

5M Program - Enrollment Form

1. Enrollee Information

Group Name: American StaffCorp		Plan Coverage Effective Date:	
Last Name:		Date you became a Full time Employee:	
First Name:		Date of Birth (DOB):	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SS #:	No. Hours Work/per week:	
Home Phone #:		Work Phone #:	
Street Address:		City:	State: Zip:

Plan Selection (per your enrollment guide):

MEC Plan <input type="checkbox"/>	MEC Preferred Plan <input type="checkbox"/>	MEC Heavy Plan <input type="checkbox"/>	MEC Heavy Plus Plan <input type="checkbox"/>	MVP Plan <input type="checkbox"/>
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Beneficiary of Life Insurance (If applicable):

Full Name:	Address:	City, State Zip:
Phone #:	Date of Birth:	Relationship:

2. Dependent Information

I would like to be covered under this plan along with the following dependents:

<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name:	First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled ¹ <input type="checkbox"/> Court Ordered ²					

¹For disabled dependents; SUBMIT appropriate documentation as proof of disabled status with this enrollment form.

²If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

I hereby apply for benefit plan participation for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I agree that no benefits will be effective until the date specified by Key Benefit Administrators. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

Employee (print name): _____ Employee Signature: _____ Date: _____

Section 125 Cafeteria Plan Salary Reduction Agreement

Employee Name (Last, First, MI) (Please Print)

Birth Date

Social Security No.

Employee Street Address / City / State / Zip Code

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the any allowed pre-tax coverage. Such reductions, considered as elective contributions under the plan shall commence on the first payroll cycle that my coverages go into effect. I further authorize future adjustment in the amount of salary reduction in the event that the cost of coverage in any program chosen under the heading "Premium Conversion" is changed during the plan year.

I understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. Coverages allowed by this code are medical, dental, vision, cancer, hospital, critical care, and accident.

The selection will remain in effect until a subsequent election form is filed, in accordance with the plan.

I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed.

This election form will remain in effect and cannot be revoked or changed unless the revocation and new election are on account of and consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of a child, termination of employment of spouse, etc. as listed in the Employers Plan Document).

I understand that the insurance claim payments under certain coverages may be subject to federal and state taxes when the premium is paid by salary reduction or employer contributions.

Signature: _____

Date: ____/____/____



ASC HEALTH CARE PLAN 2020 DECLINE / WAIVE

ASC is required to report all Health insurance information for its employees. If you are declining/waiving coverage, you must complete the following:

- ☐ I am waiving/declining plan coverage because I have other coverage
- _____ Individual coverage through Marketplace / Obama Care
 - _____ Individual coverage through Marketplace – receiving subsidy
 - _____ Tribal Coverage
 - _____ Spousal coverage
 - _____ Military Coverage
 - _____ Medicare coverage
 - _____ Medicaid (employee only)
 - _____ **Parental Coverage**
 - _____ **Other** _____

(MUST BE COMPLETED)

Carrier Name _____

Carrier Phone Number _____

Primary Insured Full Name _____

Primary Insured Date of Birth _____

Policy # _____

Member ID _____

_____ I have no Health Care Coverage at this time

Employee (print name): _____

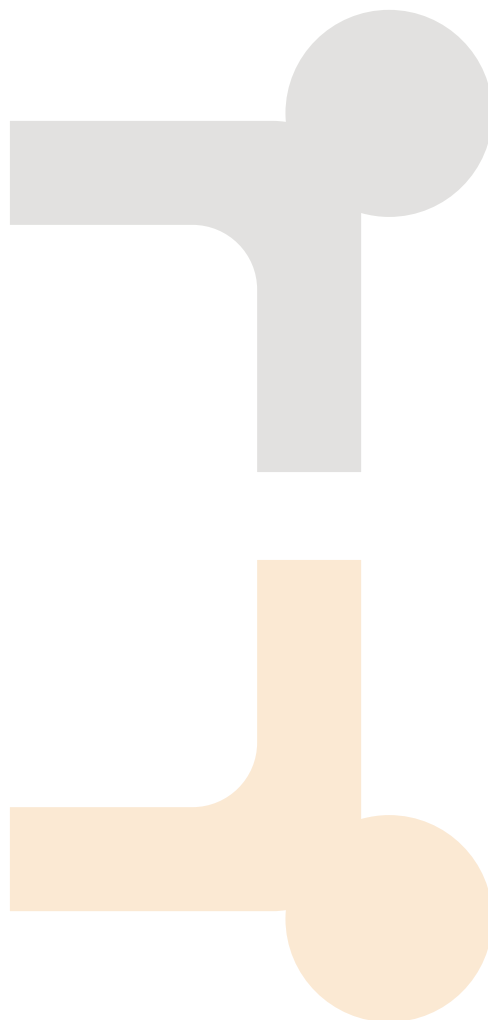
Employee Signature: _____

Date: _____



KEYSOLUTIONSM

2020 ENROLLMENT GUIDE



**Administration services by
Key Benefit Administration**

Information for eligible employees of:

American StaffCorp

MEC Minimum Essential Coverage

MEC provides first dollar coverage with access to one of the largest national preferred provider organizations (PPO) available with great discount savings for MEC benefits. The network savings can also be used for services not covered by the MEC. You will have access to a simple-to-use web portal for your local or out-of-town provider look up to be sure your provider is in the PPO Network.

There are preventive services covered at 100% under the required government list of Preventive and Wellness Benefits when you visit a network provider. The benefits drop to 40% if you use an out-of-network provider. Services covered include immunizations, blood pressure screenings, diabetes and cholesterol screenings, prenatal visits for pregnant women and more. A full list of the covered services is included in this information.

The MEC comes with a medical ID Card that needs to be presented to your medical provider at your time of service.

Administration services provided by Key Benefit Administrators.

Minimum Essential Coverage (MEC) covers 100% of the government listed Preventive and Wellness Benefits when you visit a network provider (40% out-of-network).

81 PREVENTIVE
CARE SERVICES
COVERED AT **100%**

UNLIMITED
access to
RealTimeTelemed
and
RealTimeChoices

VALUABLE
BENEFITS FOR THE ENTIRE FAMILY



Access to board-certified doctors by phone or mobile application - at anytime from anywhere with a **\$0 copay**. RealTimeTelemed was designed as an alternative to costly urgent care, ER visits or days of waiting for an appointment to see your primary care doctor for non-emergency medical issues.



RealTimeChoices is a healthcare price transparency solution that gives you the tools you need to better manage your healthcare.





Covered Preventive Services for Adults (ages 18 and older)

1. Abdominal Aortic Aneurysm one time screening for age 65-75
2. Alcohol Misuse screening and counseling
3. Aspirin use for adults ages 50-59 to prevent Cardiovascular Disease and Colorectal Cancer when prescribed by a physician
4. Blood Pressure screening for all adults
5. Cholesterol screening for all adults
6. Colorectal Cancer screening for adults starting at age 56 and continuing until age 75
7. Depression screening for adults
8. Type 2 Diabetes screening for adults
9. Diet counseling for adults
10. Fall Prevention to include physical therapy to prevent fall in community dwellings age 65 and older
11. Hepatitis B screening for adults
12. Hepatitis C screening for adults at high risk and one time for everyone born between 1945-1965
13. HIV screening for all adults
14. Immunization vaccines for adults: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella.
15. Lung Cancer Screening for adults age 55-80 who are at high risk because they smoke 30 packs a year (or have quit in the past 15 years)
16. Obesity screening and counseling for all adults
17. Sexually Transmitted Infections (STI) prevention counseling and screening for adults
18. Skin Cancer behavioral counseling for adults to age 24 with fair skin
19. Tobacco Use screening, counseling and cessation interventions for all adults
20. Syphilis screening for all adults
21. Latent tuberculosis infection screening for adults
22. Statin preventive medication for adults ages 40-75 years with no history of cardiovascular disease, 1 or more cardiovascular disease risk factors and a calculated 10 year cardiovascular disease event risk of 10% or greater.

Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women
2. Aspirin for pregnant women at high risk for preeclampsia
3. Bacteriuria urinary tract or other infection screening for pregnant women
4. BRCA counseling and genetic testing for women at higher risk
5. Breast Cancer Mammography screenings every 1 to 2 years for women age 40 and over
6. Breast Cancer Chemoprevention counseling as well as breast cancer testing and medications for women with increased risk for breast cancer
7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Non-network services will be payable as network services.
8. Cervical Cancer screening
9. Chlamydia Infection screening
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
11. Diabetes screening for women with history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.
12. Domestic and interpersonal violence screening and counseling for all women
13. Folic Acid supplements for women who may become pregnant when prescribed by a physician
14. Gestational diabetes screening
15. Gonorrhea screening for all women
16. Hepatitis B screening for pregnant women
17. Human Immunodeficiency Virus (HIV) screening and counseling
18. Human Papillomavirus (HPV) DNA Test: HPA DNA testing every three years for women with normal cytology results who are 30 or older
19. Osteoporosis screening over age 60
20. Preeclampsia screening in pregnant women with blood pressure measurements throughout pregnancy
21. Routine prenatal visits for pregnant women
22. RH Incompatibility screening for all pregnant women and follow-up testing
23. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
24. Sexually Transmitted Infections (STI) counseling
25. Syphilis screening
26. Urinary Incontinence screening
27. Well-woman visit to obtain recommended preventive services

Covered Preventive Services for Children

1. Alcohol and Drug Use assessments
2. Autism screening for children limited to two screenings up to 24 months
3. Behavioral assessments for children limited to 5 assessments up to age 17
4. Bilirubin concentration screening for newborns
5. Blood screening for newborns
6. Blood pressure screening
7. Cervical Dysplasia screening
8. Congenital Hypothyroidism screening for newborns
9. Depression screening for adolescents age 12 and older
10. Developmental screening for children under age 3, and surveillance throughout childhood
11. Dyslipidemia screening for children
12. Fluoride Chemoprevention to include supplements for children without fluoride in their water source when prescribed by a physician and fluoride varnish to primary teeth through age 5
13. Gonorrhea preventive medications for the eyes of all newborns
14. Hearing screening for all newborns and 3 additional screenings at periodic ages up to age 21
15. Height, Weight and Body Mass Index measurements for children
16. Hematocrit or Hemoglobin screening for children
17. Hemoglobinopathies or sickle cell screening for newborns
18. Hepatitis B screening for adolescents
19. HIV screening for adolescents
20. Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Hemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella
21. Iron supplements for children ages 6-12 months when prescribed by a physician
22. Lead screening for children
23. Maternal depression screening for mothers of infants at 1, 2, 4 and 6 months visits
24. Medical History for all children throughout development. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
25. Obesity screening and counseling
26. Oral Health risk assessment for young children up to age 10
27. Phenylketonuria (PKU) screening in newborns
28. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
29. Skin Cancer behavioral counseling for adolescents age 10 and up who have fair skin
30. Tobacco Use screening, counseling, and cessation interventions for children and adolescents
31. Tuberculin testing for children
32. Vision screening for children.

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MEC Minimum Essential Coverage

	MEC	WEEKLY RATES
Covered Benefits	In-Network	EMPLOYEE
Deductible (single/family)	\$0/\$0	\$8.30
Coinsurance (employee portion)	100%	EMPLOYEE + SPOUSE
Out-of-Pocket Maximum	\$0/\$0	\$17.48
PPO Network		EMPLOYEE + CHILDREN
Emergency Room Services	N/A	\$31.84
Inpatient Hospital Services	N/A	FAMILY
Primary Care Visit to Treat an Injury or Illness	N/A	\$41.02
Specialist Visit	N/A	
Mental/Behavioral Health and Substance Abuse Disorder Services	N/A	
Advanced Imaging (CT, PET Scans, MRIs)	N/A	
Rehabilitative Speech Therapy	N/A	
Rehabilitative Occupational and Rehabilitative Physical Therapy	N/A	
Preventive Care/ Screening/Immunization (MEC)	Covers 100% of the 81 listed Preventive and Wellness Benefits	
Laboratory Outpatient and Professional Services	N/A	
X-rays and Diagnostic Imaging	N/A	
Outpatient Facility Fee	N/A	
Outpatient Surgery Physician/Surgical Services	N/A	
Chronic Disease Management (CDM) Benefit	N/A	
Life AD&D Benefit	N/A	
RealTime Services		
RealTimeTelemed	Unlimited Calls	
RealTimeChoices	Unlimited Access	
Geo Fencing ER and Rx	Unlimited Access	

MEC Plus

This plan includes the MEC Preventive benefits and the Fully Insured Indemnity benefits

MEC Plus	
Covered Benefits	In-Network
Inpatient Hospital Daily Indemnity Benefit	\$200 daily benefit, 180 maximum days
Outpatient Physician Office Visit Daily Indemnity Benefit	\$60 per day, 6 day maximum per benefit period
Outpatient Diagnostic X Ray and Lab Daily Indemnity Benefit	\$50 per day with a 3 day maximum per benefit period
Daily Prescription Drug Benefit	\$15 per day, 20 day maximum per benefit period
Initial Hospital Admission Daily Indemnity Benefit	\$1,000 per day, 1 day maximum with 1 Admission per benefit period
Ambulance Service Daily Indemnity Benefit	\$100 per day, 3 day maximum per benefit period
Employee Group Term Life	\$5,000 per Employee
Inpatient Surgery & Anesthesia Daily Indemnity Benefit	\$1,000 per day/\$200 Anesthesia, 1 day maximum per benefit period
Outpatient Surgery & Anesthesia Daily Indemnity Benefit	\$500 per day/\$100 Anesthesia, 1 day maximum per benefit period
Critical Illness Benefit	\$5,000 per Employee
Emergency Room Visit Daily Indemnity Benefit *covers illness and accidents	\$100 daily benefit with max of 3 days per benefit period
Cobra	Included

WEEKLY RATES
EMPLOYEE
\$28.44
EMPLOYEE + SPOUSE
\$56.61
EMPLOYEE + CHILDREN
\$70.97
FAMILY
\$100.25

RealTime Services	
RealTimeTelemed	Unlimited Calls
RealTimeChoices	Unlimited Access
Geo Fencing ER and Rx	Unlimited Access

MEC HEAVYSM Plan

Since the MEC plan covers specific preventive services we also offer the MEC Heavy plan that provides meaningful benefits for those looking for a more encompassing MEC plan. The MEC Heavy plan covers the required MEC preventive services in addition to Hospitalization, Emergency Room Services, Primary Care and Specialist visits, Imaging (CT, PET Scans, MRIs), Laboratory Services, X-Ray and Diagnostic Imaging and Prescription Drugs. The MEC Heavy includes our acclaimed Chronic Disease management program along with the RealTimeHealth Diabetic Program and the RealTimeChoices Price Transparency tool. The MEC Heavy plan offers meaningful benefits at an affordable price.

Excluded Categories within MEC Heavy Plan

- All Inpatient Services
- Mental/Behavioral Health and Substance Abuse Disorder Services
- Rehabilitative Speech Therapy
- Rehabilitative Occupational and Rehabilitative Physical Therapy
- Skilled Nursing Facility
- Outpatient Facility Fees
- Outpatient Surgery Physician/Surgical Services
- All Brand Drugs
- Specialty Drugs (including compound drugs)
- Drugs related to mental health and substance abuse such as ADHD

The MEC Heavy offers a Co-Pay plan design with a \$5,000 single Out-of-Pocket Maximum. Out-of-Network benefits are covered with a \$500 single/\$1,000 family deductible with a 40% coinsurance (plan portion) and no out-of-pocket maximum.

As a MEC Heavy member, you will receive a medical ID Card that needs to be presented to your medical provider at your time of service.

Minimum Essential Coverage (MEC) covers 100% of the government listed Preventive and Wellness Benefits when you visit a network provider (40% out-of-network).

81 PREVENTIVE
CARE SERVICES
COVERED AT **100%**

UNLIMITED
access to
RealTimeTelemed,
RealTimeHealth and
RealTimeChoices

VALUABLE
BENEFITS FOR THE ENTIRE FAMILY



Access to board-certified doctors by phone or mobile application - at anytime from anywhere with a **\$0 copay**. RealTimeTelemed was designed as an alternative to costly urgent care, ER visits or days of waiting for an appointment to see your primary care doctor for non-emergency medical issues.



RealTimeHealth is a diabetic management program that uses a state of the art cellular based glucometer to automatically, consistently and accurately take and record a member's glucose readings.



RealTimeChoices is a healthcare price transparency solution that gives you the tools you need to better manage your healthcare.

MEC HEAVYSM Plan

	MEC Heavy SM	WEEKLY RATES
Covered Benefits	In-Network	EMPLOYEE
Deductible (single/family)	\$0/\$0	\$44.69
Coinsurance (employee portion)	100%	EMPLOYEE + SPOUSE
Out-of-Pocket Maximum	\$5,000/\$13,200	\$73.47
PPO Network		EMPLOYEE + CHILDREN
Chronic Disease Management (CDM) Benefit	Covered Services at 100% (61 services) for 26 Predefined Chronic Diseases	\$71.85
Preventive Care/ Screening/Immunization (MEC)	Covers 100% of the 81 listed Preventive and Wellness Benefits (See page titled Preventive Care)	FAMILY
Laboratory Outpatient and Professional Services (Non Emergency Room Only)	\$75 copay (per lab) then plan pays 100%	\$102.08
X-rays and Diagnostic Imaging (Non Emergency Room Only)	\$75 copay (per image) then plan pays 100%	
Advanced Imaging (CT, PET Scans, MRIs) (Non Emergency Room Only)	\$500 copay (per image) then plan pays 100%	
Prescription Drugs (Generic Only)	\$15 copay then plan pays 100%	
Life AD&D Benefit	\$10,000	
RealTime Services		
RealTimeTelemed	Unlimited Calls	
RealTimeChoices Transparency Program	Unlimited Access	
RealTimeHealth Diabetic Program	100% Covered	
Geo Fencing ER and Rx	Unlimited Access	

*Out-of-network benefits include a \$500 single \$1,000 family deductible with a 40% coinsurance (plan portion) and no out-of-pocket maximum.

FULLY INSURED INDEMNITY BENEFITS

These benefits are included as part of the MEC Heavy Plan

	MEC Heavy SM
Covered Benefits	In-Network
Inpatient Hospital Daily Indemnity Benefit	\$500 per day with 180 day benefit period maximum
Initial Hospital Admission Daily Indemnity Benefit	N/A
Inpatient Surgery & Anesthesia Daily Indemnity Benefit	N/A
Outpatient Surgery & Anesthesia Daily Indemnity Benefit	N/A
Intensive Care Daily Indemnity Benefit	N/A
Outpatient Physician Office Visit Benefit (PCP and Specialist Visits)	\$100 daily benefit with a maximum of 3 days per benefit period
Emergency Room Benefit	\$200 daily benefit with a maximum of 1 day per benefit period
Critical Illness Benefit	\$5,000 Benefit

MEC HEAVY PLUS

This plan includes the MEC Heavy and the Fully Insured Indemnity benefits

	MEC Heavy Plus	WEEKLY RATES
Covered Benefits	In-Network	EMPLOYEE
Inpatient Hospital Daily Indemnity Benefit	\$500 per day with 180 day benefit period maximum	\$50.44
Initial Hospital Admission Daily Indemnity Benefit	\$1,000 1-day benefit with a maximum of 1 admission per benefit period	EMPLOYEE + SPOUSE
Inpatient Surgery & Anesthesia Daily Indemnity Benefit	\$500 daily benefit with a maximum of 1 day per benefit period. Includes a 20% Daily Anesthesia Benefit	\$84.51
Outpatient Surgery & Anesthesia Daily Indemnity Benefit	\$250 daily benefit with a maximum of 1 day per benefit period. Includes a 20% Daily Anesthesia Benefit	EMPLOYEE + CHILDREN
Intensive Care Daily Indemnity Benefit	\$500 daily benefit with a maximum of 30 days per benefit period	\$82.66
Outpatient Physician Office Visit Benefit (PCP and Specialist Visits)	\$100 daily benefit with a maximum of 3 days per benefit period	FAMILY
Emergency Room Benefit	\$200 daily benefit with a maximum of 1 day per benefit period	\$118.47
Critical Illness Benefit	\$5,000 Benefit	

MVP Minimum Value Plan

The Minimum Value Plan (MVP) is a high deductible plan offering very limited coverage. This MVP excludes some categories of services that are typically covered by plans being offered on the Exchange and individual market. The MVP covers the following services after your \$6,500 deductible is met. Emergency Room Services, Inpatient Hospital Services, Primary Care and Specialist visits, Imaging, Laboratory Services, X-rays and Diagnostic Imaging, and certain Generic and Preferred Brand drugs. Please pay close attention to the list of excluded benefit categories outlined below.



RealTimeHealth is a diabetic management program that uses a state of the art cellular based glucometer to automatically, consistently and accurately take and record a member's glucose readings.



RealTimeChoices is a healthcare price transparency solution that gives you the tools you need to better manage your healthcare.

The MVP offers a very limited benefit plan design excluding the following major service categories:

- Mental/Behavioral Health and Substance Abuse Disorder Services
- Rehabilitative Speech Therapy
- Rehabilitative Occupational and Rehabilitative Physical Therapy
- Skilled Nursing Facility
- Outpatient Facility Fees
- Outpatient Surgery Physician/Surgical Services
- Specialty Drugs (including compound drugs)
- Drugs related to mental health such as ADHD

The MVP offers a plan design with a \$6,500 single deductible and a \$13,200 family deductible. The Coinsurance responsibility is 40% paid by the enrolled member. The out-of-pocket maximum is \$6,500 for single and \$13,200 for a family.

As a MVP member, you will receive a medical ID Card that needs to be presented to your medical provider at your time of service.

Note: Because almost every benefit category is subject to the deductible it is important that you budget for the \$6,500 deductible which comes out to be \$541 a month in addition to your maximum premium contribution.

IMPORTANT

In order to enroll in the MVP program, there is an additional application that must be completed by the applicant. This application is mandatory and will require extensive information to complete. Below is a listing of items that are needed to complete the application.

- **Prior Medical Insurance information including:** Name of Carrier, Policy No., Effective Date, Termination Date (if applicable), Policy Holder's Name, Member ID, Employer Name, List of the Dependents covered on previous policy. This includes all Employer Sponsored Medical Plans, Medicaid, Medicare, Champus and Tricare.
- **Other Health Insurance Information including:** Name of Carrier, Policy No., Effective Date, Termination Date (if applicable), Policy Holder's Name, Member ID, Employer Name, List of the Dependents covered on previous policy. This includes all Employer Sponsored Medical Plans, Medicaid, Medicare, Champus, Tricare, etc.
- **Dependent information:** Full Name, Date of Birth, Social Security No., Date of Birth, Gender, Height, Weight. This includes minor dependents and spouses.
- **Medical History for the Past Five Years:** Physician Visit History, Chronic Condition History, Name, Address and Phone Number of diagnosing and treating physicians, begin and end date of treatment, treatment description and degree of recovery.

MVP

	MVP
Covered Benefits	In-Network
Deductible (single/family)	6,500 / \$13,200
Co-Insurance	60% (plan portion)
Out-of-Pocket Maximum (Single/Family)	\$6,500 / \$13,200
Emergency Room Services	\$6,500 Deductible
Inpatient Hospital Services	\$6,500 Deductible
Primary Care Visit to Treat an Injury or Illness	\$50 Co-Pay and 60% Co-Insurance*
Specialist Visit	\$70 Co-Pay and 60% Co-Insurance*
Mental/Behavioral Health and Substance Abuse Disorder Services	NOT COVERED
Advanced Imaging (CT, PET Scans, MRIs)	\$6,500 Deductible
Rehabilitative Speech Therapy	NOT COVERED
Rehabilitative Occupational and Rehabilitative Physical Therapy	NOT COVERED
Preventive Care/ Screening/Immunization (MEC)	Covers 100% of the 81 listed Preventive and Wellness Benefits
Laboratory Outpatient and Professional Services	\$6,500 Deductible
X-rays and Diagnostic Imaging	\$6,500 Deductible
Outpatient Facility Fee	NOT COVERED
Outpatient Surgery Physician/Surgical Services	NOT COVERED
Chronic Disease Management (CDM) Benefit	Covered Services at 100% (61) for 26 Predefined Chronic Diseases
Life AD&D Benefit	N/A
RealTimeChoices Transparency Program	UNLIMITED ACCESS
RealTimeHealth Diabetic Program	100% COVERED
Prescription Drugs	
Generic Drugs	\$6,500 Deductible
Certain Preferred Brand Drugs	\$6,500 Deductible
Certain Non-Preferred Brand Drugs	NOT COVERED
Specialty Drugs & Compounds	NOT COVERED

WEEKLY RATES

FOR ACTUAL RATES

See Next Page

*60% is plan portion for primary care visits to treat an injury or illness and specialist visits.

MVP Benefit Counselor Line

PLEASE READ CAREFULLY

KEYSOLUTION MVP BENEFIT COUNSELOR LINE

The MVP Benefit Counselors are only available for questions specific to the MVP. If you have questions about any other parts of the KeySolution 5M program please contact your Human Resources representative and they will be happy to help answer any questions you might have.

WHAT DO I NEED PRIOR TO CALLING?

You must request, complete and return the MVP Health Questionnaire (MHQ) from your Human Resources Department. Prior to calling, please ensure that you have a copy of your most recent payroll stub readily available. Please allow five business days after submitting your MHQ before calling the counselor line. KBA must receive your MHQ prior to taking your call.

WHAT CAN I EXPECT FROM THIS CALL?

Our MVP Benefit Counselors are happy to help with any questions related to the KeySolution 5M MVP. The Benefit Counselor will walk through your contribution requirement for the MVP (9.86% of your gross annual income). They will also walk through the benefit categories that are and are not covered by the MVP.

PRE-CALL CHECKLIST

- ☐ Request Health Questionnaire from HR
- ☐ Complete Health Questionnaire
- ☐ Return Health Questionnaire to HR
- ☐ Obtain Copy of Recent Payroll Stub
- ☐ Wait Five (5) Business Days Before Calling

CONTACT

Key Benefit Administrators
KeySolution MVP Benefit
Counselor Line

1.866.613.3450

ASC Employee Insurance Rates
December 1, 2019 - November 30, 2020

MEC	Employee Monthly Cost	Employee Weekly Cost
Employee Only	\$36.00	\$8.30
Employee + Spouse	\$75.75	\$17.48
Employee + Child/ren	\$137.99	\$31.84
Employee + Family	\$177.74	\$41.02
MEC Plus	Employee Monthly Cost	Employee Weekly Cost
Employee Only	\$123.22	\$28.44
Employee + Spouse	\$245.31	\$56.61
Employee + Child/ren	\$307.52	\$70.97
Employee + Family	\$434.41	\$100.25
MEC Heavy	Employee Monthly Cost	Employee Weekly Cost
Employee Only	\$193.66	\$44.69
Employee + Spouse	\$318.35	\$73.47
Employee + Child/ren	\$311.34	\$71.85
Employee + Family	\$442.33	\$102.08
MEC Heavy Plus	Employee Monthly Cost	Employee Weekly Cost
Employee Only	\$218.59	\$50.44
Employee + Spouse	\$366.21	\$84.51
Employee + Child/ren	\$358.21	\$82.66
Employee + Family	\$513.38	\$118.47
MVP	Employee Monthly Cost	Employee Weekly Cost
Employee Only	Please contact American StaffCorp for Cost. (918) 362-WORK (9675)	
Employee + Spouse		
Employee + Child/ren		
Employee + Family		



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, see www.kbasolution.com or call 877-851-0906. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 877-851-0906 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. Preventive care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Yes. See www.multiplan.com or call 1-888-342-7427 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	None
	Specialist visit	Not covered	Not covered	None
	Preventive care/screening/immunization	No charge	60% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	None
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Not covered	Not covered	None
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	Specialty drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	
If you need immediate medical attention	Emergency room care	Not covered	Not covered	None
	Emergency medical transportation	Not covered	Not covered	
	Urgent care	Not covered	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	60% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Not covered	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	Not covered	Not covered	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Chiropractic Care Cosmetic Surgery Dental Care 	<ul style="list-style-type: none"> Hearing Aids Infertility Treatment Long Term Care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private Duty Nursing Routine eye care (Adult) Routine Foot Care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Weight Loss Programs 		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Plan at 877-851-0906 or www.kbasolution.com; US Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa; or the US Department of Health and Human Services at 877-267-2323 ext.61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Key Benefit Administrators at 877-851-0906 or Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? No.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-851-0906.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-851-0906.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-851-0906.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-851-0906.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$12,760
The total Peg would pay is	\$12,760

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$7,250
The total Joe would pay is	\$7,250

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,900
The total Mia would pay is	\$1,900



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see www.kbasolution.com or call 877-851-0906. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 877-851-0906 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$0; for out-of-network providers \$500 individual / \$1,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers \$5,000 individual / \$13,200 family; no maximum for out-of-network providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Copayments for certain services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.multiplan.com or call 1-888-342-7427 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	None
	Specialist visit	Not covered	Not covered	None
	Preventive care/screening/immunization	No charge	60% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$75 copay /test	60% coinsurance	Services performed in Emergency room are not covered.
	Imaging (CT/PET scans, MRIs)	\$500 copay /test or image	60% coinsurance	Services performed in Emergency room are not covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cerpassrx.com	Generic drugs (Tier 1)	\$15 copay /retail & \$37.50 copay /mail order	Not covered	Covers up to a 34-day supply (retail); 31-90 day supply (mail order). Limited to \$1,000 per prescription. Amounts over the limit do not count towards the out-of-pocket limit .
	Preferred brand drugs (Tier 2)	Not covered	Not covered	None
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	None
	Specialty drugs (Tier 4)	Not covered	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	
If you need immediate medical attention	Emergency room care	Not covered	Not covered	None
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	Not covered	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Not covered	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	Not covered	Not covered	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Chiropractic Care Cosmetic Surgery Dental Care 	<ul style="list-style-type: none"> Hearing Aids Infertility Treatment Long Term Care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private Duty Nursing Routine eye care (Adult) Routine Foot Care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Weight Loss Programs 		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Plan at 877-851-0906 or www.kbasolution.com; US Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa; or the US Department of Health and Human Services at 877-267-2323 ext.61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Key Benefit Administrators at 877-851-0906 or Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? No.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-851-0906.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-851-0906.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-851-0906.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-851-0906.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,410
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$11,220
The total Peg would pay is	\$12,630

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$500
Coinsurance	0
What isn't covered	
Limits or exclusions	\$6,140
The total Joe would pay is	\$6,640

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$80
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,820
The total Mia would pay is	\$1,900



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Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$6,500 individual / \$13,200 family; out-of-network providers not covered.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers \$6,500 individual / \$13,200 family; no maximum for out-of-network providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Copayments for certain services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.multiplan.com or call 1-888-342-7427 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$50 copay /office visit and 40% coinsurance for other outpatient services; deductible does not apply	Not covered	Copay applies to the office visit charge only.
	Minimum annual care requirements for 25 chronic diseases	No charge	Not covered	Services are limited to those stated in the Plan document.
	Specialist visit	\$70 copay /office visit and 40% coinsurance for other outpatient services; deductible does not apply	Not covered	Copay applies to the office visit charge only.
	Minimum annual care requirements for 25 chronic diseases	No charge	Not covered	Services are limited to those stated in the Plan document.
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	None
	Minimum annual care requirements for 25 chronic diseases	No charge	Not covered	Services are limited to those stated in the Plan document.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cerpasrx.com	Generic drugs (Tier 1)	0% coinsurance after deductible	Not covered	Covers up to a 34-day supply.
	Preferred brand drugs (Tier 2)	0% coinsurance after deductible	Not covered	Covers up to a 34-day supply.
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	None
	Specialty drugs (Tier 4)	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Applies to network deductible and out-of-pocket limit . Non-network subject to network deductible and out-of-pocket limit .
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	Primary care physician \$50 copay /visit; Specialist \$70 copay /visit then 40% coinsurance	Not covered	Copay applies to the office visit charge only.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	None
	Physician/surgeon fees	Primary care physician \$50 copay /visit; Specialist \$70 copay /visit then 40% coinsurance ; Surgeon fee is 0% coinsurance after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	Not covered	
	Childbirth/delivery facility services	0% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Not covered	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	Not covered	Not covered	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Chiropractic Care Cosmetic Surgery 	<ul style="list-style-type: none"> Dental Care Hearing Aids Infertility Treatment Long Term Care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private Duty Nursing Routine eye care (Adult) Routine Foot Care 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
<ul style="list-style-type: none"> Weight Loss Programs 			

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Plan at 877-851-0906 or www.kbasolution.com; US Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa; or the US Department of Health and Human Services at 877-267-2323 ext.61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Key Benefit Administrators at 877-851-0906 or Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-851-0906.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-851-0906.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-851-0906.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-851-0906.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$6,500
■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$860
The total Peg would pay is	\$7,460

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$6,500
■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$4,550
Copayments	\$300
Coinsurance	\$110
What isn't covered	
Limits or exclusions	\$1,780
The total Joe would pay is	\$6,740

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$6,500
■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$920
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,010
The total Mia would pay is	\$1,930



Welcome to MDLIVE! Your anytime, anywhere doctor's office.

Avoid waiting rooms and the inconvenience of going to the doctor's office. Visit a doctor by phone, secure video, or MDLIVE App. Pediatricians are available 24/7, and family members are also eligible.



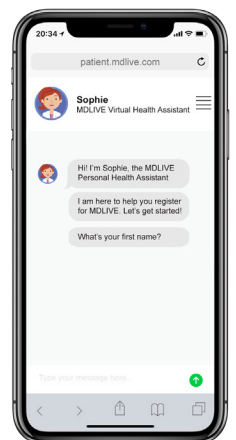
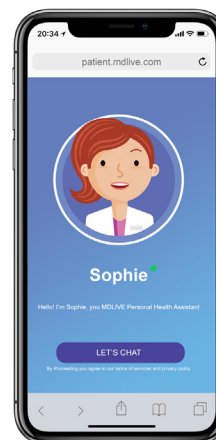
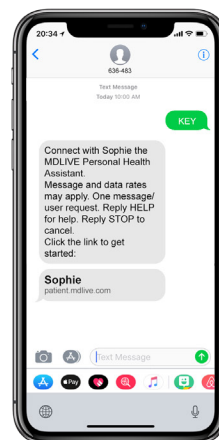
On or after your effective date of 7/1/18, Sophie will be available for your use.

Meet Sophie,

Your Personal Health Assistant! Sophie makes creating an account quick and easy using your smartphone, anytime, anywhere! **It's easy to register!**

Steps To Connect to Chatbot:

1. Member will text **KS** to 635483.
2. Tap to load preview. Member also presented with Stop/Help language.
3. Tap **"Let's Chat"** to launch a web browser page which simulates a texting conversation.



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MDLIVE.com/KS
+1 (888) 335-4310

Welcome to MDLIVE!

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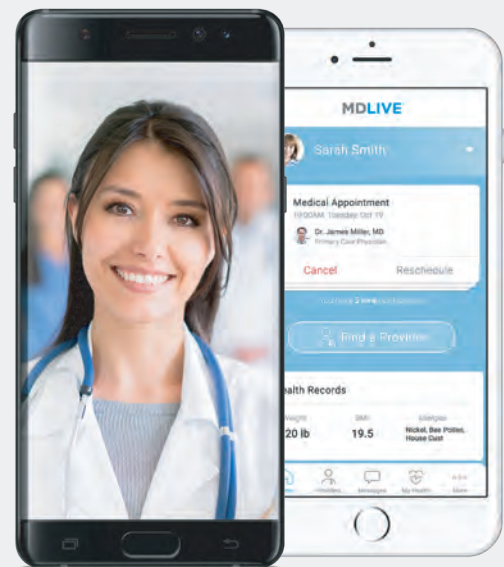
You have a telehealth benefit giving you virtual care, anywhere.

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- Available anytime, day or night
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- Prescriptions can be sent to your nearest pharmacy if medically necessary

We treat over 50 routine medical conditions including:

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- Allergies
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- Constipation
- Cough
- Diarrhea
- Ear Problems
- Insect Bites
- Nausea / Vomiting
- Pink Eye
- Rash
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- Sore Throats
- And More

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888.335.4310

List of Attached Notices

- MEDICARE PART D – YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE
- PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
- WOMEN'S HEALTH AND CANCER RIGHTS ACT – MEC
- NOTICE COVERING CHILDREN UP TO AGE 26
- NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT
- NOTICE OF NON-GRANDFATHERED STATUS
- NOTICE OF PATIENT PROTECTIONS
- GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)
MENTAL HEALTH PARITY
- HIPAA SPECIAL ENROLLMENT NOTICE
- INITIAL NOTICE OF HIPAA
- HIPAA NOTICE OF PRIVACY PRACTICES

Important Notice from American StaffCorp, Inc. About Your Prescription Drug Coverage and Medicare

This message is intended for any and all employees and/or their dependents that are or may be eligible for Medicare. If you or your dependents are eligible for Medicare, please retain this notice for your records.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Key Benefit Administrators has determined that the prescription drug coverage offered by your plan through your Employer is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from your Employer plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from your Employer. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

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 through December 7th. However, if you decide to drop your current coverage with your Employer, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under your Employer's plan. If you are losing creditable prescription drug coverage under your plan, you may also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage...

For more information, please contact the person listed below or call your human resources department. Note: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

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

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

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

Date:	October 2019
Name of Entity/Sender:	American StaffCorp
Contact:	Karol Sorensen
Address:	6301 S. Mingo Rd., Tulsa, OK 74133
Account Resources Phone:	918-362-9675

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	FLORIDA – Medicaid Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	GEORGIA – Medicaid Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	IOWA – Medicaid Website: http://www.dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPPI program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4188
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: http://www.ACCESSNebraska.ne.gov Phone: (955) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rite Share Line)
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT – Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

To: Employees Who Are Eligible to Participate in the Group Health Plan

Re: Notice of Rights to Reconstructive Surgery Following Mastectomy

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies, as ours does, to also provide coverage for reconstructive surgery and prostheses following mastectomies. Actual benefits are set out in the listing of benefits that you have already been provided. As required under the law, we are sending this notice to inform you about available benefits.

The law mandates that a participant or eligible beneficiary who is receiving benefits for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all states of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same deductible, coinsurance and/or copayment, and benefit provisions otherwise applicable under the Plan.

If you have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact your Human Resources benefit representative.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires that group health plans provide notice of the availability of certain benefits provided under the plan related to a mastectomy if the benefit plan covers services for mastectomy. We are sending this notice to inform you about your benefits that are related to a mastectomy.

Coverage under the KeySolution self-funded benefit plan sponsored by American StaffCorp provides coverage for 63 preventive and wellness services only. The KeySolution benefit plan does not provide coverage for any inpatient hospitalization services and surgery services, including but not limited to mastectomy related services such as the mastectomy or reconstructive surgery. Additionally, the benefit plan does not cover services for reconstructive surgery or prosthesis, including but not limited to mastectomy related reconstructive surgery or prosthesis.

Refer to your Summary Plan Description for more information regarding the benefits available under your plan.

If you have any questions about coverage for mastectomies, please contact your plan administrator at 918-362-9675, Karol Sorensen, 6301 S Mingo Rd., Tulsa, OK 74133.

NOTICE COVERING CHILDREN UP TO AGE 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Key Benefit Administrators. For more information contact Karol Sorensen, American StaffCorp, 918-362-9815, 6301 S Mingo Road, Tulsa, OK 74133.

NEWBORNS' AND MOTHER'S 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).

NOTICE OF NON-GRANDFATHERED STATUS

This health insurance issuer believes this plan is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 918-362-9675, Karol Sorensen, 6301 S Mingo Rd., Tulsa, OK 74133. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NOTICE OF PATIENT PROTECTIONS

Key Benefit Administrators generally allows 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 the Key Benefit Administrators at 1-888-342-7427.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Key Benefit Administrators 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 Key Benefit Administrators at 1-888-342-7427.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act (GINA) applies to the AMERICAN STAFFCORP Group Health Plan. This new law establishes a basic uniform national standard to protect the public from discrimination based on genetic information.

MENTAL HEALTH PARITY

According to the Mental Health Parity Act of 1996, the lifetime maximum and annual maximum dollar limits for mental health benefits under the AMERICAN STAFFCORP Group Health Plan are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan. However, mental health benefits may be limited to a maximum number of treatment days per year or series per lifetime.

SPECIAL ENROLLMENT NOTICE

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information contact KAROL SORENSEN, AMERICAN STAFFCORP, 918-362-9815, 6301 S MINGO ROAD, TULSA, OK 74133.

INITIAL NOTICE OF HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

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

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact your plan administrator at 918-362-9675, Karol Sorensen, 6301 S. Mingo Rd., Tulsa, OK 74133.

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how protected health information (or “PHI”) may be used or disclosed by our Group Health Plans to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact: Karol Sorensen, Director of Human Resources, 6301 S Mingo Rd, Tulsa, OK 74133 or by phone at 918-362-9675.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by giving you information where to find the amended Notice on our company intranet, on the worldwide internet, or by providing you with a paper copy.

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

- Payment and Health Care Operations

We have the right to use and disclose your PHI for all activities that are included within the definitions of “payment” and “health care operations” as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

➤ *Payment*

We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

➤ *Health Care Operations*

We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

▪ ***Required by Law***

We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

▪ ***Public Health Activities***

We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

▪ ***Health Oversight Activities***

We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil,

administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

- ***Abuse or Neglect***

We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

- ***Legal Proceedings***

We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- ***Law Enforcement***

Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

- ***Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations***

We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- ***Research***

We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

- ***To Prevent a Serious Threat to Health or Safety***

Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- ***Military Activity and National Security, Protective Services***

Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- ***Inmates***

If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

- ***Workers' Compensation***

We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- ***Emergency Situations***

We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

- ***Fundraising Activities***

We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Group Health Plan Disclosures***

We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

- ***Underwriting Purposes***

We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

- ***Others Involved in Your Health Care***

Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be

based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

Sale of PHI

We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing

We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes

We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- ***Disclosures to the Secretary of the U.S. Department of Health and Human Services***

We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- ***Disclosures to You***

We are required to disclose to you most of your PHI in a “designated record set” when you request access to this information. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

- ***Business Associates***

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, BLANK, Inc. which will be handling many of the functions in connection with the operation of our Group Health Plan; retail pharmacy; mail order pharmacy; stop loss insurance companies where applicable; managed care organizations; etc.

- ***Other Covered Entities***

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- ***Plan Sponsor***

We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result,

to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

- ***Right to Request a Restriction***

You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- ***Right to Request Confidential Communications***

If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or “EOB”). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within five business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice as soon as you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for *all* of your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

▪ ***Right to Inspect and Copy***

You have the right to inspect and copy your PHI that is contained in a “designated record set.” Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

▪ ***Right to Amend***

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment

to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

▪ ***Right of an Accounting***

You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

▪ ***Right to a Copy of This Notice***

You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

[END]