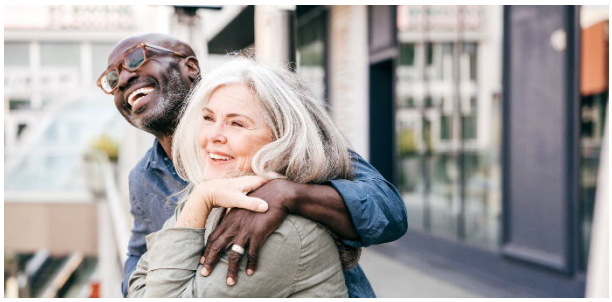
# The choice is yours.

2021



Benefits decision guide

GAUMER PROCESS®

Gaumer Process is pleased to offer a wide selection of benefits that offer you flexibility, choice, and the ability to take charge of your benefits spending. Please see below for information on eligibility, changes, enrollment and what is inside the benefit decision guide.

## Who is Eligible…

**Employees**: Full-time employees of Gaumer Process working 30 or more hours per week that have satisfied the waiting period (first of the month following thirty (30) days of service) are eligible to enroll in the benefits described in this guide.

**Legal spouse:** Your legal spouse is eligible to enroll in medical, dental, vision, and employee paid life insurance.

**Dependent Children**: Dependent children to age 26 are eligible for medical, dental, vision, and employee paid life insurance. Dependent children over the age of 26 who are incapable of self-support due to physical or mental disability, if they became disabled while an otherwise eligible dependent.

## When to make changes…

Unless you have a qualified change in status, you cannot make changes to the benefits you elect that are pre-taxed until the next open enrollment period. Your pre-taxed benefits are Medical, Dental and Vision. All other benefits may be changed at any time with proper notification to HR. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of a legal spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your legal spouse, commencement or termination of adoption proceedings, or change in legal spouse's benefits or employment status. **Please contact Human Resources within 30 days of the change in status to make benefit changes.**

## When to enroll…

The benefits you elect during annual open enrollment will be effective January 1, 2021. For annual open enrollment, the annual open enrollment period occurs within three (3) months prior to the January 1 effective date.

For new hire enrollments, the enrollment period will be communicated based on the employee's hire date. Elections MUST be completed **NO LATER THAN** the assigned deadline.

## What is inside your Group Benefits Decision Guide:



*If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Creditable Prescription Drug Coverage and Medicare Notice in the Legal Notices at the back of this booklet for more details.*

# Contacts

| BENEFIT | ADMINISTRATOR | PHONE NUMBER | WEBSITE<br>MOBILE APP |
|---|---|---|---|
| Medical and Prescription | Aetna | 888-416-2277 | www.aetna.com |
| Telahealth | Teledoc<br>Offered to Aetna medical participants only | 1-855-Teladoc (835-2362) | www.teladoc.com/Aetna |
| Dental | Delta Dental of TN | 800-223-3104 | www.DeltaDentalTN.com |
| Vision | VSP | 800-877-7195 | www.vsp.com |
| Term Life Insurance/ Accidental Death & Dismemberment | UnitedHealthcare | 866-615-8727<br><br>Employee Assistance Program: 866-302-4480 | www.myuhc.com |

# Medical and Prescription Drug Coverage

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured. The medical plans available to you include a range of coverage levels and costs, giving you the flexibility to select the plan that is right for you. You will find a summary of each of the plans in this guide.

**It's the law!**

As part of the Affordable Care Act, most Americans must have medical insurance. Be sure you are covered, either through your employer-sponsored plan or through another option available to you, such as your spouse's employer benefits or a government program such as Medicare or Medicaid.

## Affordable Care Act (ACA)

The medical plans offered meet the Affordable Care Act (ACA) Minimum Value and Affordability standards.

## Member Website: Aetna Navigator

Aetna Navigator is your secure member website that puts all of your plan information and cost-saving tools in one place. By logging into www.aetna.com you will be able to:

- Find doctors, dentists, pharmacies, and hospitals
- Get an ID card
- Look up a claim
- Check your coverage
- Keep track of health care costs
- Have medicines you take every day sent to your home
- Get a summary of your doctor visits, medical tests, prescriptions, and other health activities
- Print records of preventive shots and checkups
- Complete a Health Assessment
- Access Aetna's virtual assistant, Ann, to help you navigate www.aetna.com

It is easy to get started!
New Members: Go to www.aetna.com and select "Register now."
Already signed up for Aetna Navigator? Log in now to take advantage of the features and tools.

## Aetna Features and Programs available to make your life easier – and healthier

**Informed Health Line**: 24 hour access to a registered nurse at no extra cost.

**Aetna Discount Program**: Access to fitness, hearing, weight management, natural products and services, and vision discounts.

**Member Payment Estimator**: Free online tool lets members estimate out of pocket healthcare expenses and compare costs.

**Aetna Rx Home Delivery Mail Order Pharmacy**

**Teladoc**

**Aetna Health App:** text "AETNA to 90156 to download. Note data rates may apply.

# Medical and Prescription Drug Coverage

## Before you choose your benefits, think about…

- How much health care – and what type of care – did you need this year?
- Do you expect your needs to be similar next year? Do you foresee changes?
- Do you prefer to pay less from your paycheck and more out of your pocket when you need care, or more from your paycheck and less out of your pocket when you need care?

## Key Words to Know:

Below are general examples of key words to know and are not a guarantee of coverage. Check your Plan Documents and Benefit Summaries to confirm covered benefits.

**Copay:** An amount you pay for a covered service each time you use that service. It does not apply toward the deductible.

**Deductible:** The amount you pay before the plan begins to pay.

**Out-of-Pocket Costs:** Expenses you pay yourself, such as deductibles, copays, coinsurance, and non-covered services.

**Out-of-Pocket Maximum:** The maximum amount you pay for covered services in a year (you may need to pay additional amounts if coverage is received from an out-of-network provider).

**Coinsurance:** Percentage of the charge that your plan will pay, typically after you have met the deductible.

**HDHP:** High Deductible Health Plan.

## In-Network vs. Out-of-Network

You have the option to see any provider you choose. However, you will save money when receiving care from an in-network provider. To access a list of in-network providers register for your secure Aetna Navigator website. Once you do, you will get a personalized version of DocFind. Each time you sign on, your plan name and zip code are already filled in. That makes your search even easier! If you are not an Aetna member, go to www.aetna.com. Click on "Find a Doctor." If you would like a paper directory, just call the toll-free Member Services number on your member ID card and request the directory. If you are not yet a member, call 1-888-87-AETNA (1-888-872-3862).

**How to find a Network Provider**

1. Go to www.aetna.com
2. Under "***Quick Links***", Click "***Find a Doctor***"
3. Under '***Continue as Guest***', enter zip code and radius, then click search
4. When prompted to ***Select a Plan*** from the dropdown menu, choose Aetna Open Access Plans > ***Managed Choice POS (Open Access)*** click continue
5. From there it is possible to search for providers and hospitals by name or category

## Prescription Drug Tiers

| TIER | YOU PAY | WHAT'S COVERED |
|---|---|---|
| 1 | Lowest Cost Sharing | **Most Generic Prescription Drugs**<br>Generic prescription drugs use the same active ingredients as brand-name prescription drugs and work the same way. Generic drugs are equivalent to a brand product in dosage form, strength, quality, and intended use. |
| 2 | Second Lowest Cost Sharing | **Preferred Brand Name Drugs**<br>Drugs sold under a specific trade name that are favorably priced by the pharmacy plan. |
| 3 | Highest Cost Sharing | **Non-Preferred Brand Name Drugs (some generics included)**<br>Drugs sold under a specific trade name that have a reasonable, more cost-effective alternative on Tier 1 or Tier 2. |

# Medical and Prescription Drug Coverage

## *Aetna*

Network: Open Access Managed Choice (OAMC) POS is *the largest Aetna provider network for your state.*

## MEDICAL PLAN SUMMARY

| | Buy Up Plan: $1,500 Deductible TX19 OAMC 1500 | | Base Plan: $5,000 Deductible TX19 OAMC 5000 | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **In-Network** | | | | |
| Individual/Family Deductible | $1,500 / $3,000 | $3,000 / $9,000 | $5,000 / $10,000 | $10,000 / $30,000 |
| Member Coinsurance | 20% | 50% | 30% | 50% |
| *Individual/Family Out-of-Pocket Max | $5,000 / $10,000 | $10,000 / $30,000 | $6,600 / $13,200 | $13,000 / $39,000 |
| Office Visit (Primary Care/Specialist) | $30 / $50 Copay | You pay 50% after deductible | $40 / $70 Copay | You pay 50% after deductible |
| Urgent Care | $75 Copay | You pay 50% after deductible | | |
| Preventive Doctor's Visit | Covered at 100%, deductible waived | You pay 50% after deductible | Covered at 100%, deductible waived | You pay 40% after deductible |
| **Retail Prescriptions** | | | | |
| Value Drugs Tier 1A | $3 Copay | 30% of allowed cost after applicable copay | $3 Copay | 30% of allowed cost after applicable copay |
| Preferred Generic Drugs | $10 Copay | | $10 Copay | |
| Preferred Brand Drugs | $35 Copay | | $35 Copay | |
| Non-Preferred Drugs Generic / Brand | $70 Copay | | $70 Copay | |
| Specialty Drugs | $150 Copay ($300 for mail-order) | | $150 Copay ($300 for mail-order) | |
| Mail Order Prescriptions | 2.5X Copay | | | |

*Includes deductible, coinsurance, copays.

** Copays apply after deductible is satisfied. Please note, if the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Note: In-Network facilities may have Out-of-Network providers, so balance billing may apply

**Helpful information about Deductibles and Out-of-Pocket Maximums**

For either medical plan, if you cover any family member(s) in addition to yourself:

Once one family member meets the Individual Deductible, benefits begin to be paid for that individual.

Once one family member meets the Individual Out-of-Pocket Maximum, the plan pays covered benefits in full for that individual.

This chart highlights some of the plan provisions. For a more detailed listing of benefits, please refer to your Summary of Benefits and Coverage or your Certificate of Coverage.

# Medical and Prescription Drug Coverage

## Aetna Program Features

***Teladoc:*** *This service provides members access to a national network of U.S. board-certified doctor who are available 24/7/365 to resolve many of your non-urgent medical issues. This is a $40 copay at time of service, which is less than an urgent care or ER visit. You can access Teladoc three (3) different ways:*

- Online: www.teladoc.com/Aetna
- Phone: 1-855-Teladoc (835-2362)
- Mobile App: www.teladoc.com/mobile

  *Please note: You must register online prior to using the mobile app*

## *Aetna Discount Program:*

- **Fitness Discounts:** Get the guaranteed lowest rates at your choice of over 10,000 gyms (and growing) in the GlobalFit® network. This offer is for new gym members only. If you belong to a gym now, or belonged recently, call GlobalFit at 1-800-298-7800 to see if a discount applies.
- **Hearing discounts:** Save on hearing aids and exams through Hearing Care Solutions or Amplifon Hearing Health Care.
- **Weight management discounts**: Lose weight, feel great and save on CalorieKing, Jenny Craig, or Nutrisystem.
- **Natural products and services discount**s: Save on good health through the ChooseHealthy program.

If you are an Aetna member, you can get started in three easy steps:

1. Log in to your secure member website at www.aetna.com once you're an Aetna member.
2. Choose "Health Programs," then "See the discounts."
3. Follow the steps for each discount you want to use.

***Informed Health Line:*** 24-hour information line for health questions. You and your covered family members can call as many times as you need at no extra cost. Contacting the Informed Health Line gives you access to:

- Obtain information on a wide range of health and wellness topics
- Make better health care decisions
- Find out more about a medical test or procedure
- Get help preparing for a visit to your doctor
- Receive e-mails with links to videos that relate to your question or topic
- Go online to use our symptom checker, learn about treatment options and health risks, research a medicine, and more

You can access this service by calling the health line toll-free number on the back of your medical card or visit **www.aetna.com**.

***Aetna Member Payment Estimator:*** This free online tool allows Aetna medical members to estimate what you will pay out of pocket for common healthcare services and procedures and compare cost and shop for a lower-cost provider. You can access this service by visiting **www.aetna.com**.

# Flexible Spending Account (FSA)

A Health Care Flexible Spending Account (FSA) is an employer-sponsored benefit that enables employees to set aside pre-tax dollars out of their paycheck to pay for eligible health care expenses. Monies put into the plan avoid both Federal Income Tax and FICA.

Gaumer Process offers you the following FSAs:

## Health Care FSA

- Pay for eligible health care expenses, such as plan deductibles, copays, and coinsurance.
- Contribute up to $2,400

## Dependent Care FSA

- Pay for eligible dependent care expenses, such as day care for a child or adult dependent care, so you and/or your spouse can work, look for work, or attend school full time.
- Contribute up to $5,000 in 2021, or $2,500 if you are married and file separate tax returns.

| | Health Care FSA | Dependent Care FSA |
|---|---|---|
| Eligible for company contributions | No | No |
| Change your contribution amount any time | No | No |
| Access your entire annual contribution amount from the beginning of the plan year | Yes | No |
| Access only funds that have been deposited | No | Yes |
| “Use-it-or-lose-it” at year-end | Yes | Yes |
| Money is always yours to keep | No | No |

## Estimate carefully

Keep in mind, FSAs are “use-it-or-lose-it” accounts. You will forfeit any remaining amount in the account at the end of the plan year.

When you enroll in a Health Care FSA, you will receive a debit card, which you can use to pay for eligible expenses. Depending on the transaction, you may need to submit receipts or other documentation to your FSA administrator.

What’s an eligible expense?

**Health Care FSA** – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at **www.irs.gov**.

**Dependent Care FSA** – Child day care, babysitters, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at **www.irs.gov.**

# Dental Insurance

## *Delta Dental of TN*

*Dual Network: PPO & Premier Network*

Your smile says a lot about your overall health. Healthy teeth and gums are an essential part of your general health and well-being. Research shows there may be a connection between poor dental health and serious health conditions. Dental exams can detect some health conditions, which is why it is important to have regular dental check-ups and maintain good oral hygiene.

**Delta Dental Mobile App**

- Mobile ID card
- Claims and coverage information
- Dentist network search tool
- Dental care cost estimator tool

**Provider Network**

Delta Dental offers two (2) provider networks. The Delta Dental PPO Network provides a smaller network with richer discounts, while the Delta Dental Premier Network provides a larger network with standard discounts. You can also visit an out-of-network dentist; however, there are no discounts, you may be balance billed and need to file your own claims.

**Find a Provider**

Find network providers online at www.DeltaDentalTN.com, click on "FIND A DENTIST," and then choose your network; PPO or Premier or call toll-free 800-223-3104.

**COVID-19 Resources for Delta Dental of TN Members**

Visit the link below to find out what to expect at dental appointments and keep up your oral hygiene at home.

https://tennessee.deltadental.com/en/covid-19-member-update.html

## DENTAL PLAN SUMMARY

| | Option 1: Base Plan | | | Option 2: Buy-Up Plan | | |
|---|---|---|---|---|---|---|
| Network | **PPO** | **Premier** | **Out-of-Network** | **PPO** | **Premier** | **Out-of-Network** |
| Calendar Year Annual Maximum Benefit | $2,000 per person<br>*Preventive Advantage Plan – Each year member receives a preventive service, the members' annual maximum will increase by $100 the following year, not to exceed a $500 increase* | | | $2,000 per person<br>*Preventive Advantage Plan – Each year member receives a preventive service, the members' annual maximum will increase by $100 the following year, not to exceed a $500 increase* | | |
| Individual/Family Deductible | $50/$150 | | | $50/$150 | | |
| Preventive Services | Plan pays 100%* | Plan pays 100%* | Plan pays 100%* | Plan pays 100%* | Plan pays 100%* | Plan pays 100%* |
| | Diagnostic & Preventive Services, Sealants, Brush Biopsy, Radiographs, Periodontal Maintenance | | | | | |
| Basic Services | Plan pays 80% | Plan pays 80% | Plan pays 80% | Plan pays 80% | Plan pays 80% | Plan pays 80% |
| | Emergency Palliative Treatment, Minor Restorative Services, Simple Extractions, Relines & Repairs | | | Emergency Palliative Treatment, Minor Restorative Services, **Endodontics, Periodontics,** Oral Surgery, Relines & Repairs | | |
| Major Services | Plan pays 50% | Plan pays 50% | Plan pays 50% | Plan pays 50% | Plan pays 50% | Plan pays 50% |
| | **Endodontics, Periodontics**, Oral Surgery, Major Restorative Services, TMD Treatment, Prosthodontics | | | Major Restorative Services, TMD Treatment, Prosthodontics | | |
| Orthodontia Services | Not covered | | | Plan pays 50% | Plan pays 50% | Plan pays 50% |
| Orthodontia Maximum Lifetime | Not covered | | | $1,500** | | |

** Deductible does not apply.*

*** Orthodontia coverage available for eligible children and adults.*

Key Words to Know: Below are general examples of key words to know and are not a guarantee of coverage. Check your Plan Documents and Benefit Summaries to confirm covered benefits.

**Annual Maximum Benefit:** The maximum total amount the plan will pay during the plan year.

**Deductible:** The amount you pay before the plan begins to pay.

**Preventive Services:** Services designed to prevent or diagnose dental conditions including oral evaluations, routine cleanings, X-rays, fluoride treatments and sealants.

**Basic & Major Services:** Services such endodontics and periodontics and vary based on plan option.

**Orthodontia:** Services such as straightening or moving misaligned teeth and/or jaws with braces and/or surgery.

# Vision Insurance

## *VSP*

*VSP Choice Plan*

Having an annual eye exam is one of the best ways to make sure you are keeping your eyes healthy. Eye exams can help prevent and treat easily correctable vision problems, which can cause permanent vision impairment. You can enroll in vision coverage to save money on eligible vision care expenses, such as eye exam, glasses and contact lenses.

**Find a Provider**

Find network providers online at www.vsp.com, click on "Find an In-Network Doctor", and then select your network location, office or doctor. VSP customer service is also available at 800-877-7195 to help you locate a local provider.

**ID Cards**

Electronic ID cards are available by logging in as a member at www.vsp.com. However, ID cards are not required to obtain benefits. At time of service, please provide your doctor with your name, social and VSP as your provider. Your doctor will be able to locate your benefits electronically.

## VISION PLAN SUMMARY

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Routine Eye Exam | $20 copay | $45 Reimbursement |
| | Once every rolling 12 months | |
| Eyeglass Lenses<br>**(single vision, bifocal and trifocal)** | Single vision, bifocal and trifocal: $20 copay<br>Standard progressive: $20 copay | Single: $30 Reimbursement<br>Bifocal: $50 Reimbursement<br>Trifocal: $65 Reimbursement<br>Progressive: $50 Reimbursement |
| Contact Lenses<br>**(in lieu of Frames & Lenses)**<br>***Conventional*** | $130 Allowance;<br>Additional 20% off balance over allowance | $105 Reimbursement |
| ***Disposable*** | $130 Allowance | $105 Reimbursement |
| ***Medically Necessary*** | $20 Copay | $210 Reimbursement |
| | Once every 12 rolling months to purchase either 1 pair or eyeglass lenses or 1 order of contact lenses | |
| Frames | $130 Allowance;<br>Additional 20% off balance over allowance | $70 Reimbursement |
| | Once every rolling 24 months | |

### Key Words to Know:

Below are general examples of key words to know and are not a guarantee of coverage. Check your Plan Documents and Benefit Summaries to confirm covered benefits.

**Copay:** An amount you pay for a covered service each time you use that service.

**Retail Allowance:** Maximum allowance paid toward the cost of vision materials. You are required to pay any amounts in excess of the retail allowance.

### Exclusive Member Extras

We put our members first by providing Exclusive Member Extras from VSP and leading industry brands, totaling more than $2,500 in savings. Check out a sample below.

| | |
|---|---|
| Contacts | Exclusive mail-in savings on eligible contacts<br>Savings on EyePromise EZ Tears dry eye and contact lens comfort formula |
| Glasses | Up to 50% savings on UNITY® digital lenses<br>Up to 40% savings on sunsyncTM light-reactive lenses<br>Average savings of $325 on Nike-authorized prescription sunglasses<br>Extra $20 to spend on featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more |
| LASIK | Up to $500 savings on LASIK |
| More Offers | Free shipping, shop-at-home convenience, and savings on contacts and sunglasses at eyeconic.com<br>Access to special financing for vision and health care expenses with the CareCredit credit card |
| Hearing Aids | Savings of up to 60% on a pair of digital hearing aids and savings on batteries for you and your extended family members through TruHearing® |

Above offers are updated frequently. Learn more about these and other offers at vsp.com/specialoffer.

# Life Insurance

## *UnitedHealthcare – TERM LIFE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)*

Life insurance provides important financial protection for you and your family. You can choose from different levels of life insurance coverage to meet your needs.

**Employer-Paid Life and Accidental Death and Dismemberment (AD&D)** – Your employer provides you with a base level of employee term life and accidental death and dismemberment (AD&D) insurance **at no cost to you**. This coverage provides a **$50,000** benefit.

Please note: Basic Life & AD&D Benefit will reduce to 65% at age 65, 40% at age 70, 25% at age 75 and terminate at retirement.

**Employee-Paid Term Life/AD&D** – To supplement the coverage provided by your employer, you can purchase additional term life insurance for yourself. This coverage is tied to your employment and typically ends if you leave your employer. However, you may be able to retain this coverage on your own with the same insurance carrier if you leave your employer. **You must purchase this coverage if you wish to purchase spouse and/or child term life.**

**Spouse Term Life** – You can purchase term life insurance for your spouse. This coverage is tied to your employment, and typically ends if you leave your employer. However, you may be able to retain this coverage for your spouse on your own with the same insurance carrier if you leave your employer.

**Child Term Life** – You can purchase term life insurance for your dependent children up to age 26. This coverage is tied to your employment, and typically ends if you leave your employer. However, you may be able to retain this coverage for your children on your own with the same insurance carrier if you leave your employer.

**Important Information**

**Select a beneficiary**
It's important to choose a beneficiary or beneficiaries to receive the policy's benefit payment in the event of the insured person's death. For Spouse and Child Term Life policies, you (the employee) are automatically listed as the beneficiary.

**Statement of Health**
Life insurance coverage over a certain amount may require an approval from the insurance company. After electing coverage, you will receive more information.

## EMPLOYEE-PAID LIFE/AD&D PLAN SUMMARY

| | Minimum | Guarantee Issue Amount | Maximum |
|---|---|---|---|
| **Employee** | $10,000 | $100,000 | Incremental amounts of $10,000 up to the Lesser of five (5) x basic annual earnings or $400,000 |
| **Spouse** | $5,000 | $30,000 | Increment amounts of $5,000 up to $150,000 not to exceed 50% of Employee's election |
| **Child** | $2,500 | $10,000 | Increment amounts of $2,500 up to $10,000 and cannot exceed 50% of the Employee's Voluntary Life amount. *Maximum benefit for Children live birth to 6 months is $1,000 |

# 2021 ANNUAL NOTICES

**Your Company reserves the right to change, amend or terminate any benefits plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.**

The Benefits Decision Guide, combined with these legal notices, provides an overview of the benefits available to you and your family. In the event of a discrepancy between the information presented in the Benefits Decision Guide and official plan documents, the official plan documents will govern.

## STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the health and welfare plans. It is meant to supplement certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

## SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available. You may request a paper copy by calling your Human Resources department.

The legal notices listed below are provided on following pages:

- ✓ Women's Health and Cancer Rights Act (WHCRA)
- ✓ Newborn's and Mother's Health Protection Act (NMHPA or Newborns Act)
- ✓ HIPAA Special Enrollment Notice
- ✓ Right to Special Enrollment in Another Plan
- ✓ USERRA
- ✓ Wellness Program Disclosure
- ✓ HIPAA Privacy Notice
- ✓ Public Exchange Notice
- ✓ Initial COBRA Notice
- ✓ Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- ✓ Creditable Prescription Drug Coverage and Medicare

# 2021 ANNUAL NOTICES

**WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE**

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical carrier at the phone number listed on the back of your ID card.

**NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA OR "NEWBORNS' ACT") NOTICE**

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). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

**HIPAA SPECIAL ENROLLMENT NOTICE**

**Notice of special enrollment rights for health plan coverage**

If you have declined enrollment in your employer's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, if 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Your employer will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in your employer's group health plan. Note that this new 60-day extension does not apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

**RIGHT TO SPECIAL ENROLLMENT IN ANOTHER PLAN**

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for Protecting Your Health Insurance Coverage).

These publications and other useful information are also available on the Internet at:
http://www.dol.gov/ebsa,
the DOL's interactive web pages - Health Laws, or
www.cms.hhs.gov/healthinsreformforconsume/.

**WELLNESS PROGRAM DISCLOSURE**

If you have a health plan available to you, the health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify an opportunity to earn the same reward by different means. Contact your HR Department and we will work with you to find a wellness program with the same reward that is right for you in light of your health status.

**USERRA**

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

# 2021 ANNUAL NOTICES

SUMMARY NOTICE OF PRIVACY PRACTICES

This is a summary of your Group Health Plan's Notice of Privacy Practices, and is a reminder that a copy of the Privacy Notice can be obtained from the Human Resource Department. **Please review this summary carefully.**

In order to provide you with benefits, your employer's group health plan (hereafter referred to as the Plan) may receive personal health information from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This Summary Notice of Privacy Practices is intended to remind you of the ways we may use your information and the occasions on which we may disclose this information to others.

The following is a summary of the circumstances under which your health information may be used and disclosed:
To provide treatment
To obtain payment
To conduct health care operations

We use participants' health information to provide benefits. We may disclose participants' information to health care providers to assist them in providing you with treatment, or to help them receive payment. We may disclose information to insurance companies or other related businesses to receive payment. We may use the information within our organization to evaluate a request for coverage or a claim for benefits, to evaluate quality, and improve health care operations. We may make other uses and disclosures of participants' information as required by law or as permitted by our policies.

**Your Rights with Respect to your Health Information**
You have the following rights regarding your health information:
Right to request restrictions
Right to receive confidential communications
Right to inspect and copy your health information
Right to request an amendment to your health information
Right to an accounting of your health information
Right to a paper copy of the Notice of Privacy Practices

This is a reminder that you generally have a right to access and in certain instances to request an amendment to your Personal Health Information. This does not apply to information collected in connection with, or in anticipation of, a claim or legal proceeding.

**Our Legal Duty**
We are required by law to maintain the privacy and security of your health information and to provide you with a reminder that our complete Notice of Privacy Practices is available upon request. We reserve the right to implement new privacy and security provisions for health information that we maintain. If we change the Privacy Notice, we will provide you with a copy of the complete revised notice to you at that time. In addition, you have the right to express complaints to the contact person referenced below and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to your employer should be made in writing to the contact person listed at the end of this notice.

**Contact Person-** For more information on the Plan's privacy policies or your rights under HIPAA, contact your Human Resources Department.

**EXCHANGE NOTICE**

**PART A: General Information**
When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

**What is the Health Insurance Marketplace?**
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

**How Can I Get More Information?**
For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

**Summary of Rights and Obligations Regarding COBRA Continuation Coverage**

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 Human Resources Department.

**What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens: Your hours of employment are reduced, or your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens: 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 any of the following qualifying events happens: 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."

> Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Human Resources Department has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Human Resources Department of the qualifying event.

**You Must Give Notice of Some Qualifying Events**

**For the 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 Human Resources Department within 30 days after the qualifying event occurs.**

**How is COBRA Coverage Provided?**

Once the Human Resources Department 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Human Resources Department in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Human Resources Department informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Human Resources Department.

**Plan Contact Information:** Call your Human Resources department for more information.

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

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

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

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

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –**

| | |
|---|---|
| **ALABAMA – Medicaid** | **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** |
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: http://flmedicaidtplrecovery.com/hipp/<br>Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162 ext 2131 |
| **CALIFORNIA – Medicaid** | **INDIANA – Medicaid** |
| Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx<br>Phone: 1-800-541-5555 | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com<br>Phone 1-800-403-0864 |
| **IOWA – Medicaid and CHIP (Hawki)** | **MONTANA – Medicaid** |
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563 | Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 |
| **KANSAS – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://www.kdheks.gov/hcf/default.htm<br>Phone: 1-800-792-4884 | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **KENTUCKY – Medicaid** | **NEVADA – Medicaid** |

| LOUISIANA – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Website: https://www.dhhs.nh.gov/oii/hipp.htm<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **MAINE – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Website: http://www.mass.gov/eohhs/gov/departments/masshealth/<br>Phone: 1-800-862-4840 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MINNESOTA – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website:<br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp<br>[Under ELIGIBILITY tab, see "what if I have other health insurance?"]<br>Phone: 1-800-657-3739 | Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MISSOURI – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **UTAH – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx<br>Phone: 1-800-692-7462 | Website: https://www.coverva.org/hipp/<br>Medicaid Phone: 1-800-432-5924<br>CHIP Phone: 1-855-242-8282 |
| **RHODE ISLAND – Medicaid and CHIP** | **WASHINGTON – Medicaid** |
| Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 |
| **SOUTH CAROLINA – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://mywvhipp.com/<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **SOUTH DAKOTA - Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website:<br>https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf<br>Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website: https://wyequalitycare.acs-inc.com/<br>Phone: 307-777-7531 |

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

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

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

**Paperwork Reduction Act Statement**

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

## IMPORTANT NOTICE FROM GAUMER PROCESS ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Gaumer Process medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage. This is known as "creditable coverage."

Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during the plan year listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

**Notice of creditable coverage**

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium. Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period. If you are covered by your employer's prescription drug plan, you will be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for the plan year. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary, as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the plan.

You should know that if you waive or leave coverage with your employer and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this coverage changes, or upon your request.

**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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans: Visit www.medicare.gov for personalized help; Call your state Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number); Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

**Remember:** Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

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

**Date: October 15, 2020 (Last Issue: September 30, 2019)**

**Name of Entity/Sender: Gaumer Process**

**Human Resources**

**13616 Hempstead Road, Houston, TX 77040**

**713-460-5200**

# Notes