth
- Employer's Name
- Itemized bill of service from your provider or an explanation of benefits (EOB) from the carrier

Benefit Advocates are available to assist you Monday through Friday, 8:00 am to 5:00 pm ET. All calls are kept confidential and are tracked and monitored to resolution. Benefit Advocates work with an interpretation service that supports 125 different languages. If you need this service, please be prepared to tell the Benefit Advocate what language you need when you call.

Call Your Benefit Advocates: (877) 819-9413

Available: Monday – Friday / 8:00am – 5:00pm
All calls are confidential, and are monitored to resolution. If you leave a message, you will receive an answer before close of business the following day. For your convenience, you can also send an e-mail to **benefithelpteam@alliant.com**

Steps to Enroll in Your Benefits

View Your Benefit Elections Live in Workday. Available 24 hours a day / 7 days a week.

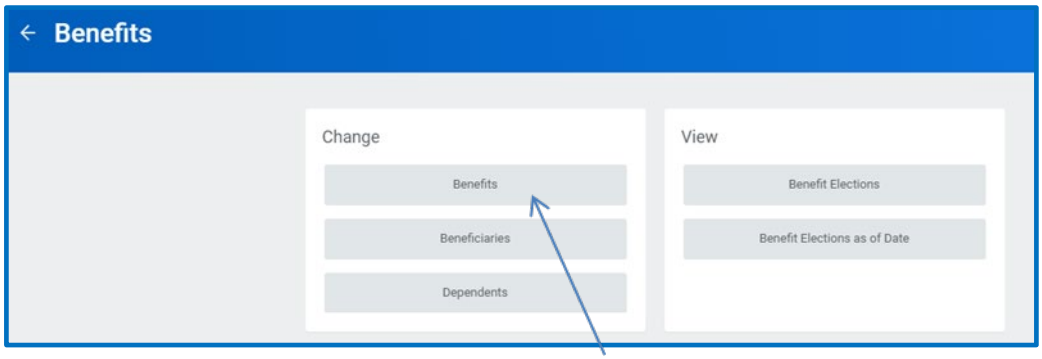
Log into Workday: https://wd5.myworkday.com/centerlight

Username: Your 6 digit CL ID **Password**: Same password used for Workday

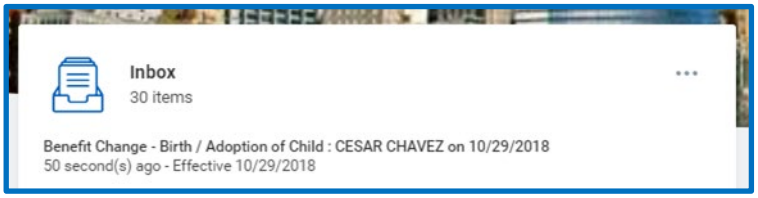
- Make benefit changes throughout the year if you experience a Qualified Life Event
- Enroll in benefits for the first time if you are a New Hire
- Contact IT HELP Desk at 913-945-4737 and/or email at centerlight@ihs911.com or HRBenefitsOps@centerlight.org with questions regarding the self-service portal

Find the Benefits icon on your home page:

You can view Benefit Elections or make changes for a Qualified Life Event (birth, marriage, and divorce). You can also add, edit or delete dependents and beneficiaries.



To make changes for a Qualified Life Event select Benefits tab under "Change". You will receive this type of inbox item to elect Benefits. Follow the benefit election instructions on each screen.



For **New Hires / Open Enrollment,** you will automatically receive an inbox item to elect Benefits. Follow the Benefit election instructions on the screens. **New Hire** deadline is 10 business days after your hire date.

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Annual Notices

SPECIAL ENROLLMENT RIGHTS (HIPAA)
If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

NO GUARANTEE ON TAX CONSEQUENCES
Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of an Employee under any Plan will be excludable from the Employee's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Employee. An Employee shall indemnify and reimburse the Company for any liability it may incur for failure to withhold federal or state income tax or social security tax from such payments or reimbursements.

NEWBORNS & MOTHERS HEALTH PROTECTION ACT
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MICHELLE'S LAW
Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.
The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan.

Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)
Federal law imposes certain requirements on employee benefit plans voluntarily established and maintained by employers. [29 USC §1001 et seq.; 29 CFR 2509 et. seq.] ERISA covers two (2) general types of plans: retirement plans, and welfare benefit plans designed to provide health benefits, scholarship funds, and other employee benefits. As a participant, you are entitled to certain rights & protections under ERISA.
•Examine, without charge, at the office of the Administrator and at other specified locations, such as worksites, all Plan documents and copies of all documents filed by the Plan with the US Department of Labor, such as detailed annual reports and Plan descriptions.
• Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
• Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
• Obtain a statement telling you whether you have a right to receive a benefit at normal retirement age and, if so, what your benefit would be at normal retirement age if you stopped working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing, and no one is required to give such a statement more than once a year. The Administrator must provide the statement free of charge.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to run the Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire your or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you may take to enforce your rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you win the suit, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – for example, if it finds that your claim is frivolous. If you have any questions about the Plan, you should contact the plan administrator at your Human Resources Department. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of labor, listed in your telephone directory or the or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE
Written notice stating whether or not the expected amount of paid claims under a group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the standard drug benefit under Medicare Part D. Must be sent to participants and beneficiaries eligible for Medicare Part D. The notice must be provided by (1) October 15th each year; (2) prior to an individual's individual enrollment period for Part D; (3) prior to the effective date of coverage for any Part D eligible individual who enrolls in the employer's prescription drug coverage; (4) when the plan no longer provides drug coverage or when the coverage is no longer creditable; and (5) upon request.

JANET'S LAW WOMEN'S HEALTH AND CANCER RIGHT'S ACT OF 1998
On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As required by this law, annual notice of the mandated post- mastectomy benefits must be provided to all covered persons. Please review this information carefully. If your spouse is covered under a health plan sponsored by your employer, please make certain that she or he also has the opportunity to review this information. The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:
• Reconstruction of the breast on which the mastectomy has been performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
• Prostheses and coverage for any complications in all stages of mastectomy, including lymphedemas.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided under the plan. The coverage may be subject to annual deductibles and coinsurance provisions. The Act prohibits any group health plan from:

Annual Notices Continued

• Denying a participant or a beneficiary eligibility to enroll or renew coverage under the plan in order to avoid the requirements of the Act;

• Penalizing, reducing, or limiting reimbursement to the attending provider (e.g., physician, clinic or hospital) to induce the provider to provide care consistent with the Act; and Providing monetary

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances: The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.

• The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

HIPAA INFORMATION NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer recognizes your right to privacy in matters related to the disclosure of health related information. The Notice of privacy Practices (provided to you upon your enrollment in the health plan) details the steps your employer has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this Notice is available to you at any time, free of charge, by request through your local Human Resources Department.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for preexisting conditions except for service-connected injuries or illnesses.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited circumstances.

CAN CHILDREN STAY ON A PARENT'S PLAN UNTIL AGE 26?

If a plan covers children, they can be added or kept on the health insurance policy until they turn 26 years old.

Children can join or remain on a plan even if they are:

• married
• not living with their parents
• attending school
• not financially dependent on their parents
• eligible to enroll in their employer's plan

HOW TO GET COVERAGE FOR ADULT CHILDREN

Adult child may be enrolled during a plan's open enrollment period or during other special enrollment opportunities. The employer or insurance company can provide details. Under-26-year-olds can be signed up directly in new Marketplace plans. Be sure to include him or her on the list of people to be covered.

Appendix

FSA Reimbursement Claim Form. You can download additional copies with this link: https://forms.benefitresource.com/fsa-hra-claim-form.pdf

FSA/HRA REIMBURSEMENT CLAIM FORM *(Please Print Clearly)*

Want your reimbursement faster? File your claim online via the employee portal (www.BRiWeb.com) or via the BRiMobile app, if allowed by your plan.

PART 1	PART 2 ☐ *Check here if address has changed and provide new information below.*
Employee Name:	**Street or PO Box:**
Member ID:	**City:**
Employer:	**State:** **Zip Code:**

PART 3

Provider & Service Rendered/Item Purchased	Date(s) of Service	*First & Last Name of Person Receiving Service (HRA Only)	*Relationship (HRA Only)	*Date of Birth (HRA Only)	Amount	*For Office Use Only*
				TOTAL =	0.00	

Submit claim by:

Fax: (585) 427-9320

or

Mail: ATTN: Claims Department
Benefit Resource, Inc.
245 Kenneth Drive
Rochester NY 14623-4277

BRi Benefit Resource, Inc.

Sign Here

Signature Required: _____ *Date:* _____

Employee Certification: By signing the above, I request reimbursement for Medical and/or Dependent Care expenses listed above. Enclosed are itemized bills, receipts or EOBs verifying these expenses. Each expense listed is for a service/item provided to me or a qualifying individual, has not been purchased with a Beniversal® Prepaid Mastercard®, and will not be reimbursed from any other source. Medical expenses were incurred only for an immediate medical purpose. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and cannot be claimed as deductions on my personal income tax.

**Effective for plan years that begin on or after January 1, 2017, reimbursement of eligible expenses from your HRA can only be for you, your spouse and/or your eligible dependents who are covered under a group health insurance plan as outlined in your Plan Highlights. For example:*

- *if your HRA plan year begins January 1, 2017 and your Plan Highlights indicate that expenses must be provided to you, your spouse or eligible dependents who are covered by a group health insurance plan, then you can be reimbursed only for eligible services provided on/after January 1, 2017 for qualifying individuals.*
- *if your HRA plan year begins June 1, 2017 and your Plan Highlights indicate that expenses must be provided to you, your spouse or eligible dependents who are covered by a group health insurance plan, then you can be reimbursed only for eligible services provided on/after January 1, 2017 for qualifying individuals.*

The following information is required:

Relationship: Complete this column using Self, Spouse or Dependent.
Qualifying individual's date of birth.

See page 2 for important information on completing and submitting this form.

FSA Reimbursement Claim Form. You can download additional copies with this link: https://forms.benefitresource.com/fsa-hra-claim-form.pdf

FSA/HRA REIMBURSEMENT CLAIM FORM *(continued)*

INSTRUCTIONS FOR COMPLETING YOUR CLAIM:

1. Part 1 of the claim form *must* be completed in full.
2. Part 2 of the claim form should only be completed if your address has changed.
3. Part 3 of the claim form ***must*** be completed in full.
4. For each item you are claiming in Part 3, you must attach a copy of itemized bills, statements, receipts or insurance company Explanation of Benefits (EOBs). This documentation from your provider *must* include the following information *(please retain originals for your personal records)*.
   • Name of provider • Your out-of-pocket cost for the service • Type of service provided • Date(s) service was provided • Name of person receiving the service
   Credit or debit card information should not be included.
5. IRS regulations require additional documentation for the following:
   • Effective 01/01/2011, over-the-counter drugs and medicines require a prescription.
   • Dual purpose items require a Certification of Medical Necessity form (*can be obtained from the Benefit Resource website)*.
6. The claim form ***must*** be signed and dated after reading the Employee Certification.
7. Submit the completed claim form and all related documentation to: **Fax: (585) 427-9320 or ATTN: Claims Department**
   Benefit Resource, Inc.
   245 Kenneth Drive
   Rochester NY 14623-4277

CLAIM SUBMISSION REMINDERS:

- Credit card statements, cancelled checks and balance forward/prior balance statements *are not* acceptable.
- The service being claimed must be provided to you or a qualifying individual within the time frame indicated in your Plan Highlights.
- In general, IRS regulations do not require that you pay for a service before requesting reimbursement. A request for reimbursement must be based on the date when the service was provided, not the date when a payment was made. (The IRS allows one exception: orthodontia expenses can be based on date of payment, date of service or payment due date on statements/coupons.)
- Claims must be submitted *after* a service is provided, but *before* the end of the run-out period following the end of your plan year.
- Claims must be received by Benefit Resource, Inc. within the time frames specified in the Plan Highlights.
- An expense paid with the Beniversal Card or that has been reimbursed from any other source cannot be submitted for reimbursement.
- Items on a claim form or supporting documentation should never be highlighted since highlighted items can be hard to read. Credit or debit card information should not be included.

SOME EXPENSES THAT ARE *NOT* ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT INCLUDE:

- Personal care items (e.g. shampoo, soap, electric toothbrush, toothpaste, mouthwash)
- Teeth whitening
- Insurance premiums

SOME EXPENSES ARE *ONLY* ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT IF CERTIFIED BY A LICENSED MEDICAL PROVIDER AS PREVENTING, TREATING, OR MITIGATING A SPECIFIC PHYSICAL DEFECT OR ILLNESS:

- Cosmetic services
- Vitamins
- Non-prescription sunglasses
- Exercise and weight loss programs

BRi Benefit Resource, Inc.
Phone: (800) 473-9595
Website: www.BenefitResource.com

Appendix

Dependent Care FSA Reimbursement Claim Form. You can download additional copies with this link: https://forms.benefitresource.com/dependent_care_receipt.pdf

STATEMENT OF DEPENDENT CARE EXPENSE

Submit this form, along with a completed claim form, to Benefit Resource, Inc.

Name of Employee *(please print clearly)*: _____ Date: _____

Dependent care services were provided for _____

by _____

for services provided on the dates ____/____/_____ through ____/____/_____.

Cost of these services: $ _____

_____ _____

Name of Provider (please print clearly) *Provider Signature*

(separate here)

STATEMENT OF DEPENDENT CARE EXPENSE

Submit this form, along with a completed claim form, to Benefit Resource, Inc.

Name of Employee *(please print clearly)*: _____ Date: _____

Dependent care services were provided for _____

by _____

for services provided on the dates ____/____/_____ through ____/____/_____.

Cost of these services: $ _____

_____ _____

Name of Provider (please print clearly) *Provider Signature*

Appendix

FSA Mileage Reimbursement Claim Form. You can download additional copies with this link: https://forms.benefitresource.com/mileage-log.pdf

BRi Benefit Resource, Inc.

Mileage Expense Certification Log

You may use this form to itemize mileage expenses necessary to obtain eligible medical care.

Please note: the total from this page must be transferred to a completed and signed claim form and this Mileage Log must be submitted with your claim form as supporting documentation.

Name of provider of eligible medical service/ Where service was provided	Reason for/type of service	Date(s) of service	# of round trip miles traveled	Mileage expense*
***Total** (transfer this total to your claim form and submit log with your claim form)*				0.00

** The mileage rate for services provided:*
- *on or after 1/1/2020: 17 cents x # of miles.*
- *from 1/1/2019 - 12/31/2019: 20 cents x # of miles.*

I hereby certify that an amount equal to the amount set forth above was expended by me on the dates set forth above for mileage expenses incurred while traveling to/from a provider of eligible medical services.

Employee Name: _____ ***Member ID:*** _____
(Please print clearly)

Name of Employer: _____
(Please print clearly)

Employee Signature: _____ ***Date:*** _____

Notes

Notes

Notes


CenterLight
Health System