Missouri Belton

2022 BENEFITS GUIDE

Proud Past
Bright Future

City of Belton Benefits Open Enrollment 2022 Plan Year

The City offers many different benefit options to meet the needs of our employees. We understand that employee benefits are an important part of your total compensation package.

Please complete changes to your benefits elections online.

Deadline is
November 22, 2021

How to Begin!

- ✔ Please review this benefit guide completely
- ✔ Submit questions to employeebenefits@belton.org
- ✔ Watch videos posted to Benefits page
- ✔ **Don't hesitate to ASK QUESTIONS**

We value you as a member of the City of Belton family and look forward to a healthy 2022.

2022 CHANGES AT A GLANCE

- Your medical deductible and out of pocket maximum resets January 1, 2022.
- Eligible employees electing Employee Only coverage on the QHDHP will receive an employer contribution each month in their HSA.
- 2022 HSA Contribution limits are $3,650 for employee only and $7,300 for a family.
- The Flexible Spending contribution limits are $2,850 for an individual and $5,000 for Dependent Care.
- There are no benefit or rate changes on dental and vision.
- Open enrollment is the time of year you can make any adjustments to your benefits for the coming year.
- Throughout the year you can ONLY change your elections if you have a qualifying event change your status. See page 4 for additional details.

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact Employee Benefits, or our CBIZ representative(s) listed below.

Medical

Cigna
www.cigna.com
866-494-2111

Dental

Delta Dental of Missouri
www.deltadentalmo.com
800-335-8266

Vision

Superior
www.superiorvision.com
800-507-3800

Basic Life and AD&D, Voluntary Life and AD&D, and Long-Term Disability

USAble Life
www.usablelife.com
800-370-5856

Health Savings Account

United Missouri Bank
www.umb.com
816-474-4472

Your Benefits Team

The City of Belton
EmployeeBenefits@belton.org

CBIZ Representatives

Kristin Grace
kgrace@cbiz.com

Allison Elliott
allison.elliott@cbiz.com

TABLE OF CONTENTS

Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

QUALIFYING LIFE EVENT

When you participate in our health plans or Section 125 plan, you are obligated to maintain your election through the full year.

However, certain qualifying events may occur that would allow you to add, change or terminate your election(s).

- **Birth or adoption of a child**
- **Marriage or divorce**
- **Legal Separation**
- **Loss of dependent status**
- **Change in employment status for yourself, spouse, or eligible dependent**
- **Gain or loss of eligibility for Medicare/Medicaid for yourself, spouse, or dependent**

HOW DO I MAKE A CHANGE TO MY PLANS DURING THE YEAR

To change any of your elections due to a qualifying event, you must notify Employee Benefits within 30 days of the event date.

If Employee Benefits is not notified within 30 days, you will not be allowed to make any changes to your elections until the annual enrollment period.

Please note that proper documentation of the qualifying event will be required.

Additionally, the change you make to your election must be consistent with and appropriate for your new circumstance.

FULL TIME EMPLOYEE BENEFIT SUMMARY

Medical Rates	Monthly Rate	Monthly City Portion	Monthly EE Portion
Open Access Plus HMO			
Individual	$840.14	$745.94	$94.20
Employee Plus	$1,975.80	$1,477.75	$498.05
Family	$2,212.20	$1,477.75	$734.45
Open Access Plus PPO			
Individual	$745.94	$745.94	$0.00
Employee Plus	$1,753.78	$1,477.75	$276.03
Family	$1,963.01	$1,477.75	$485.26
Open Access Plus QHDHP			
Individual	$674.04	$745.94	*
Employee Plus	$1,586.07	$1,477.75	$108.32
Family	$1,776.15	$1,477.75	$298.40
* The city contributes $71.90 to the employee's HSA.			

- **Life insurance for employee** (1.5 times annual salary) through USAble – fully paid
- **Dental insurance for employee and family** through Delta Dental – fully paid
- **Vision insurance for employee and family** through Superior Vision – fully paid
- **Long term disability insurance** through USAble – fully paid
- **Retirement plan** – Missouri Local Government Employees' Retirement System – fully paid
- **Employee Assistance Program** through New Directions Behavioral Health – fully paid
- **Paid vacation:** per city code available for use after 90 days of employment
- **Paid sick leave** – 96 hours earned each year for regular full time employees
  130 hours earned each year for 24-Hour fire
- **Paid Holidays:** 15 paid Holidays
- **Deferred Compensation Plans**
- **Section 125 Tax Savings Plan** for health and dependent care expenses
- **Wellness program** membership partially paid by City of Belton
- **Tuition reimbursement program**

The City retains the right to modify the employee benefits package as necessary.

MEDICAL INSURANCE

HOW TO GET STARTED

1 SELECT YOUR MEDICAL PLAN

- ☐ **OPTION 1: Open Access Plus QHDHP**
- ☐ **OPTION 2: Open Access Plus OAP (PPO)**
- ☐ **OPTION 3: Open Access Plus OAPIN (HMO)**

TIP: Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis

Does the deductible run on a calendar year or policy year basis?

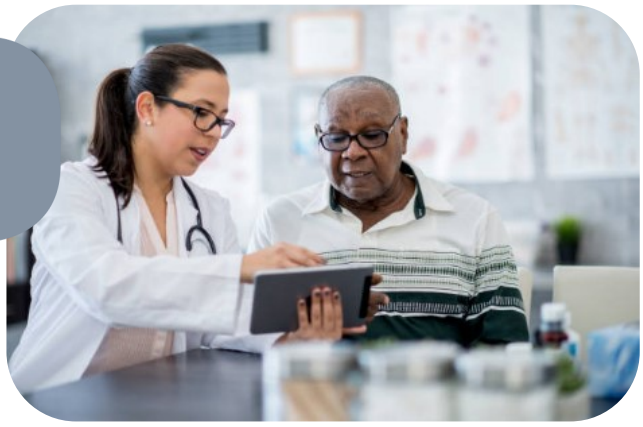
A calendar year basis.

How long can I cover my dependent children?

Dependent children are eligible until the end of the calendar year in which they turn age 26.

I just got hired. When will my benefits become effective?

Your medical insurance benefits will begin on the 1st of the month following 60 days of employment.



YOUR HEALTH PLAN OPTIONS

As a full-time employee of the City of Belton, you have the choice between three medical plan options: a Qualified High Deductible (QHDHP) plan, OAP/PPO plan, or OAPIN/HMO plan.

All three plans use the same network of providers - the Cigna Open Access Plus network.

For each, your deductible and/or out of pocket maximum will run from January 1–December 31.

While the QHDHP and OAP/PPO plans give you the option of using out-of-network providers, you can save money by using in network providers because CIGNA has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and the CIGNA UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

The QHDHP option offers you lower premiums than the other two plans, and you can establish a Health Savings Account (HSA) with UMB Bank and contribute all or part of the premium savings into the HSA. These funds can be used to cover medical expenses, including deductibles, and they're yours forever—even if you leave the City of Belton. And unlike a Flexible Spending Account (FSA), they are not forfeited at the end of each year.

As a reminder, when you enroll in the OAPIN/HMO plan, you must stay in-network for all services using the Open Access Plus network. Only true emergencies will be covered at an out-of-network hospital. With the OAPIN/HMO, you must choose a Primary Care Physician for each covered member in your family. Each person may have a different PCP. Family Practice, General Practice, Internal Medicine, and Pediatricians are considered PCPs.

To look up your provider, go to www.cigna.com, click on Find a Doctor, Dentist or Facility, click on Employer or School, enter your location, click on type of provider, continue as a Guest, and finally choose "**Open Access Plus, OA plus, Choice Fund OA Plus**"

MEDICAL INSURANCE

Employee Cost Per Month	Open Access Plus QHDHP		Open Access Plus OAP/PPO		Open Access Plus OAPIN/ HMO
Employee	$0.00*		$0.00		$94.20
Employee & Spouse or One Child	$108.32		$276.03		$498.05
Employee & Family	$298.40		$485.26		$734.45
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Deductible					
Individual	$3,000	$3,000	$2,000	$4,000	N/A
Family	$6,000	$6,000	$6,000	$12,000	N/A
Coinsurance					
Member Pays	20%	50%	20%	40%	0%
Maximum Out-of-Pocket					
Individual Family (includes deductible, coinsurance & copay)	$4,000 $8,000	$8,000 $16,000	$4,900 $13,700	$9,800 $27,400	$5,500 $12,775
Physician Services					
Preventive Care Office Visits Diagnostic X-Ray Diagnostic Labs Urgent Care Center	$0 Ded then 20% Ded then 20% Ded then 20% Ded then 20%	Ded then 50% Ded then 50% Ded then 50% Ded then 50% Ded then 20%	$0 $40 / $80 $0 $0 $80	Ded then 40% Ded then 40% Ded then 40% Ded then 40% $80	$0 $40 / $80 $0 $0 $80
Hospital Services					
Inpatient Care Outpatient Surgery High Tech Diagnostics Ambulance	Ded then 20% Ded then 20% Ded then 20% Ded then 20%	Ded then 50% Ded then 50% Ded then 50% Ded then 20%	Ded then 20% Ded then 20% Ded then 20% Ded then 20%	Ded then 40% Ded then 40% Ded then 40% Ded then 20%	$750 per day[1] $750 per day $0 $0
Emergency Room	Ded then 20%	Ded then 20%	$200 then 20%	$200 then 20%	$200 per visit
Prescription Drug Copays					
Retail Level 1 Level 2 Level 3 Mail Order (90 day supply)	 Ded then $15 Ded then $50 Ded then $70 Ded then 2x copays	 Ded then 50% Ded then 50% Ded then 50% Not Covered	 $15 $50 $70 2x copays	 Ded then 50% Ded then 50% Ded then 50% Not Covered	 $15 $50 $70 2x copays

[1]For first 5 days per person per calendar year (only in network hospital services capped)

Care Options

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. And, be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card.

PRIMARY CARE

- Routine, primary/ preventive care
- Non-urgent treatment
- Common infections (bronchitis, bladder and ear infections, pink eye, strep throat)

CONVENIENCE CARE

- Minor skin conditions (athlete's foot, cold sores, minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

URGENT CARE

- Sprains
- Small cuts
- Strains
- Sore throats
- Minor infections

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Sudden change in vision
- Spinal injuries
- Difficulty breathing
- Major burns
- Sudden weakness or trouble walking
- Severe head injuries

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 9-1-1

PRIMARY CARE

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

CONVENIENCE CARE

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS Caremark, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours—or if you can't be seen by your doctor immediately—you may consider going to an Urgent Care Center, where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in any of the following:

- Serious jeopardy to your health or the health of an unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

If you obtain care at an emergency room, you will likely pay more out of pocket than if you were treated at your doctor's office, a Convenience Care Center, or Urgent Care facility. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

HSA

Health Savings Account

WHAT IS IT?

FSA

Flexible Spending Account

An HSA is a great choice if you have a high-deductible health plan. You set up the HSA and the account belongs to you, not your employer. Anyone can contribute to your HSA, such as your family. However, contributions cannot exceed the annual maximum IRS allowed amount.

Your HSA stays with you when you change jobs or retire. You contribute with pre-tax earnings, earn interest on your money, and can roll over the year end balance.

You can build up a fund to pay for your health care expenses throughout the year. If you have a doctor visit or medical procedure scheduled, you can plan ahead and make contributions to cover your out-of -pocket costs.

Your HSA money comes out of your paycheck pretax and you can use the money for qualified medical expenses tax free. It's not treated as income when you take money out for medical bills, and other qualified expenses.

The money must be in your account before you can spend it - you cannot draw ahead.

You can use the money for other members in your taxable family.

What will I pay at the physician's office with the HSA qualified plan?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to CIGNA. You'll receive an Explanation of Benefits (EOB) from CIGNA that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

This type of account is set up by your employer, and your contributions come out of your paycheck before taxes, lowering your taxable income. That saves you money with every contribution! During enrollment you will choose the amount of money you would like to have available in your FSA. This amount cannot be changed during the year unless you have a qualifying event.

The funds are immediately available to you and can be used for your health care expenses throughout the year. Claims can be incurred until March 15, 2023 and will be paid with 2022 funds until the money is gone. You have until March 30,2023 to file any claims incurred during the 2022 plan year. Any unused balance at the end of this period will revert to your employer. You forfeit the balance if you leave your job.

There are two separate Flexible Spending Accounts into which you can enroll–

1.Health Care Reimbursement Account

2.Dependent Care Reimbursement

At date of hire or annual enrollment time, you make a plan year election for how much you want to set aside tax-free for the year to cover your health care and/or daycare qualified expenses.

Your election is then divided by the number of pay periods in a year. That pre-tax deduction is then withheld from your paycheck each pay period.

You cannot adjust your annual election amount unless you have a change in status such as marriage, birth, adoption, etc. Please visit the Benefits Department to determine if your situation qualifies as a change in status.

Where can I get a copy of an EOB?

You can access all of your EOB information, as well as obtain other important information, by registering on www.cigna.com

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

Two ways you can put money into your HSA:(1) Regular payroll deductions on a pre-tax basis and (2) lump-sum contributions of any amount, anytime, up to the IRS calendar year maximum limit.

Contribute up to **$3,650** Single, or **$7,300** Family

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished when appropriate.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

Enrolling in the City's QHDHP Medical plan and opening an HSA may be the best plan option for you if any of the following is true:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for qualified expenses permitted under Federal Law.
- You would like the opportunity to contribute pretax income to a Health Savings Account.

WHAT ARE THE RULES?

- You must be covered under the Open Access Plus **QHDHP** Plan in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Dependent Care or Limited Purpose FSA.
- You cannot be enrolled in Medicare, Medicaid or Tricare due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.
- Money must be in the account before you can withdraw it.
- You can start/stop/increase/decrease contributions on a monthly basis.

WHAT ELSE SHOULD I KNOW?

You can use the money in your HSA to pay for your deductible and other expenses not covered by your health plan, like dental or vision expenses. It's yours to:

- **SAVE:** You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2022 are $3,650 for Single and $7,300 for Family coverage. If you or your spouse are age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- **GROW:** The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision and some over-the-counter medications).
- **OWN:** Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- **CHOOSE:** Use for current expenses, save for the future, or explore investment options.
- Just like you report pre-tax dollars that you contribute to other benefit plans, like a 401(k), the IRS requires that you report your pre-tax contributions to your HSA using Form 8889. Your contribution will appear on your W-2 for easy reference.

FLEXIBLE SPENDING ACCOUNTS

2 SELECT FSA ACCOUNTS

- ☐ **Health Care Flexible Spending Account**
- ☐ **Dependent Care Expense Account**

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware—any unused portion of the account at the end of the roll over period is forfeited.

Eligible Expenses Examples	
• Alcoholism treatment	• Laboratory fees
• Artificial limbs	• Licensed osteopaths
• Ambulance	• Licensed practical nurses
• Braces	• Orthodontia
• Chiropractors	• Orthopedic shoes
• Coinsurance and copayments	• Obstetrical expenses
• Contact lens solution	• Oxygen
• Contraceptives	• Prescription drugs
• Crutches	• Podiatrists
• Dental expenses	• Psychiatric care
• Dentures	• Psychologist expenses
• Dermatologists	• Routine physical
• Diagnostic expenses	• Seeing-eye dog expenses
• Eyeglasses, including exam fee	• Smoking cessation programs
• Handicapped care and support	• Sterilization and reversals
• Nutrition counseling	• Substance abuse treatment
• Hearing devices and batteries	• Surgical expenses
• Hospital bills	• Prescribed vitamin supplements (medically necessary)
• Deductible Amounts	

How the Health Care Flexible Spending Account Works

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to BASIC. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

2022 Maximum Contributions

Health Care Flexible Spending Account	$2,850 max
Dependent Care Expense Account	$5,000 max

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a immediate family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

Contact Information

Request a full statement of your accounts at any time by calling 800-372-3539 ext. 6270, or log on to www.basiconline.com/hq/ to review your FSA balance. The address to mail claims to is 9246 Portage Industrial Dr., Portage, MI 49024.

At www.basiconline.com/hq/, you can:

Sample Instructions

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

DENTAL INSURANCE

3 REVIEW YOUR DENTAL PLAN

DELTA DENTAL OF MISSOURI

The dental plan is a PPO that offers coverage in and out-of-network. It is to your advantage to utilize an in-network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Delta Dental's negotiated fees, plus any deductible and coinsurance associated with your procedure. Dependent children are eligible until the end of the calendar year in which they turn age 26.

DELTA DENTAL®

FIND A DENTIST

To find a Delta Dental provider in your area, visit the website at www.deltadentmo.com.

Directions:

- Hover over "Find a Provider" tab at the top of the page
- Click on "Find a Dentist"
- Select "Delta Dental PPO" as the plan you have access to. You also have access to the Premier network, but the PPO will provide the greatest discounts
- You can then search for dentists. You have the option to narrow your search based on your location, dentist last name, practice name, and more.

Dental Insurance Plan Options and Costs

Delta Participating Providers: Provider is reimbursed based on contracted fees and cannot balance bill you.

Non-Participating Providers: Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

Delta Dental of Missouri	Employee Cost Per Pay period		
Employee Employee & Family	No cost to the employee for this coverage		
	In-Network (PPO or Premier)	**Out-of-Network**	
Deductible Individual / Family	$50 / $150	$50 / $150	Applied to Type B & C Services
Calendar Year Maximum	$1,250 + MAXAdvantage	$1,250 + MAXAdvantage	Applied to Type A, B & C Services
	Carrier Pays		
Diagnostics/ Preventive Services	Carrier pays 100% (no deductible)	Carrier pays 100% (no deductible)	• Oral examinations • Bitewing, full mouth, periapical, and other x-rays • Fluoride treatments • Sealants • Prophylaxis: cleanings
Basic Services	80%	80%	• Fillings • Periodontics • Endodontics • Simple and surgical extractions
Major Services	50%	50%	• Oral surgery, except for extractions covered under Basic • Prosthetics: bridges and dentures • Crowns, jackets, veneers, inlays, onlays
Orthodontia Services Adult and Child(ren)	50% up to $1,250 lifetime maximum	50% up to $1,250 lifetime maximum	Diagnostics and treatment

MAXAdvantage: Charges for exams, cleanings, x-rays and fluoride treatments do not apply towards the annual maximum
Healthy Smiles: Patients who are pregnant, diabetic, have a suppressed immune system, or have a history of periodontal therapy are eligible to receive up to two additional cleanings each benefit year

VISION INSURANCE

4 REVIEW YOUR VISION PLAN

DID YOU KNOW?
There are discounts available for Lasik surgery.

SUPERIOR VISION

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery, there is a discount available with some providers. To find a participating provider, go to www.superiorvision.com

SUPERIOR VISION
See yourself healthy.

FIND A PROVIDER

- On the right side of the webpage click on "members" and then on the next page click on "Find an eye care professional"
- Enter your location, coverage type (Insurance through Employer), network (Superior National Network), and distance
- Results list providers closest to your ZIP code first
- You can then refine your search by picking your service or name then scroll through the list

Vision Insurance Plan Options and Costs

Superior	Employee Cost Per Paycheck	
Employee Employee + One Employee + Family	**No cost to the employee for this coverage**	
	In-Network	Out-of-Network
Examination Copay	$10 copay	Up to $34 retail
Frequency of Service (Based on date of service) Exam Lenses Frames	Every 12 months Every 12 months Every 24 months	
Lenses Single Bifocal Trifocal Standard Progressive Lenses	$15 copay; Included Included Included Included	Up to $29 retail Up to $43 retail Up to $53 retail Up to $53 retail
Frames	$15 copay; $130 retail allowance, 20% off balance over allowance	Up to $65 retail
Contact Lenses (Instead of glasses)	$15 copay on fitting fee; $130 retail allowance	Up to $100 retail

Materials copay applies to lenses and frames only, not contact lenses.
One copay applies to both lenses and frames.

[What is Vision Insurance?]

LIFE INSURANCE AND AD&D

USAble Life℠

5 **REVIEW YOUR LIFE INSURANCE POLICY**

- ☐ **Add your spouse**
- ☐ **Add your dependents**
- ☐ **Increase your coverage**

DID YOU KNOW?

USAble Life provides you Basic Life and AD&D AT NO CHARGE

BASIC LIFE AND AD&D

USAble Life provides 1½x your annual earnings to a maximum of $250,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

This coverage is offered through USAble Life at no cost to you.

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what the City of Belton provides. USAble Life guarantee issues coverage during your initial enrollment period—which means you can't be turned down for coverage based on medical history.

- If you don't enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be approved by USAble Life before you're able to get coverage in the future.

- **Voluntary Employee Life & AD&D:** minimum $10,000 to a maximum of 5x your annual salary, or $500,000, in $10,000 increments. Guarantee issue, up to age 69, is $50,000.

- **Optional Dependent Life & AD&D for spouse:** minimum $5,000 up to 100% of the employee amount, to $250,000 maximum in $5,000 increments. Guarantee issue up to age 69, is $10,000

- **Optional Dependent Life & AD&D for children:** age 6 months to 26 minimum $2,500 up to $10,000 maximum. Guarantee issue up to $10,000. Live birth to 6 months $1,000.

Please note: If you elect Voluntary Life for yourself and/ or your dependents, Voluntary AD&D is an automatic election based on the voluntary life insurance amount. Employee must elect coverage in order for spouse and/or child to be covered.

VOLUNTARY LIFE INSURANCE AND AD&D

USAble Life℠

Premiums Based on 12 Payroll Deductions Per Year			
Employee's Guaranteed Issue, up to age 69, is $50,000	Applying for coverage over Guaranteed Issue will require evidence of medical insurability	**VADD Rates for Employees, Spouse, & Child Per $10,000**	$0.30
Spouse's Guaranteed Issue, up to age 69, is $10,000		**VGTL Premiums for Child Rate Per $2,500**	$0.21
Spouse premiums are determined by Spouse's age			

VGTL PREMIUMS

BENEFIT	PREMIUM	BENEFIT	PREMIUM	BENEFIT	PREMIUM	BENEFIT	PREMIUM	BENEFIT	PREMIUM
$10,000	$2.22	**$110,000**	$24.42	**$210,000**	$46.62	**$310,000**	$68.82	**$410,000**	$91.02
$20,000	$4.44	**$120,000**	$26.64	**$220,000**	$48.84	**$320,000**	$71.04	**$420,000**	$96.24
$30,000	$6.66	**$130,000**	$28.86	**$230,000**	$51.06	**$330,000**	$73.26	**$430,000**	$95.46
$40,000	$8.88	**$140,000**	$31.08	**$240,000**	$53.28	**$340,000**	$75.48	**$440,000**	$97.68
$50,000	$11.10	**$150,000**	$33.30	**$250,000**	$55.50	**$350,000**	$77.70	**$450,000**	$99.90
$60,000	$13.32	**$160,000**	$35.52	**$260,000**	$57.72	**$360,000**	$79.92	**$460,000**	$102.12
$70,000	$15.54	**$170,000**	$37.74	**$270,000**	$59.94	**$370,000**	$82.14	**$470,000**	$104.34
$80,000	$17.76	**$180,000**	$39.96	**$280,000**	$62.16	**$380,000**	$84.36	**$380,000**	$106.56
$90,000	$19.98	**$190,000**	$42.18	**$290,000**	$64.38	**$290,000**	$86.58	**$390,000**	$108.78
$100,000	$22.20	**$200,000**	$44.40	**$300,000**	$66.60	**$400,000**	$88.80	**$500,000**	$111.00

Important Note: The above rates are subject to change. The rate shown here are meant as an illustration for you to determine the approximate deduction you may expect to see each paycheck. Due to the rounding of rates, these deductions will vary, though differences should be slight. This is not part of an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions apply and that benefits may reduce or terminate. If you enroll for coverage, you will be provided with a certificate of insurance. Please read your certificate carefully.

DISABILITY INSURANCE

REVIEW YOUR DISABILITY COVERAGE

- ☐ **Long-Term Disability**

LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance offered through USAble Life is provided at no cost to you. The plan benefit is 60% of basic monthly earnings up to a maximum of $7,000 per month. Basic earnings is the average of your gross monthly income for the year immediately prior to the onset of disability and excludes commissions, bonuses, overtime pay, shift differential pay, or any other earnings.

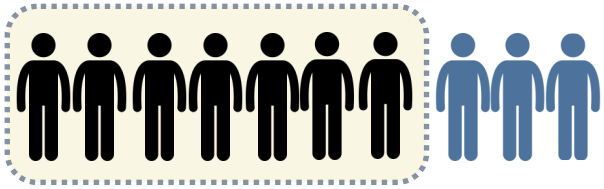
The benefits begin after a 90 day waiting period.

Covered disabilities are payable for up to 36 months if you cannot perform the duties of your own occupation. After that, you are considered disabled if you are unable to perform any occupation in which you can be expected to earn at least 60 percent of your pre-disability earnings until you reach SSNRA.

Could you pay the bills if you weren't working?

Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

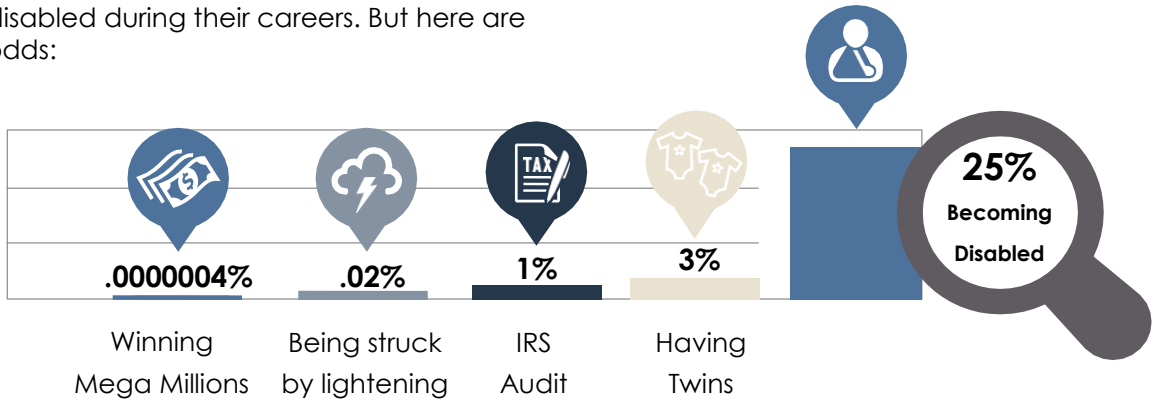
This benefit is 100% paid by the City.



Nearly **70%** of workers that apply to Social Security Disability Insurance **are denied.**

What's more likely?

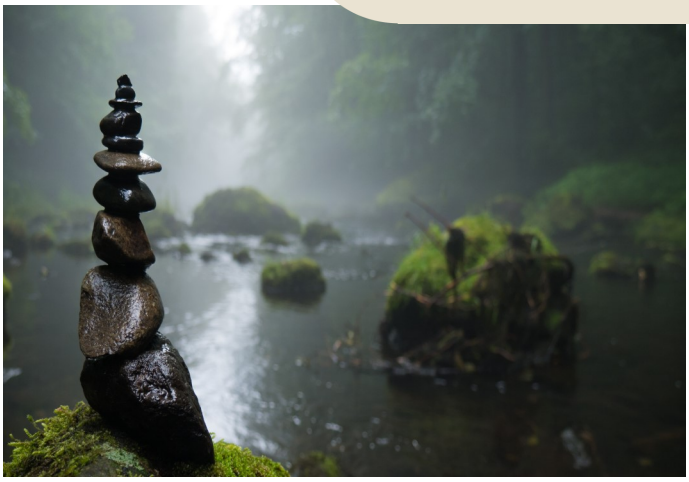
Many workers think these events are more likely than becoming disabled during their careers. But here are the actual odds:



In fact, nearly **40 million** American adults live with a disability

EMPLOYEE ASSISTANCE PROGRAM

NEW DIRECTIONS®



Your well-being, productiveness and happiness depend on how well you balance your life at home and your life at work. It's difficult to be on task on the job if you're worried about problems at home; and you can't devote sufficient time to yourself and your family if you're feeling overwhelmed by work issues.

New Direction's Employee Assistance Program is available 24 hours a day, seven days a week, to help you and your family find answers and resolve personal problems. Confidential support, guidance and resources are available to help you be happier and more productive.

This benefit is 100% paid by the City of Belton.

Assistance is available to you and immediate household family members by calling 1-800-624-5544.

You can also log onto www.ndbh.com and enter "Belton" as the company code. Many resources are available on line at no cost to you.

EAP BENEFITS INCLUDE:

- Up to (6) in-person counseling sessions per issue
  - Stress
  - Depression
  - Relationships
  - Parenting
  - Substance Abuse
  - Grief and Loss
- 24x7x365 telephone and Web access
- Telephone access to legal counsel
- Work / life services to include assistance with:
  - Parenting and childcare
  - Eldercare
  - Relationships
  - Work and career
  - Financial
  - Criminal actions
  - Civil lawsuits
  - Contracts
  - Real estate transactions
  - Landlord and tenant issues

GLOSSARY OF MEDICAL TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

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

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

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

IMPORTANT NOTICES

NOTE: Details regarding The City of Belton's plans can be found in the Summary Plan Description/ Summary of Benefits and Coverage documents. To request these documents please contact the Benefits Department.

MEDICARE PART D CREDITABLE COVERAGE

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare, the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan.

All Medicare drug plans provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

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

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage may not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents may be able to get this coverage back.

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

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the "Medicare & You" handbook or you can visit medicare.gov or call 800.MEDICARE (800.633.4227).

TTY users: 800.486.2048. If you have limited income and resources, visit Social Security at socialsecurity.gov, or call 800.772.1213 (TTY users call 800.325.0778).

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

This notice is intended as a brief outline; please see the Benefits Department for more information.

IMPORTANT NOTICES

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Employee Benefits office (see page 3 for contact information).

Two additional special enrollment events are available to you and your eligible dependents. They are:

1. Becoming ineligible for Medicaid or the Children's Health Insurance Program (CHIP). If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

2. Becoming eligible for Premium Assistance through Medicaid or CHIP. If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

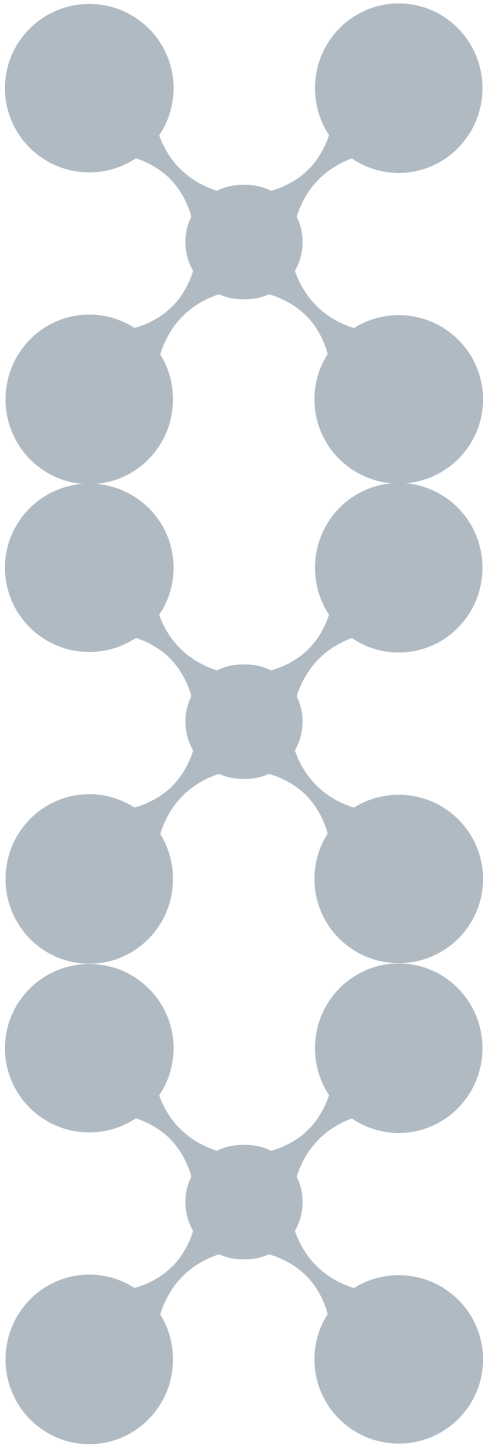
Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? Call your Plan Administrator at 816.359.4021 for more information.

NOTICE OF MATERIAL CHANGE (ALSO MATERIAL REDUCTION IN BENEFITS)

The City of Belton has amended the Medical benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Employee Benefits office (see page 3 for contact information).

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more employees, we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2019. If you were eligible for coverage under our group plan, you'll receive a personalized 1095-C form. We are also required to send a copy of your 1095-C form to the IRS. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit. You'll need the 1095-C form to complete your Federal tax return.



MEDICAID CHIP NOTICE

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

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

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

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

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

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

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://flmedicaidtplrecovery.com/flmedicaidplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MAINE – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Enrollment Website: http://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
INDIANA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.in.gov/medicaid Phone 1-800-457-4584	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
IOWA – Medicaid and CHIP (Hawki)	**MINNESOTA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
KANSAS – Medicaid	**MISSOURI – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY – Medicaid	**MONTANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA – Medicaid	**NEBRASKA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	**OREGON – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://healthcare.oregon.gov/Pages/index.aspx https://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEW HAMPSHIRE – Medicaid	**PENNSYLVANIA – Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
NEW JERSEY – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEW YORK – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NORTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://dss.sd.gov Phone: 1-888-828-0059
NORTH DAKOTA – Medicaid	**TEXAS – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WASHINGTON – Medicaid	**WYOMING – Medicaid**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 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 and 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.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more employees, we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2021. If you were eligible for coverage under our group plan, you'll receive a personalized 1095-C form. We are also required to send a copy of your 1095-C form to the IRS. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit. You'll need 1095 form to complete your Federal tax return.

INITIAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

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

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

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

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

INITIAL COBRA NOTICE *CONTINUED*

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

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

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 [*enter name of employer sponsoring the Plan*], 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. 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 continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

INITIAL COBRA NOTICE *CONTINUED*

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

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

Are there other coverage options besides COBRA Continuation Coverage?

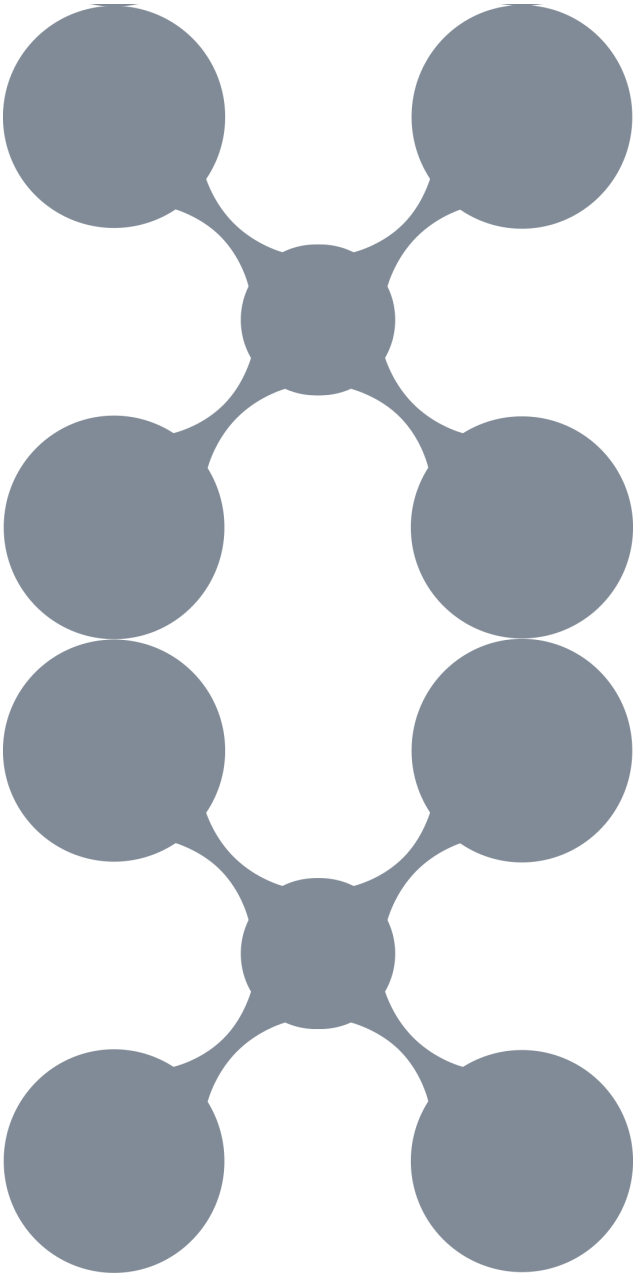
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of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

If you have questions

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

Keep your Plan informed of address changes

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



The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.