A MESSAGE FROM THE COUNTY OF LAKE

At County of Lake, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason County of Lake offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues to you that are not addressed here. A list of plan contacts is provided at the back of this summary.

The benefits in this summary are effective January 1st - December 31st, 2020

After you are acquainted with what County of Lake has to offer you and your family, if you decide you want to make changes, you must complete an online enrollment application at http://www.workterra.net. You have 30 days from your date of permanent hire to complete the enrollment application.

The benefits described herein are offered to eligible employees of County of Lake. All benefits are subject to change and there is no guarantee that these benefits will be continued indefinitely. The descriptions are very general and are not intended to provide complete details about any or all plans.

Exact specifications for all plans are provided in the official Plan Documents, copies of which are available from the Human Resources Department.

This package of material will give you information about the benefits which are available to you. Please read the information carefully. To help you make important decisions about your benefits, Human Resources is available to answer any questions you may have.

OPEN ENROLLMENT

Beginning on October 7, 2019 and lasting through October 18, 2019, all benefits-eligible employees will be eligible to participate in the annual open enrollment period. During open enrollment, you have the option to change group medical plans and add or drop dependent coverage.

Your new plan benefits will be effective January 1, 2020 and will run through December 31, 2020. In order to ensure a smooth implementation, you must complete self-service enrollment by 5 p.m. on October 18, 2019. If you do not enroll by this date, your benefits from 2019 will roll over, excluding opt out, FSA, and HSA participation. If you did not upload required documentation, those items must be corrected by 5 p.m. on November 1, 2019 or you will not be able to make a change for January 1, 2020.

IMPORTANT NOTICE

The information in this brochure is a general outline of the benefits offered under the County of Lake benefits program. This brochure may not include all relevant limitations and conditions. Specific details and limitations are provided in the plan documents, which may include a Summary Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this brochure differs from the plan documents, the plan documents will prevail.
Who Can You Cover?

Employees who are permanent full-time or permanent part-time, work at least 20 hours per week or are on approved leave of absence are benefit eligible for enrollment. You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit guidelines. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your Domestic Partner’s Child Legal Guardianship Foster Child Adoptive Child Stepchild):
  - Under age 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

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

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of County of Lake cannot also be covered as a dependent.
- Employees who work fewer than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage begins the first day of the following online enrollment which must be done within 30 days of the date of hire. New employees who do not enroll online within 30 days of becoming eligible will not be eligible for benefits until open enrollment for next year.

Open enrollment is generally held in October. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce
This chart is an easy guide to which form and documents must be submitted.

For further clarification, please contact the Human

<table>
<thead>
<tr>
<th></th>
<th>Nothing Required</th>
<th>Marriage Certificate</th>
<th>Dependent Verification (Economically dependent child affidavit)</th>
<th>State of California DP Registration</th>
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<tbody>
<tr>
<td>Employee only</td>
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<td>Employee &amp; Spouse</td>
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<tr>
<td>Employee &amp; Domestic Partner only</td>
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<tr>
<td>Employee &amp; Children to 26 years of age</td>
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**RETIREMENT OPTIONS:**
For anyone considering retirement during the upcoming Plan Year (January 1, 2020 through December 31, 2020), remember that you must be enrolled in benefit plans (i.e. cannot Opt-out of benefits in your final year of employment) if you want benefit coverage as a retiree. You must be enrolled as an employee and elect benefit coverage as a retiree in order to be able to keep your benefits as a retiree. Retirees must have continuous coverage to participate in either the bundle of dental, vision, and life insurance or the separate health insurance in order to enroll in these benefits. Retirees are not allowed back into the plans if their coverage lapses. As such, consider your retirement plans carefully if you are thinking about opting out of benefits for the 2020 plan year.

**LEAVE OF ABSENCE POLICY:**
A planned unpaid leave of absence should be requested 30 days in advance and requires Department Head approval. Failure to do so could result in a leave being denied. Leave of Absence for an unplanned event as a result of a qualified serious health condition does not require 30 days advance notice. You are responsible to provide medical certification the entire period of time you are off on leave of absence. Employees who fail to return from Family Medical Leave or do not work a minimum of 30 days after Family Medical Leave may be subject to reimbursing the County for employer paid insurance premiums. Please call Human Resources if you have questions (707) 263-2213.

**RESTRICTED RIGHTS:**
This document is subject to change without notice. The County of Lake does not warrant that the material contained in this document is error-free. If you find any issues with this document, please report them to Human Resources. Should a discrepancy exist between the plan information provided in this booklet and the carriers' document(s), the insurance carriers' policies will always prevail. This is not a legal document. Please refer to each insurance carrier's Summary Plan Descriptions, Evidence of Coverage, Policy, or other document(s) for additional information about your benefits, plan limitations and exclusions.

Each section of this handbook describes where you can obtain copies of the controlling plan materials. You may also request a paper copy of any of these materials by contacting the Human Resources Department at (707) 263-2213.

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualifying event or qualify for a “special enrollment”. If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.
QUALIFYING EVENTS INCLUDE:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- An event that is a “special enrollment” under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment:
  - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
  - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Two rules apply to making changes to your benefits during the year:

- Any change you make must be consistent with the change in status, AND
- You must make the change within 30 days of the date the event (marriage, birth, etc.) occurs (unless otherwise noted above).

WHEN YOUR BENEFITS TERMINATE

- Insurance benefits will terminate on the last day of the month in which the termination occurs. (Including retirement, unpaid absence or FMLA exhausting).
- When terminating, the employee must work at least one full schedule day in the month to get coverage for that month. Employees who terminate due to a medical condition / exhaustion of leave should contact Human Resources
- COBRA, if elected, will be effective the first of the month following date of termination.
BENEFITS DURING THE FAMILY AND MEDICAL LEAVE (FMLA) AND CALIFORNIA FAMILY RIGHTS ACT (CFRA)

An employee who qualifies for and is taking Family Medical Leave will be allowed to continue participating in any health and welfare benefit plan in which he/she was enrolled before the first day of leave (for a maximum of 12 work-weeks) at the level and under the same conditions of coverage as if the employee had continued in employment for the duration of such leave. The County will continue to make the same premium contributions as if the employee had continued working. The continued participation in health benefits begins on the date leave first begins under the Family and Medical Leave Act (e.g. for pregnancy disability leaves) or under the Family and Medical Leave Act/CFRA (e.g. for all other family care and medical leaves).

In some instances, the County may recover premiums it paid to maintain health coverage for you if you fail to return to work following pregnancy disability leave/FMLA leave.

An employee’s use of family/medical leave will not result in the loss of any employment benefit that the employee earned before using family/medical leave.

All employees must notify Human Resources at (707) 263-2213 as soon as possible for requesting FMLA for your own illness or for caring for a family member.
Medical Plan Descriptions

The goal of the County is to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The County offers a choice of medical plans through Anthem Blue Cross.

- **PPO (Preferred Provider Organization)** – The PPO plan is designed to provide choice, flexibility and value. Participants have a choice of using Preferred Providers (PPO) or going directly to any other physician (non-PPO provider) without a referral. Generally, there are annual deductibles to meet before benefits apply. You are also responsible for a certain percentage of the charges (co-insurance), and the plan pays the balance up to the agreed upon amount. Proof of PORAC membership is required to enroll in the PPO Law Enforcement plan.

- **ABHP (Account Based Health Plan) and Bronze Plan** – ABHP and Bronze Plan are PPO plans with higher deductibles and use the PPO network description above but coverage is different and these plans allow an employee to make contributions to a Health Savings Account (HSA). Unused portions of the account roll over to the next plan year and if you separate from the organization the account belongs to the account holder/employee to use toward qualified medical expenses. These accounts are governed by IRS code 502.

- **Opt-out** – Employees may Opt-out of the County’s group insurance plan if they provide proof of similar employer sponsored group coverage for 2020 and waive County benefits. Similar coverage must meet Minimum Essential Coverage definition as outlined by the ACA. Opt-out employees receive a $200 per month cash in lieu benefit and are enrolled in the employee only basic life and AD&D insurance plan paid for by the County. Employees covered by Tri-Care or other military insurance may now receive the $200 cash in lieu per federal law. Employees who obtain private (non-group coverage) on their own, or through the Exchange, may choose to waive the County insurance, but are not eligible for either the Opt-out or County contribution.

- **LCDSA** – The Anthem Blue Cross health plan options listed in this booklet are not available to LCDSA employees. LCDSA employees should contact the Human Resources Department or their department contact for information about their health plan options and their separate open enrollment period dates.
Anthem Blue Cross Preferred Provider Organization (PPO) Plan: Anthem Blue Cross PPO Plans allows you and your dependents to seek needed medical care from any Hospital, Physician, or other provider you wish. To avoid higher charges and reduced benefit payments, you are urged to obtain such care from Preferred Providers (in-network) whenever possible.

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<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-Of-Network</th>
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<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$500 per individual</td>
<td>$500 per individual (combined with in-network)</td>
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<td></td>
<td>$1,000 family limit</td>
<td>$1,000 family limit (combined with in-network)</td>
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<tr>
<td><strong>Annual Out-of-Pocket Max</strong></td>
<td>$3,500 per individual</td>
<td>Unlimited</td>
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<td>$7,000 family limit</td>
<td>Unlimited</td>
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<tr>
<td><strong>Lifetime Max</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td><strong>Office Visit</strong></td>
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<tr>
<td>Primary Provider</td>
<td>$20 copay then plan pays 100%</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$20 copay then plan pays 100%</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>Plan pays 80% after deductible (combined acupuncture limit: up to 15 visits per year)</td>
<td>Plan pays 60% after deductible (in-network limitations apply)</td>
</tr>
<tr>
<td><strong>Lab and X-ray</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible (complex imaging: up to $800 per test; all other: up to $350 per day)</td>
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<tr>
<td><strong>Inpatient Hospitalization</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible (up to $600 per day for non-emergency admission)</td>
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<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible (up to $350 per day)</td>
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<tr>
<td><strong>Urgent Care</strong></td>
<td>$20 copay then plan pays 100%</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$150 copay then plan pays 80% after deductible (copay waived if admitted)</td>
<td>$150 copay then plan pays 80% after deductible (copay waived if admitted)</td>
</tr>
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</table>
Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

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<th>In-Network</th>
<th>Out-Of-Network</th>
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<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$1,000 per individual</td>
<td>$1,000 per individual (combined with in-network)</td>
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<tr>
<td></td>
<td>$2,000 family limit</td>
<td>$2,000 family limit (combined with in-network)</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Max</strong></td>
<td>$4,000 per individual</td>
<td>Unlimited</td>
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<td>$8,000 family limit</td>
<td>Unlimited</td>
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<tr>
<td><strong>Lifetime Max</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td><strong>Office Visit</strong></td>
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<tr>
<td>Primary Provider</td>
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<tr>
<td>Specialist</td>
<td>$35 copay then plan pays 100%</td>
<td>Plan pays 60% after deductible</td>
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<td></td>
<td>$35 copay then plan pays 100%</td>
<td>Plan pays 60% after deductible</td>
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<tr>
<td><strong>Preventive Services</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>Plan pays 80% after deductible (combined acup. limit: up to 15 visits per year)</td>
<td>Plan pays 60% after deductible (in-network limitations apply)</td>
</tr>
<tr>
<td><strong>Lab and X-ray</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
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<tr>
<td></td>
<td>(complex imaging: up to $800 per test; all other: up to $350 per day for outpatient hospital)</td>
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<tr>
<td><strong>Inpatient Hospitalization</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible (up to $600 per day for non-emergency admission)</td>
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<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible (up to $350 per day)</td>
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<td><strong>Urgent Care</strong></td>
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<td>Plan pays 60% after deductible</td>
</tr>
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<td><strong>Emergency Room</strong></td>
<td>$150 copay then plan pays 80% after deductible (copay waived if admitted)</td>
<td>$150 copay then plan pays 80% after deductible (copay waived if admitted)</td>
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</table>
Please note that proof of current PORAC membership is required to enroll in the Law Enforcement PPO plan.

### Law Enforcement PPO Plan

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<th>In-Network</th>
<th>Out-Of-Network</th>
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<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$300 per individual $900 family limit</td>
<td>$600 per individual (combined with in-network) $1,800 family limit (combined with in-network)</td>
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<tr>
<td><strong>Annual Out-of-Pocket Max</strong></td>
<td>$5,300 per individual $10,600 family limit</td>
<td>$5,300 per individual (combined with in-network) $10,600 family limit (combined with in-network)</td>
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<tr>
<td><strong>Lifetime Max</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td><strong>Office Visit</strong></td>
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<tr>
<td>Primary Provider</td>
<td>$20 copay then plan pays 100%</td>
<td>Plan pays 90% after deductible</td>
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<tr>
<td>Specialist</td>
<td>$20 copay then plan pays 100%</td>
<td>Plan pays 90% after deductible</td>
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<tr>
<td><strong>Preventive Services</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>Plan pays 90% after deductible (combined outpatient rehab limit: up to 20 visits per year)</td>
<td>Plan pays 90% after deductible (in-network limitations apply)</td>
</tr>
<tr>
<td><strong>Lab and X-ray</strong></td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 90% after deductible (complex imaging: up to $800 per test; all other: up to $350 per day)</td>
</tr>
<tr>
<td><strong>Inpatient Hospitalization</strong></td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 90% after deductible (up to $600 per day for non-emergency admission)</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 90% after deductible (up to $350 per day)</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$20 copay then plan pays 100%</td>
<td>Plan pays 90% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 90% after deductible</td>
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Anthem Account Based Health Plan

Anthem Blue Cross Account Based Health Plan: The County of Lake is offering the following low cost account based health plan to all eligible employees. This plan is designed to educate you about health care decisions and empower you to take control of your health, as well as the dollars you spend on your care. The Account Based Health Plan has similar features as the Blue Cross PPO Plan such as visiting any doctor – even a specialist – without a referral, choosing from a large network of providers for greater savings. Or go out-of-network and share more of the cost.

The Account Based Health Plan has differences from the traditional PPO or HMO in that you pay the annual deductible amount before coverage begins for all services except preventive care services (which are covered at 100%). If you have family coverage, the entire family deductible must be met before covered benefits begin for anyone in the family (except for preventive care). Once you have satisfied your annual deductible your traditional health coverage kicks in. You pay the appropriate coinsurance for covered services, up to the annual out-of-pocket maximum. Typically you won’t pay at the time you receive services. Instead the office staff will file the claim for you to benefit from the network discounts. Pay applicable coinsurance for prescription drugs after you have satisfied your annual deductible (January 1st 2019 - December 31st 2019). And finally, Premiums are substantially lower.

<table>
<thead>
<tr>
<th>ABHP Plan</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
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<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$2,000 employee coverage (offset by HSA funds)</td>
<td>$4,000 employee coverage (offset by HSA funds)</td>
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<td>$4,000 family coverage (offset by HSA funds)</td>
<td>$8,000 family coverage (offset by HSA funds)</td>
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<tr>
<td><strong>Annual Out-of-Pocket Max</strong></td>
<td>$4,000 per individual</td>
<td>$8,000 per individual</td>
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<td></td>
<td>$8,000 family limit</td>
<td>$16,000 family limit</td>
</tr>
<tr>
<td><strong>Lifetime Max</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td><strong>Office Visit</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
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<tr>
<td>Primary Provider</td>
<td>Plan pays 60% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
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<tr>
<td><strong>Preventive Services</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 60% after deductible</td>
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<tr>
<td><strong>Chiropractic Care</strong></td>
<td>Plan pays 80% after deductible (combined outpatient rehab limit: up to 24 visits per year)</td>
<td>Plan pays 60% after deductible (in-network limitations apply)</td>
</tr>
<tr>
<td><strong>Lab and X-ray</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible (complex imaging: up to $800 per test, all other: up to $350 per day)</td>
</tr>
<tr>
<td><strong>Inpatient Hospitalization</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible (up to $600 per day for non-emergency admission)</td>
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<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible (up to $350 per day)</td>
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<tr>
<td><strong>Urgent Care</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 80% after deductible</td>
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</table>
Anthem Blue Cross Bronze Account Based Health Plan: The County of Lake is offering the following low cost account based health plan to all eligible employees. This Account Based Health Plan has similar features as the Blue Cross PPO Plan such as visiting any doctor – even a specialist – without a referral, choosing from a large network of providers for greater savings. Or go out-of-network and share more of the cost. Just like all other plans, preventative services are covered at no cost to you.

### Bronze Plan

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<tr>
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<th>In-Network</th>
<th>Out-Of-Network</th>
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<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$2,000 employee coverage (offset by HSA funds)</td>
<td>$4,000 employee coverage (offset by HSA funds)</td>
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<td></td>
<td>$6,000 family coverage (offset by HSA funds)</td>
<td>$12,000 family coverage (offset by HSA funds)</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Max</strong></td>
<td>$6,450 per individual</td>
<td>$12,700 per individual</td>
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<td></td>
<td>$12,900 family limit</td>
<td>$38,100 family limit</td>
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<tr>
<td><strong>Lifetime Max</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td><strong>Office Visit</strong></td>
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</tr>
<tr>
<td>Primary Provider</td>
<td>Plan pays 70% after deductible</td>
<td>Plan pays 50% after deductible</td>
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<tr>
<td>Specialist</td>
<td>Plan pays 70% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>Plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>Plan pays 70% after deductible (up to 30 visits per year)</td>
<td>Plan pays 50% after deductible (in-network limitations apply)</td>
</tr>
<tr>
<td><strong>Lab and X-ray</strong></td>
<td>Plan pays 70% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospitalization</strong></td>
<td>Plan pays 70% after deductible</td>
<td>Plan pays 50% after deductible (up to $600 per day for non-emergency admission)</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>Plan pays 70% after deductible</td>
<td>Plan pays 50% after deductible (up to $350 per day)</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Plan pays 70% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Plan pays 70% after deductible</td>
<td>Plan pays 70% after deductible</td>
</tr>
</tbody>
</table>
**Drug Plans - PPO 80, 35 and Law Enforcement**

Below are the prescription drug plans that are offered with our Anthem Blue Cross PPO 80 and PPO 35 and Law Enforcement.

Express Scripts delivers up to a 90-day supply of your medication right to you and standard shipping is free. Discuss with your doctor ways to pay less for the medications you need. If you need a medication on a long-term basis, you'll save money by using your mail-order pharmacy.

To avoid paying more, use the Express Scripts pharmacy and pay your mail-order co-payment for up to a 90-day supply. That means you'll pay less over time. Your medications will be delivered right to you, and standard shipping is free. Once you get started, you can request refills easily by mail, online or over the phone.

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPO Plan 80</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit</td>
<td>$3,100 per individual</td>
<td>$6,200 per family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Network claims do not apply to the Out-of-Pocket Maximum</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$5 copay then plan pays 100%</td>
<td>$5 copay then plan pays 100%</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$20 copay then plan pays 100%</td>
<td>$20 copay then plan pays 100%</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$50 copay then plan pays 100%</td>
<td>$50 copay then plan pays 100%</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$30 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$80 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>90 days</td>
<td></td>
</tr>
<tr>
<td><strong>PPO Plan 35</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit</td>
<td>$3,100 per individual</td>
<td>$6,200 per family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Network claims do not apply to the Out-of-Pocket Maximum</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$5 copay then plan pays 100%</td>
<td>$5 copay then plan pays 100%</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$20 copay then plan pays 100%</td>
<td>$20 copay then plan pays 100%</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$50 copay then plan pays 100%</td>
<td>$50 copay then plan pays 100%</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$40 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$100 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>90 days</td>
<td></td>
</tr>
<tr>
<td><strong>Law Enforcement PPO Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit</td>
<td>$1,300 per individual</td>
<td>$2,600 per family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Network claims do not apply to the Out-of-Pocket Maximum</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 copay then plan pays 100%</td>
<td>$10 copay then plan pays 100%</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$25 copay then plan pays 100%</td>
<td>$25 copay then plan pays 100%</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$45 copay then plan pays 100%</td>
<td>$45 copay then plan pays 100%</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$25 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$45 copay then plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>90 days</td>
<td></td>
</tr>
</tbody>
</table>
Unlike members who elect medical coverage on Anthem’s Traditional PPO Plans, Account Based Health Plan and Bronze Plan members do not have Express Scripts (ESI) as their Pharmacy Benefit Manager; instead these plans use IngenioRx. Here are the prescription drug plans that are offered with our Anthem Blue Cross Account Based Health Plan and Anthem Blue Cross Bronze Plan administered by Anthem Blue Cross.

<table>
<thead>
<tr>
<th>ABHP Plan</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Deductible</td>
<td>Prescriptions subject to medical deductible</td>
<td>Prescriptions subject to medical deductible</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit</td>
<td>Prescriptions subject to medical out-of-pocket maximums</td>
<td>Prescriptions subject to medical out-of-pocket maximums</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Generic</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td>Mail Order</td>
<td>Plan pays 80% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Generic</td>
<td>Plan pays 80% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>Plan pays 80% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>Plan pays 80% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>90 days</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bronze Plan</th>
<th>Prescription Drug Deductible</th>
<th>Annual Out-of-Pocket Limit</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prescriptions subject to medical deductible</td>
<td>Prescriptions subject to medical out-of-pocket maximums</td>
<td>Plan pays 70% after deductible</td>
</tr>
<tr>
<td></td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Plan pays 70% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plan pays 70% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plan pays 70% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30 days</td>
</tr>
<tr>
<td></td>
<td>Mail Order</td>
<td>Plan pays 70% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Generic</td>
<td>Plan pays 70% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand</td>
<td>Plan pays 70% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Brand</td>
<td>Plan pays 70% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Supply Limit</td>
<td>Plan pays 70% after deductible</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>90 days</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
Health Savings Account (HSA)

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?
An HSA is a tax-deductible savings account that works with a qualified health plan to help you pay for the cost of out-of-pocket health care and prescription medication expenses. You take the money you would have paid for higher health insurance premiums and use it to pay for qualified medical expenses or save it and let it grow!

• Your HSA money is yours, ALWAYS! You won’t lose it if you don’t spend it, change jobs, retire or change health plans.
• You never pay taxes on withdrawals for qualified medical expenses.
• Your money earns interest and you don’t pay taxes on the interest earned.
• Your contributions are tax deductible, and reduce your overall taxable income (Note that any funds contributed to the Health Savings Account are tax-deductible on the federal level only as California does not consider employer or employee contributions to be tax-deductible)
• Plan for retirement—after age 65, participants can use HSA funds for non-qualifying expenses

WHO IS ELIGIBLE FOR AN HSA?
Anyone meeting the following requirements is eligible for an HSA:

• Is enrolled in County of Lake's qualified ABHP or Bronze medical plan,
• Is not covered under another medical plan that is not HSA compatible,
• Is not enrolled in Medicare,
• Is not eligible to be claimed on another person’s tax return,
• Is not active in the military, and
• Is a U.S. resident.

<table>
<thead>
<tr>
<th>2020 Contribution Limit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,550</td>
</tr>
<tr>
<td>Family</td>
<td>$7,100</td>
</tr>
<tr>
<td>For participants age 55 or older</td>
<td>An additional $1,000</td>
</tr>
</tbody>
</table>

You are allowed to contribute the entire year’s limit when you first become eligible for the HSA (even if that is in December); however, you must remain eligible for at least 12 months after that date, or you will be subject to taxes and penalties on the amount you contributed.

Your Health Savings Account (HSA) is through OPTUM Bank. To learn more about taking advantage of a Health Savings Account please visit:
www.optumbank.com
or call 1-844-326-7967
Monday to Friday, 8am to 10pm ET
Have you ever been at work and didn’t feel well? Maybe you had a fever or a sore throat but you didn’t have time to leave and see your doctor or go to urgent care. Now, with LiveHealth Online, you can see a board-certified doctor in minutes.

Just use your smartphone, tablet or computer with a webcam. It’s so convenient, almost 90% of people who’ve used it feel they saved two hours or more and would use it again in the future. Plus, online visits using LiveHealth Online are already part of your Anthem Blue Cross and Blue Shield benefits. To start using LiveHealth Online, all you need to do is sign up at livehealthonline.com or download the app.

Sign up for free today and get:

1. **24/7 access to doctors.** They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice, if needed. It’s a great way to get care when your doctor isn’t available.

2. **Medical care when you need it.** For things like the flu, a cold, sinus infection, pink eye, rashes, fever and more.

3. **Convenience.** Since there are no appointments or long waits. In fact, most people are connected to a doctor in about 10 minutes or less.

Doctors using LiveHealth Online typically charge $49 or less per visit, depending on your health plan.

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**LiveHealth Online Psychology**

An easy, convenient way to see a therapist or psychologist in just a few days

If you’re feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology. It’s easy to use, private and, in most cases, you can see a therapist within four days or less. All you have to do is sign up at livehealthonline.com or download the app to get started. The cost is similar to what you’d pay for an office therapy visit.

Make your first appointment — when it’s easy for you

- Use the app or go to livehealthonline.com and log in. Select LiveHealth Online Psychology and choose the therapist you’d like to see.
- Or, call LiveHealth Online at 1-844-784-8408 from 7 a.m. to 11 p.m.
- You’ll get an email confirming your appointment.

---

Get started today

It’s quick and easy to sign up for LiveHealth Online. Just go to livehealthonline.com or download the mobile app at Google Play™ or the App Store™.
Anthem Resources, continued

LiveHealth Online: what you need to know

What kind of doctors can you see on LiveHealth Online?

Doctors on LiveHealth Online are:
- Board certified with an average of 15 years of practicing medicine
- Mainly primary care physicians
- Specially trained for online visits

When can you use LiveHealth Online?

LiveHealth Online is a great option for care when your own doctor isn’t available and more convenient than a trip to the urgent care. With LiveHealth Online, you can receive medical care for things like:
- Cold and flu symptoms, such as a cough, fever and headaches
- Allergies
- Sinus infections and more

How do I pay for an online visit using LiveHealth Online?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online doctor visit. Keep in mind that charges for prescriptions aren’t included in the cost of your doctor visit.

How much does a therapist visit cost?

The cost should be similar to what you’d pay for an office therapy visit, depending on your benefits, copay or coinsurance. You’ll see what you owe before you start a visit and any cost is charged to your credit card. The cost is the same no matter when you have the visit — whether it’s a weekday, the weekend, evening or a holiday.

How do I decide which therapist to see?

After you log in at livehealthonline.com or with the app, select LiveHealth Online Psychology. Next, you can read profiles of therapists and psychologists. Once you select the one you would like to see, schedule a visit online or by phone. At the end of the first visit, you can set up future visits with the same therapist if both of you feel it’s needed. You always have the choice of the therapist you want to see.

What else do I need to know about LiveHealth Online Psychology?

- You must be at least 18 years old to see a therapist online and have your own LiveHealth Online account.
- Psychologists and therapists using LiveHealth Online do not prescribe medications.
- Visits usually last about 45 minutes.
Getting Care When You Need It Now

WHEN TO USE THE ER
The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE
Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW
What do you do when you need care right away, but it's not an emergency?

Anthem Medical Plan Participants
- Call Anthem's 24/7 NurseLine at 800-977-0027
- Find an urgent care center by visiting anthem.com/ca
- Use Anthem LiveHealth Online

GET A VIDEO HOUSE CALL
Anthem members can video chat with a doctor from the comfort of their own homes, without an appointment. LiveHealth Online provides 24/7 access to U.S. board-certified physicians, for the fraction of the cost of an office visit. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. For more information, visit livehealthonline.com.

PREVENTIVE OR DIAGNOSTIC?
Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change. Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.
Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Save money with a Delta Dental PPO dentist. Delta Dental PPO network dentists accept reduced fees for covered services they provide to you. Get information about your plan anytime, anywhere by signing up for an Online Service account at deltadentalins.com. This free service allows you to check benefits, eligibility information, network dentist and more.

### Delta Dental Plan PPO Plan

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$25 per individual</td>
<td>$25 (combined with in-network)</td>
</tr>
<tr>
<td></td>
<td>$75 per family</td>
<td>$75 per family (combined with in-network)</td>
</tr>
<tr>
<td><strong>Annual Plan Maximum</strong></td>
<td>$1,100 per individual</td>
<td>$1,100 per individual (combined with in-network)</td>
</tr>
<tr>
<td><strong>Waiting Period</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Diagnostic and Preventive</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Root Canals</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Periodontics</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
<td>Plan pays 75% after deductible</td>
<td>Plan pays 75% after deductible</td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Plan pays 50%</td>
<td>Plan pays 50%</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$1,250</td>
<td>$1,250 (combined with in-network)</td>
</tr>
<tr>
<td>Dependent Children</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Full-time Students</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>
USING THE APP WITHOUT LOGGING IN
Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in.

LOGGING IN TO VIEW BENEFITS
Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered, there is a link on the home screen to register for an account. If you've forgotten your username or password, you can also retrieve these via Delta Dental Mobile.

SECURELY ACCESS YOUR BENEFITS
You must enter your user name and password each time you access the secure portion of the app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed via a link on the Login page of the app.

ONLINE SERVICES - WWW.DELTADENTALINS.COM
- Printable ID cards
- Secure login for benefits and eligibility lookup
- Claims status available to enrollees & dentists
- Dentist directory with maps & driving directions
- Extensive dental health section
- Enrollee section in Spanish
- SmileKids – an interactive site for children
- Fee Finder
- Explanation of Benefits – use it!
- Articles and Quizzes on Oral Health Dental Wire Newsletter

IMPORTANT TIPS
- Pre-Treatment estimate - Make sure you always get one so you know how much you will be paying BEFORE you get to your appointment!
- If you are having extensive dental work done
- Ensuring that a procedure is covered
- To see if you will exceed your maximum
- If you need to plan your payment in advance
- If you would like an advance breakdown of the charges and coverage
Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through Vision Service Plan (VSP).

### VSP Choice Plan

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examination</strong></td>
<td>Plan pays 100%</td>
<td>Reimbursed up to $45</td>
</tr>
<tr>
<td><strong>Benefit</strong></td>
<td>1x every 12 months from last date of service</td>
<td>In-network limitations apply</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Materials**          | Plan pays 100%                                  | See schedule below                                   |
| **Benefit**            |                                                 |                                                      |
| **Frequency**          |                                                 |                                                      |

| **Eyeglass Lenses**    | Plan pays 100% of basic lens                    | Reimbursed up to $30                                  |
| **Single Vision Lens** | Plan pays 100% of basic lens                    | Reimbursed up to $50                                  |
| **Bifocal Lens**       | Plan pays 100% of basic lens                    | Reimbursed up to $65                                  |
| **Trifocal Lens**      | 1x every 24 months from last date of service    | In-network limitations apply                         |
| **Frequency**          |                                                 |                                                      |

| **Frames**             | Reimbursed up to $150 plus a plan pays 20% discount from the remaining balance | Reimbursed up to $70                                  |
| **Benefit**            | 1x every 24 months from last date of service    | In-network limitations apply                         |
| **Frequency**          |                                                 |                                                      |

| **Contacts (Elective)**| Reimbursed up to $130 (instead of eyeglasses)  | Reimbursed up to $105 (in-network limitation applies) |
| **Benefit**            | 1x every 24 months from last date of service    | In-network limitations apply                         |
| **Frequency**          |                                                 |                                                      |
THE ULTIMATE PROVIDER PLAYLIST

The right song can set the mood, and the right vision provider can set the tone for a great eye care experience. With VSP®, your employees have the freedom to choose a provider they can really groove with.

MORE CHOICES. MORE FREEDOM. VSP NETWORK PROVIDERS

VSP has your employees and their eyes covered with a huge network of independent doctors, popular retailers, and an online option.

**Independent Doctors**
- 91% offer early morning, evening, and weekend appointments.
- 24-hour access to emergency care.
- Eye Health Management Program®.
- VSP Premier Program gives members the most out of their eye care experience at one location.

**Retail Chains**
- For employees who prefer their favorite retailer, our network includes tons of participating retail chains, including:
  - Costco Vision Centers
  - Pearle Vision
  - Visionworks

**Buy Online, Anytime!**
- Want even more options? You got it! Your employees can shop the latest designer glasses and name brand contacts online at Eyeconic.com® with their VSP benefits.

**Effortless Out-of-network Shopping.**
- Saying, “I have VSP,” is all it takes to shop out-of-network. We’ll do the rest!

Enjoy the sweet song of employee satisfaction with true freedom of choice from VSP.
VSP Resources, resources

VSP® Vision Care members can save up to 60% on the latest brand-name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too.

Hearing loss is growing in the workplace.
Like vision loss, hearing loss can have a huge impact on productivity and overall quality of life. Unfortunately, of the over 38 million people who need hearing aids, only one in five has them. And the high cost of hearing aids is a major factor keeping people from addressing their hearing loss.

96% of customers surveyed would recommend TruHearing to their friends and family.*

More Than Just Great Pricing
TruHearing also provides members with:
• Three provider visits for fitting and adjustments
• A 45-day trial
• Three-year manufacturer warranty for repairs and one-time loss and damage replacement
• 48 free batteries per hearing aid

Plus, members get:
• Access to a national network of more than 3,800 hearing healthcare providers
• Straight-forward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids
• Deep discounts on batteries shipped directly to their door

Best of all, if your organization already offers a hearing aid benefit, members can combine it with TruHearing prices to reduce their out-of-pocket expense even more!

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or, call 877.396.7194 with questions.

Here’s how it works:
1. Members call TruHearing.
   Members and their family call 877.396.7194 and mention VSP.

2. Schedule exam.
   TruHearing will answer questions and schedule a hearing exam with a local provider.

3. Attend appointment.
   The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for the member.

*Based on a 2013 satisfaction study of VSP members.
*The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representation or warranty regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is solely responsible for the products or services offered by them. Savings based on a survey of national average retail hearing aid prices compared to average TruHearing pricing. Actual customer savings will vary. Three follow-up visits must be used within one year after the date of initial purchase. Forty-five-day trial and hearing aid returns, repairs, and replacements subject to provider and manufacturer fees. For questions regarding fees, contact TruHearing customer service. Not available in the state of Washington.

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VSP is a registered trademark of Vision Service Plan. All other brands or marks are the property of their respective owners.
Voya Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

**BASIC LIFE AND AD&D**

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company. Coverage is provided by Voya Financial. Basic Life Insurance provides protection for your beneficiary in the event of your death. All employees who are permanent full-time or permanent part-time, work at least 20 hours per week or are on approved leave of absence are eligible to enroll in Basic Life Insurance coverage.

The County of Lake provides you with Basic Life and AD&D insurance coverage through Voya. All Active Members receive $5,000 for basic life and $5,000 AD&D, and all Retired Members receive $1,000 (Please note Retiree Members do not receive AD&D Benefit). This benefit is provided to all eligible employees at no cost to you, and all eligible employees will be automatically enrolled.

**SUPPLEMENTAL LIFE**

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya Financial. In addition to the basic life insurance plan, you are eligible to purchase supplemental Life and/or AD&D insurance for yourself and your eligible dependents. The Supplemental Life and AD&D plans offer the convenience of low group rates, no health underwriting with timely enrollment on amounts below the guarantee issue amounts, and convenient payroll deductions.

You have the option to choose supplemental coverage in increments of $10,000 up to a maximum benefit of $500,000 for employees under age 70. If you are applying for the first time, you can elect up to the maximum benefit, subject to medical underwriting approval. If you are already enrolled and want to increase your coverage, you will be subject to medical underwriting approval.

You also have the option of purchasing supplemental spouse life coverage in increments of $5,000 up to $100,000.

<table>
<thead>
<tr>
<th>Age of Employee/Spouse/DP</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25</td>
<td>$.071</td>
</tr>
<tr>
<td>25 - 29</td>
<td>$.071</td>
</tr>
<tr>
<td>30 - 34</td>
<td>$.086</td>
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<tr>
<td>35 - 39</td>
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<tr>
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<tr>
<td>60 - 64</td>
<td>$1.21</td>
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<tr>
<td>65 - 69</td>
<td>$2.24</td>
</tr>
<tr>
<td>70 – Over</td>
<td>$4.49</td>
</tr>
</tbody>
</table>

- Dependent Children Life rates are as follows: $2.00 per month for $10,000 of coverage.
- Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.
- Evidence of Insurability: Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.
How to file an insurance claim
ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies

Online submission via the Voya Claims Center
Step 1 - Visit the Voya Claims Center and click on “Start A Claim”.

Step 2 - Complete the questionnaire.
This generates a custom claim form package for you.

Step 3 - Download your claim form package.

Step 4 – Complete the form package.
Have each form completed by the appropriate party, as outlined in the claim form package.

Step 5 – Gather additional documents.
Collect any additional supporting documents, as instructed on the claim form “for you”.

Step 6 – Submit.
Using your preferred submission method, submit your completed and signed forms, as well as any supporting documents.
• To submit online via a secure upload, visit Voya.com and click on “Contact & Services > Claims Center > Upload a Claim”.
• To mail or fax your submission, see the top of your custom claims form package.

Questions about the claim process?
For Life Insurance call 1-888-238-4840.

For Disability Income Insurance, call 1-888-305-0602.

Insurance products are issued by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Voya Employee Benefits is a division of ReliaStar Life Insurance Company. Product availability and specific provisions may vary by state.

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Plan Name, Group #316407, Date Prepared: 12/1/20017
175254 – 02/20/2017
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Voya Resources

Contact Us... Anytime, Anywhere
No-cost, confidential solutions to life’s challenges.

Confidential Emotional Support
Our highly trained clinicians will listen to your concerns and quickly refer you to in-person counseling and other resources for:
- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Online Support
GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:
- Articles, podcasts, videos, slideshows
- On-demand trainings
- “Ask the Expert” personal responses to your questions

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 877.533.2363
TDD: 800.697.0353
Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant™, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: My5848i
Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

Contact Your GuidanceResources® Program
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Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: My5848i

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Voya Resources, continued

Voya Travel Assistance

Security when you travel

We live in a highly connected world where frequent domestic and international travel is the norm. Voya Travel Assistance offers you enhanced security for your leisure and business trips. You and your dependents will have toll-free or collect-call access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year – from anywhere in the world.

Available services

When traveling more than 100 miles from home, Voya Travel Assistance offers you and your dependents four types of services: pre-trip information, emergency personal services, medical assistance services, and emergency transportation services.

Pre-trip information

These valuable services help you start your trip the right way. Voya Travel Assistance can provide you with important, up-to-date travel information including:

- Immunization requirements
- Visa & passport requirements
- Foreign exchange rates
- Embassy/consular referral
- Travel/tourist advisories
- Temperature & weather conditions
- Cultural information

Emergency personal services

In the event of an unexpected situation of a non-medical nature, Voya Travel Assistance offers access to several valuable services, including:

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage or personal possessions
- Legal assistance and/or bail bond

If you need emergency or pre-trip services...

...use the contact information on the reverse and identify yourself as an eligible participant in the Voya Travel Assistance program.

You will be asked to provide some additional information in order to confirm your eligibility under this program. Once your eligibility has been verified, Voya Travel Assistance will arrange and provide the Emergency Transportation Services previously described.

Please note: Services are only eligible for payment through Voya Travel Assistance if Voya Travel Assistance was contacted at the time of service and arranged for the service. If costs are incurred for other services, you are responsible for those costs or reimbursement of those costs if initially paid by Voya Travel Assistance; Voya Travel Assistance will ask for your credit card and debit your account for the required amount.

Voya Travel Assistance

Contact Voya Travel Assistance 24 hours a day, 365 days a year for Pre-Trip Information, Emergency Personal Services, Medical Assistance Services, and Emergency Transportation Services.

- In the US, Toll Free: 800.859.2821
- Worldwide, Collect: 202.296.8355
- Email: ops@europassistance-usa.com
- Online Portal: https://eservices.europassistance-usa.com/sites/Voya
- Group ID: NV0Y
- Activation Code: 140623

ReliaStar Life Insurance Company (Minneapolis, MN) and ReliaStar Life Insurance Company of New York (Woodbury, NY), members of the Voya® family of companies

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27
Voya Resources, continued

Medical assistance services include:
- Medical referrals for local physicians and dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Arrangement and payment of emergency medical services (up to $10,000 with a written guarantee of reimbursement from the eligible participant)

Emergency transportation services* Should you need medical care or assistance while traveling, Voya Travel Assistance can help. When deemed medically necessary by a Voya Travel Assistance designated physician, evacuation and transportation to the nearest adequate medical facility that can properly treat your condition will be arranged and paid for on your behalf. Additional transportation services include:
- Visit of family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

Exclusions and limitations
A. Voya Travel Assistance shall not provide services enumerated above if the service is sought as a result of your or your dependent's:
- Involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power;
- Travel against the advice of a physician;
- Travel for the purpose of obtaining medical treatment;
- Travel in any country in which the U.S. State Department issued travel restrictions;
- Commission of or attempt to commit an unlawful act;
- Being under the influence of drugs or intoxicants unless prescribed by a physician;
- Pregnancy and childbirth (except for complications of pregnancy);
- Mental or emotional disorders, unless hospitalized;
- Participation as a professional in athletics;
- Services provided for which no charge is normally made;
- Travel within 100 miles of your permanent residence, unless in a foreign country.

B. The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, Voya Travel Assistance may not be able to respond in the usual manner.

It is your responsibility to inquire whether a country is "open" for assistance prior to your departure and during your stay. Voya Travel Assistance also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit Voya Travel Assistance to fully provide services.

C. If you request a transport related to a condition that has not been deemed medically necessary by a physician designated by Voya Travel Assistance in consultation with a local attending physician or to any condition excluded hereunder, and the Employer or Plan Sponsor agrees to be financially responsible for all expenses related to that transport, Voya Travel Assistance will arrange but not pay for such transport to a medical facility or to your residence and will make such arrangements using the same degree of care and completeness as if Voya Travel Assistance was providing service under this agreement. A waiver of liability will be required prior to arranging these transportation services.

D. Voya Travel Assistance shall not be responsible for any claim, damage, loss, cost, liability or expense which arises in whole or in part as a result of Voya Travel Assistance's inability to reach the Employer's or Plan Sponsor's authorized Contact person for any reason beyond Voya Travel Assistance's control, or as a result of the failure and/or refusal of the Employer or Plan Sponsor to authorize services proposed by Voya Travel Assistance.

Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.
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149385 09/01/2016
ReliStar Life Insurance Company (Minneapolis, MN) and ReliStar Life Insurance Company of New York (Woodbury, NY), members of the Voya® family of companies

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Voya.com
Peace of mind when it’s needed the most

Funeral planning services

Available to employees who are covered for group life insurance through their employer. Funeral planning and concierge services are provided by Everest Funeral Package, LLC.

Everest is pleased to provide a value-added service that empowers individuals who are dealing with funeral related issues.

Who is Everest?

Everest, the first nationwide funeral planning and concierge service, is an independent consumer advocate who works on your behalf. Everest’s sole purpose is to provide the information you need to make the most informed decisions about all funeral related issues, and then put those wishes into action.

You’re never locked into a decision because Everest’s funeral advisory services can be used at any funeral home across North America.

Everest is an impartial consumer advocate, not a funeral home. Everest does not sell funeral goods or services, nor does Everest receive any commissions from funeral homes or other service providers in the funeral industry. With Everest, you are removed from a sales-focused environment allowing you and your family to make well-informed and confident decisions during a stressful time.

Everest offers both pre-planning and at-need services at or near the time of need. Everest’s online planning tools help you prepare for the future. At-need services include price negotiation assistance and communicating the family’s wishes to the funeral home. Everest Advisors are available by phone 24/7 and can determine eligibility for the expedited life insurance claim process.

While you can’t predict life’s outcome, you can prepare for it...

RollStar Life Insurance Company (Minneapolis, MN) and RollStar Life Insurance Company of New York (Woodbury, NY), members of the Voya® family of companies
EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through MHN Inc. can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free.

Help is available 24/7, 365 days a year by telephone at (800) 242-6220. Other resources are available online at www.members.mhn.com. When you log in, enter lake as the company code.

In-person counseling may also be available, depending on the type of help you need. The program allows you and your family/household members up to 5 per incidents.

Additional benefits are available through your medical plan. Review your medical benefit summary for more information.

<table>
<thead>
<tr>
<th>MHN</th>
<th>EAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-Face Counseling</td>
<td>5 Sessions per participant per issue</td>
</tr>
<tr>
<td>Financial Counseling</td>
<td>One 30 – 60 minute telephonic consultation per issue</td>
</tr>
</tbody>
</table>
| Legal Consultations                       | One 30 minute consultation per issue (telephonic or office)  
For those who wish to engage with an attorney after a 30 minute session, will receive a 25% discount on the hourly rate |
| Substance Abuse                           | 30 minute sessions/unlimited issues (telephonic or office) |
Flexible Spending Account

The Flexible Spending Account (FSA) offered through Workterra allows you to pay for eligible healthcare and dependent care expenses using tax-deductible dollars. When you participate in an FSA plan via salary reduction, you reduce your federal, FICA, social security, Medicare (and in some cases, state) taxes and increase take-home pay. The money that is deposited into your FSA comes straight out of your gross pay, therefore reducing your taxes.

HEALTH CARE FSA
This plan allows you set aside pre-tax dollars to help pay for certain out-of-pocket health care expenses. Contributions are made annually and can range from $400—$2,700 per year. This plan offers a benefit debit card for your convenience.

HEALTH FSA ELIGIBLE EXPENSES*:
• Medical expenses: co-pays, co-insurance, and deductibles
• Dental expenses: exams, cleanings, X-rays, and braces
• Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
• Professional services: chiropractor and acupuncture
• Prescription drugs and insulin

LIMITED PURPOSE FSA
If you elect the Anthem ABHP or the Anthem Bronze Plan with a Health Savings Account, you cannot participate in the Traditional Healthcare FSA, you must choose a Limited Purpose Healthcare FSA. This plan allows you to use your pretax dollars to pay for eligible Dental and Vision expenses only. Contributions are made annually and can range from $400—$2,700 per year. Funds in your Limited Purpose FSA must be used up before you can access your HSA funds for Dental and Vision Expenses.

LIMITED PURPOSE FSA ELIGIBLE EXPENSES*:
• Dental cleaning
• Dental fillings
• Dental crowns
• Braces
• Contact lenses
• Eyeglasses
• Eye exams
• Vision correction (Lasik)

* For a full list of eligible expenses see IRS publication 502 https://www.irs.gov/forms-pubs/about-publication-502
Flexible Spending Account, continued

DEPENDENT CARE FSA
This plan allows you to set aside pre-tax dollars that can be used to help pay for day care services for eligible dependents. The maximum amount you can contribute to this plan annually is $5,000 (if you are married but filing separately, federal regulations limit the use of a Dependent Care FSA to $2,700 each year). In order to qualify for Dependent Care FSA the IRS has established the following regulations:
An eligible dependent is any child under the age of 13 or eligible dependent who is physically or mentally incapable of caring for his or her own needs, such as an invalid parent.
If you claim the dependent care credit on your tax return or collect compensation through your Dependent Care FSA, you must report the name, address, and tax payer identification number of each dependent care provider.

DEPENDENT CARE FSA ELIGIBLE EXPENSES:
- Care for your child who is under age 13 before and after-school
- Baby sitting and nanny expenses
- Day care, nursery school, and preschool
- Summer day camp
- Care for a relative who is physically or mentally incapable of self-care and lives in your home

THE “USE IT OR LOSE IT” RULE
This rule states that if you contribute your pre-tax dollars to an FSA and then do not use all of the dollars you deposit, you will lose the remaining balance in the account at the end of the plan year. For this reason, it is essential that you plan ahead before deciding how much to contribute to your two FSA accounts and that you put in those dollars you are confident you will use.

GRACE PERIOD
Your medical FSA has a grace period of two and half months. Beginning January 1, 2020 through March 15, 2021, you can continue to incur claims against your previous year’s medical FSA funds. Once your funds from the previous year are depleted, all ongoing claims will be paid using your 2020 election.
Carrum Health’s new program for active employees, early retirees, and COBRA participants who are eligible for Carrum Health lets you find the best surgeons for your healthcare needs. Carrum Health provides an outpatient program at Hoag Orthopedic Institute that offers 80 new procedures, along with new locations at Saint John’s Health Center and Providence. This program provides peace of mind by ensuring no surprise costs and concierge care at any of your visits. Explore more by visiting carrum.me/EIAHEALTH, calling 1-888-855-7806, or texting “EIA” to 555888.
Carrum Health, continued

More Providers, More Coverage
You now have access to Providence Saint John’s Health Center in Santa Monica and The Hoag Institute in Orange County, in addition to Scripps and Stanford ValleyCare. Plus, there are over 80 new procedures available through your Carrum benefit.

PROVIDENCE SAINT JOHN’S HEALTH CENTER IN SANTA MONICA
Saint John’s is a nationally renowned, top rated center of clinical excellence. Eligible procedures:
- Total Knee Replacement Surgery
- Hip Replacement Surgery

Hoag Orthopedic Institute Surgery Center excels in orthopedic and musculoskeletal care. Carrum has partnered with Hoag to offer you many new outpatient procedures. This includes 80 NEW orthopedic and spine procedures.

HOAG ORTHOPEDIC INSTITUTE SURGERY CENTER IN ORANGE COUNTY

EXPLORE MORE
Visit: carrum.me/EIAHEALTH
Text: “EIA” to 555888
Call us: 1-888-855-7806

Better Surgeons, Better Results
What is the Solera4me Lifestyle Change Program?

Also known as the Diabetes Prevention Program (DPP), the lifestyle change program helps participants lose weight, adopt healthy habits and significantly decrease their risk of developing type 2 diabetes. The program meets weekly for 16 weeks and then monthly for the balance of a year. The program teaches participants to make lasting changes by eating healthier, increasing physical activity, and managing the challenges that come with lifestyle change.

What's included in the program?

There are many versions of the lifestyle change program, but most include the following components:

- 16 weekly lessons, followed by monthly sessions for the rest of the year
- Lifestyle health coach to help set goals and keep participants on track
- Small group for support and encouragement
- Helpful tools, like wireless scales and fitness trackers

Who is eligible for the program?

The solera4me lifestyle change program is a new preventive benefit for qualified health plan members over the age of 18. Some Medicare members are also eligible. Medicare members should contact Solera Health at 877-486-0141 to find out if they’re eligible.

How do members find out if they qualify?

Members who are identified as having prediabetes or who score as high risk for developing type 2 diabetes can qualify for the program. Members should visit solera4me.com/eia and take a 1-minute quiz to see if they qualify.

Is there a cost to members for participating?

This program is at no cost to members if they are covered by a participating health plan. Once a member enrolls in the program on Solera4Me.com, their health plan provider will receive a claim from Solera to cover the program services for this preventive benefit. Members may receive an Explanation of Benefits (EOB) from their health plan for this benefit. No action is necessary if a member receives an EOB. DPP is a covered preventive benefit.

Who should I contact if I have questions about the program?

Call Solera at 877-486-0141 if you have questions.
Reach Air Medical Services

Dear County of Lake Employees,

AirMedCare Network would like to offer you the opportunity to join our air ambulance membership program at a very affordable rate. REACH and CALSTAR are the local air ambulance providers in Lake, Mendocino, Sonoma and Napa counties.

Accidents and critical illnesses can happen anywhere, anytime and they are never planned. AMCN has more than 320 locations across 38 states and is the largest air ambulance membership program in the US. Being a member of our network offers you peace of mind for just dimes a day.

County of Lake has negotiated a discounted group rate on your behalf and for just $175/year you can have access to both our Emergent and the Fly-U-Home programs. This is a $44 savings!

**AMCN/REACH MEMBERSHIP RATES FOR EMPLOYEES**

**OPTION 1: $55 – AMCN MEMBERSHIP (EMERGENT):**
Covers all costs for emergency air transport should be flown by REACH, CALSTAR or any other AMCN provider. This includes scene transports along with hospital-to-hospital transports. You pay zero out-of-pocket and it covers everyone living in your household.

**OPTION 2: $120 – FLY-U-HOME MEMBERSHIP (NON-EMERGENT):**
Fly-U-Home provides access to a fleet of medically equipped, private aircraft ready to transport you to your local hospital of choice, should you become hospitalized more than 150 nautical miles from home. And as with AMCN membership, you’ll have no out-of-pocket expenses in relation to your flight. Fly-U-Home also covers the transport of Mortal Remains.

**OPTION 3: $175 – BEST VALUE:**
Includes both the AMCN membership and the Fly-U-Home membership.

**JOINING IS EASY!**
The County of Lake offers a one-time payroll deduction in January of every year. In order to take advantage of this, you must have a completed application to Human Resources no later than December 1st. If you are a new hire and have missed this deadline, you must contact our local Membership Manager to find out what the pro-rated cost would be for you to join and follow the process given by her.

Sincerely,

Nicole Vice | (707) 239-2505
nicole.vice@airmedcarenetwork.com | www.amcnrep.com/nicole-vice
County of Lake Retirement Plan affords you an excellent opportunity to help accumulate money for a secure retirement. You contribute pretax dollars automatically by convenient payroll reduction, which might lower current income taxes. Your accounts benefit from the opportunity for tax-advantaged growth.

This is not your plan document. The administration of each plan is governed by the actual plan document. If discrepancies arise between this summary and the plan document, the plan document will govern.

**Eligibility**
You are immediately eligible to participate in the plan and may begin contributing to the plan upon enrollment.

Certain classes of employees are not eligible to participate in this plan:
- 960 hour/Extra help employees

**Enrolling is easy! Here’s how-**
Simply decide how much you want to save and how you want to invest contributions to your account. There are three convenient ways to enroll:
- Online at VALIC.com
- By phone at our Enrollment Center at 1-888-569-7055
- In person with your financial advisor.

Jim Manly, Financial Advisor  
(707) 291-3372 or (916) 780-6000  
2901 Douglas Blvd., Ste. 150  
Roseville, CA 95661  
james.manly@valic.com  
CA Insurance Lie.# 0F32369

**Your contributions (subject to plan terms)**
Generally, you may contribute as much as 100% of your annual includible compensation up to $19,000 in 2019. You may increase or decrease your contributions as often as your employer allows.

**Catch-up contributions**
You may be able to contribute up to an additional:
- $19,000 in 2019 if you are within the last three taxable years ending the year before the year you reach normal retirement age as specified under the plan and have under contributed in prior years, or
- $6,000 in 2019 if you are age 50 or older.

If you are eligible for both, you may not combine the two catch-up amounts, but you may contribute up to the higher amount.

Pretax only contributions: You are subject to the annual contribution limits detailed previously.

Fee disclosure information: Obtain specific fee disclosure and fund performance information by visiting VALIC.com and clicking on "Fee Disclosure" in the dark box at the bottom of the screen.

Stop/change contributions: You may change your contribution amount or discontinue contributing to your plan at any time and resume contributing again later, subject to plan provisions and any administrative requirements. In the meantime, your account will continue to grow on a tax-deferred basis.

Under a 457(b) plan, an election start, change or stop contributions will become effective no sooner than the first pay period of the month following the date the election is made.

Vesting: You are always 100% vested in your own contributions.

Account consolidation: You might be able to transfer your vested retirement account balance from a prior employer’s plan to your County of Lake Retirement Plan with VALIC.
This may be a way to simplify your financial profile and to ensure your overall investments are suitably diversified and consistent with your investment preferences. However, before moving funds, check with your other provider to determine if your account has any restrictions, imposes a withdrawal penalty or provides favorable terms.

**Tax-free loans**

Tax-free loans make it possible for you to access your account, subject to certain limitations, without permanently reducing your account balance. Defaulted loan amounts (not repaid on time) will be taxed as ordinary income.

**Withdrawal restrictions**

Your plan was established to encourage long-term savings, so withdrawals prior to age 70½ are subject to federal restrictions. Unlike many other plan types, there is no 10% federal early withdrawal tax penalty in the 457(b) plan.

Generally, depending on plan provisions, you may withdraw your vested account balance if you meet one of the following requirements:
- Retirement or severance from employment
- Unforeseeable emergencies
- Your death
- Age 70½ (if your plan allows in-service distributions)

In addition, you must begin taking distributions once you reach age 70½ or you retire, whichever is later.

**Distribution options**

Your plan offers many distribution options, allowing you to tailor your benefits to meet your individual needs. Depending on plan provisions, your withdrawal options include:
- Transferring or rolling over your vested account balance to another tax-advantaged plan that accepts transfers of rollovers
- Electing systematic or partial withdrawals
- Taking a lump-sum distribution
- Choosing one of the many annuity options available

- Deferring distributions until the later of age 70½ or severance of employment and allowing your account to continue to grow on a tax-deferred basis

Generally, income taxes must be paid on all amounts you withdraw from your plan.

Consult your financial advisor for more specific information.

**Account statement:** VALIC sends all participants a comprehensive account statement at least annually. This account statement documents all activity for the preceding period, including total contributions and transfers among investment options.

You can choose to "go paperless" if you wish. Receive secure, paperless, electronic notification when your retirement account statements, transaction confirmations and certain regulatory documents are available online through our secure connection, PersonalDelivery®.

Managing these items electronically is faster and more secure than paper mail. To sign up for this free service simply log in to your account at VALIC.com.

Account access: Once you are enrolled, you can access your account information and perform certain transactions, 24 hours a day, seven days a week from anywhere at any time:

- Online at VALIC.com
- By phone at 1-800-448-2542

Access account information on your mobile device.

- VALIC Mobile for iPad®, iPhone® or Android™-based phones
- VALIC Mobile Access for web-enabled devices at my.valic.com/mobility

Personal service: For assistance, please visit VALIC.com, call our Client Care Center at 1-800-448-2542, or contact your financial advisor(s).
Have You Ever

☐ Needed your Will prepared or updated?
☐ Signed a contract?
☐ Received a moving traffic violation?
☐ Been denied a warranty or insurance claim?
☐ Been overcharged or had a billing dispute?
☐ Purchased or leased a home?
☐ Worried about being a victim of identity theft?
☐ Been concerned about your child's identity?
☐ Lost your wallet?
☐ Been involved in a data breach?
☐ Had someone commit tax or employment fraud in your name?
☐ Had your driver's license or medical information stolen/used?

The LegalShield Membership Includes:

- **Dedicated Law Firm** Direct access, no call center
- **Legal Advice/Consultation** on unlimited personal or business issues
- **Letters/Calls** made on your behalf (initial letter or call on an unlimited basis)
- **Contracts/Documents** Reviewed up to 10 pages per document
- **Will Preparation** Last Will and Testament (for the named member)
- **Moving Traffic Violations** (must be on the road legally) 15 day waiting period
- **IRS Audit Assistance** (begins with the tax return due April 15th of the year you enroll)
- **Trial Defense** (if named defendant/respondent in a covered civil action suit)
- **25% Preferred Member Discount** (bankruptcy, criminal charges, DUI, and other matters outside of normal coverage)
- **24/7 Emergency Access** for covered situations

The IDShield Membership Includes:

- **Continuous Credit Monitoring** IDShield continuously monitors your credit report. If changes occur, you’ll receive an instant alert.
- **High Risk Application and Transaction Monitoring** We monitor the largest proprietary database of new account application data to detect potentially fraudulent new accounts when an application is submitted.
- **Dark Web Monitoring** Monitors your Personally Identifiable Information (PII) across the dark web, where criminals purchase personal data.
- **Username/Password (Credential) Monitoring** This powerful feature helps protect against takeovers of your social, financial and other online accounts.
- **Identity Threat & Credit Threat Alerts** You’ll receive a threat alert if your PII is found.
- **$1 Million Protection Policy** Offers coverage for lost wages, legal defense fees, stolen funds and more.
- **Unlimited Consultation** On any cyber security issue.
- **Full-Service Restoration** Our Licensed Private Investigators will work tirelessly to restore your identity to its pre-theft status.
- **24/7 Emergency Access** We’re here in the event of an identity theft emergency.

Prepared for: COUNTY OF LAKE

For more information, contact your Independent Associate:

<table>
<thead>
<tr>
<th>Judy Samson</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.judysamson.com">www.judysamson.com</a></td>
</tr>
<tr>
<td>Email:<a href="mailto:judysamson@sonic.net">judysamson@sonic.net</a></td>
</tr>
<tr>
<td>707-479-1702</td>
</tr>
</tbody>
</table>
Nationwide 457(b) Plan

What makes the Nationwide 457(b) Plan a right choice for you?

Flexibility
- Easy enrollment over the phone, online or in-person
- Increase, decrease or stop deferrals, according to your needs
- No coordination of contributions with other qualified plan types
  - Contribute up to the maximum to your 457(b) and a 403(b) or 401(k) account
- No-penalty withdrawals after separation from service, regardless of age
- Purchase pension plan service credit using 457(b) assets, if the pension plan allows
- Plan allows consolidation of outside retirement assets from qualified plans and IRAs

Interactivity
- My Interactive Retirement Planner
- Support as you plan for retirement healthcare costs and Social Security benefits
- Web-based Learning Center to help you feel more confident about your retirement decision through the Plan
- Appointments with an Internal Retirement Specialist
  - Easily scheduled at retirementspecialists.myretirementappt.com

Investment options
- Fixed account offering a competitive yield
- Broad spectrum of funds selected specifically for long-term investors
- Professional managed account solution for “do it for me” participants

People
- Personal Retirement Counselors who deliver financial needs analysis
- Local Specialists present educational workshops on topics related to your needs
- Flexible Customer Service availability during the day, night and even on Saturday

Contact your Nationwide® Retirement Specialist:
Pam Menard
916-541-7032
paul.menard@nationwide.com
MEET BEN-IQ

Ben-IQ is a free app that includes much of the information that's included in this overview, but in a place that's always at your fingertips - your smartphone. Ben-IQ is available for Android and iPhone.

Simply download Ben-IQ and enter the Employer Key:

- Key: lake

Take a tour of Ben-IQ and review plan summaries, and important contacts like our nurse line and EAP. Store and organize ID cards using your phone's camera, and much more! Be sure to share Ben-IQ with your covered family members and caregivers too. For technical assistance, email beniq@alliant.com or call 888-778-4567

USING BEN-IQ:

Open the app any time you need benefits plan information, like:

- Plan summaries
- The estimated cost of a procedure
- Your stored plan ID cards
- Your nurse line number
- Your insurance company's phone number
- Definitions of healthcare terms
- Wellness tips
- Access to helpful videos

Q: How do I get Ben-IQ?
A: If you have an iPhone or Android phone, it’s as easy as 1-2-3.
  1. If you have an iPhone, go to the Apple App Store; if you have an Android phone, visit Google Play
  2. Search for “Ben-IQ”
  3. Download and install the app

It’s free—just read and agree to the Terms & Conditions, and you’re all set.

Q: How do I log in to Ben-IQ?
A: Your HR administrator will send you an Employer Key to enter, ensuring that you see the most accurate and up-to-date benefits that belong to you and your family.

Q: How do I use Ben-IQ?
A: Anytime you need plan information. Ben-IQ’s got a wealth of information right at your fingertips.

Q: Will Ben-IQ work on my iPad?
A: Yes! Although Ben-IQ is optimized for the iPhone, it also works on your iPad. You do NOT need to have an iPhone to download and use the iOS version of Ben-IQ. To download it to your iPad, type “Ben-IQ” in the App Store search box. On the top of the search results screen, tap the “iPad Only” menu and change it to “iPhone only”. When you run the app, you’ll notice that it’s formatted to fit an iPhone screen. But you may tap the “2x” button to enlarge the view.
# Carrier and Human Resource Contacts

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Provider</th>
<th>Phone Number</th>
<th>Website</th>
<th>Policy/Group #</th>
</tr>
</thead>
</table>
| Medical            | Anthem Blue Cross         | (800) 333-0912 | www.anthem.com/ca/eiahealth/                 | PPO 35: 175075M934  
                               |               |                                             | Law PPO: 175075M905  
                               |               |                                             | PPO 80: 175075M910  
                               |               |                                             | ABHP: 175075M922  |
| Rx                 | Express Scripts           | (877) 554-3091 | www.express-scripts.com                     | PPO 35: 175075M934  
                               |               |                                             | Law PPO: 175075M905  
                               |               |                                             | PPO 80: 175075M910  |
| Dental             | Delta Dental              | (800) 765-6003 | www.deltadentalins.com                      | 04406            |
| Vision             | VSP                       | (800) 877-7195 | www.vsp.com                                  | 30010967         |
| Life & AD&D        | VOYA                      | (888) 238-4840 | www.voya.com                                 | 316407-157       |
| Employee Assistance Program | MHN                   | (800) 242-6220 | www.members.mhn.com                          | 6750              |
| Employee Assistance Program | ComPsych  
                               |               |                                              | Web ID: MY5848i   |
|                   | GuidanceResources         | (877) 533-2363 | www.guidanceresources.com                  |                  |
| Flexible Spending Account | Employee Benefit  
                               |               |                                              |                  |
|                   | Specialists               | (888) 327-2770 | www.ebsbenefits.com                         | N/A              |
| Travel Assist      | VOYA                      | (800) 859-2821 | [https://eservices.europasistanc.eusa.com/sites/voya](https://eservices.europasistanc.eusa.com/sites/voya) | Group ID: N1VOY  |
| Human Resources    | County of Lake            | (707) 263-2213 | [www.co.lake.ca.us](https://www.co.lake.ca.us) | N/A              |
Words You Need to Know

MEDICAL

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

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

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

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

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

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

PRESCRIPTION DRUG

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

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

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

DENTAL

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

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

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Santa Rosa and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your City of Santa Rosa coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under health plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Santa Rosa prescription drug coverage, be aware that you and your dependents will not be able to get your coverage back through the City of Santa Rosa.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with The City of Santa Rosa and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to request a copy of this notice at any time.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Santa Rosa changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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

Date:          October 1, 2019
Name of Entity/Sender:  County of Lake
Contact-Position/Office:  Human Resources
Address:  255 N. Forbes St. Lakeport, CA 95453
Phone Number:  (707) 263-2213
Women’s Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns’ & Mothers’ Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the City of Santa Rosa health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the City of Santa Rosa health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.
If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the City of Santa Rosa’s health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for the City of Santa Rosa describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Human Resources Department.

Notice of Choice of Providers

Your health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your health plan directly. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan.

Michelle’s Law

The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child’s eligibility would end earlier for another reason.

Extended coverage is available if a child’s leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child’s physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Human Resources as soon as the need for the leave is recognized. In addition, contact your child’s health plan to see if any state laws requiring extended coverage may apply to his or her benefits.
Notice of Availability of Alternative Standard for Wellness Plan

Your 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 for an opportunity to earn the same reward by different means. Contact us at Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

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 1-866-444-4EBSA (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 August 10, 2017. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
<th>CHIP Website</th>
<th>CHIP Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td><a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>1-855-692-5447</td>
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<td>FLORIDA – Medicaid</td>
<td><a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
<td>1-877-357-3268</td>
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<td>ALASKA – Medicaid</td>
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<td>GEORGIA – Medicaid</td>
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<td>State</td>
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<td></td>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td></td>
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<tr>
<td>COLORADO – Health First Colorado (Colorado's Medicaid Program) &amp; Child Health Plan Plus (CHP+)</td>
<td><a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>1-800-221-3943/ State Relay 711</td>
<td></td>
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<tr>
<td></td>
<td>Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
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<td></td>
<td>Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus</td>
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<td>KENTUCKY – Medicaid</td>
<td>New Jersey – Medicaid</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
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<td></td>
<td>Medicaid Phone: 609-631-2392</td>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
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<tr>
<td>MAINE – Medicaid</td>
<td>North Carolina – Medicaid</td>
<td><a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a></td>
<td>919-855-4100</td>
<td></td>
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<tr>
<td>MASSACHUSETTS – Medicaid and CHIP</td>
<td>North Dakota – Medicaid</td>
<td><a href="https://www.nd.gov/dhs/services/medicalserv/medicaid/">https://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
<td>1-844-854-4825</td>
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<tr>
<td>MINNESOTA – Medicaid</td>
<td>Oklahoma – Medicaid</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
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<tr>
<td>State</td>
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<td>NEVADA – Medicaid</td>
<td><a href="https://dwss.nv.gov/">https://dwss.nv.gov/</a></td>
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To see if any other states have added a premium assistance program since January 31, 2017, 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

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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.