2017

ABILITY360

Employee Benefit Guide

Home Care Services

Please Note:

Information Regarding Your Ability360 Prescription Drug Coverage and Medicare starts on page 25 of this document.

Disclosure

This Benefit Guide is provided for employees to have a comprehensive resource for Ability360 health and welfare benefits. This Benefit Guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligations on the part of Ability360, its agents, or its employees. The purpose of this Benefit Guide is to summarize Ability360's employee benefits and the policies and procedures regarding these benefits. For the most detailed and up-to-date information, please refer to the appropriate plan document, evidence of coverage booklet, insurance policy or contract, as well as applicable rules and regulations. These documents can be obtained by contacting the Ability360 Benefits line at 1-844-274-7284, or email: Benefits@Ability360.org or accessing our Employee Benefits webpage at

http://ability360.org/hcs-employee-news

Please do not click on link; type the link or cut and paste link into your web browser.

The included information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

Introduction | Eligibility | Enrollment | ACA

Ability360 recognizes that your benefits are important to you and your family. Ability360 provides benefits with a portion of the cost shared by Ability360. You can choose between different benefits to meet your individual and family needs.

Eligibility

CLIENT-SPECIFIC CAREGIVERS are eligible the 1st of the month after 60 days employment if they have been hired to work at least 30 hours per week, and maintain that minimum number of hours for the first 60 days.

GENERAL CAREGIVERS (VARIABLE HOUR EMPLOYEES) - to be eligible for medical benefits through Cigna or the Allegiance MEC Plan, you must be working an average of 30 hours or more per week. Your hours worked will be tracked for six months after your date of hire. This is your **initial tracking period**. After six months, your hours are averaged to determine if you are benefits eligible. If you have worked an average of 30 hours or more per week over the six month period, you will be eligible to enroll in benefits on the first of the month following 60 days from the end of the six month tracking period.

After your **initial tracking period**, your hours are reviewed bi-annually (April-October for a January 1 start date; October-April for a July 1 start date). This will be the **ongoing tracking periods.** If it is determined that your average hours worked has fallen below the 30 hour threshold during either of the two **ongoing tracking periods**, you will not be able to keep your medical benefits.

Example: Employee A begins work on March 3rd. Employee A's hours are tracked in March – September (6 months) as their **initial tracking period**. Employee **does not** work an average of 30 hours/weekly over that period. Now the employee will fall into the next **ongoing tracking period** (October-April). For this period of time Employee A **does** work an average of 30 hours/weekly and is eligible for benefits starting July 1st. Employee A's average hours worked will be tracked from April - October and October-April every year to determine if (s)he is eligible for benefits for the next six months. Once an employee qualifies for benefits they are able to stay on the medical plan for the next six months despite their hours worked.

If you are eligible for the Cigna medical plans or the Allegiance MEC plan you cannot choose the Optimed *medical* plan. Also, if you are on the Optimed medical plan and become eligible for the Cigna or Allegiance MEC plans, you will be dropped from the Optimed medical plan.

PART-TIME EMPLOYEE BENEFITS

(Working 20 to 29 hours per week)

Optimed Limited Medical Plan

To be eligible for the Optimed limited medical plan you must be working an average of at least 20 hours but less than 30 hours per week. Your hours worked will be tracked for six months after your date of hire.

Premium deductions are taken on a post-tax basis for the OptiMed medical plans.

Cigna Dental Plan

The Cigna dental plan is available to all caregivers working an average of 20 or more hours per week.

Eligible dependents include natural born, step-, adopted and foster children as well as children for whom you have court appointed guardianship or custody and a legally married spouse. You must provide legal documentation of marriage, birth, adoption, foster appointment and guardianship to enroll your dependent(s).

It is important you enroll timely. If you miss this enrollment window, due to IRS guidelines, you must wait until the next open enrollment period unless you have a **"qualifying event" (see next page)**. If you experience a qualifying event you have the opportunity to change your coverage. You will need to provide written notice to HR within 30 days of the qualifying event in order to be able to make changes to your coverage elections. Premiums for the Cigna dental plan will be deducted on a pre-tax basis.

Qualifying events include:

- Marriage or divorce
- Loss of a dependent or dependent turns 26
- Involuntary loss or change of spouse's coverage
- Becoming Medicare eligible
- Qualifying or loss of qualification for Medicaid
- Adoption, birth or legal custody of child(ren)
- Reduction in hours to less than 30 hours per week
- Child Support Court Order

You can terminate your OptiMed Limited Medical Plan at any time, but you will not be able to enroll again until open enrollment unless you experience a qualifying event.

Terms of Enrollment

Open Enrollment | Mid-Year Changes Change in Eligibility

Once a year, Ability360 holds an open enrollment period. During this time, you may change your medical or dental plan election, enroll or terminate your coverage and/or you may add or terminate dependents on your coverage without a qualifying event.

If you become eligible for the Allegiance or Cigna medical plans you will not be able to keep your OptiMed medical plan even if you choose not to enroll in any the Allegiance or Cigna medical plans.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order requiring coverage of your dependent child under the medical plan. If we receive a QMCSO, we notify you and we will deduct from your paycheck the premiums required for such coverage. Once a QMCSO is in effect, no changes to the child's coverage will be allowed, other than as specified in a QMCSO or upon our receipt of proof that the QMCSO is no longer in effect.

When Coverage Ends

Your (and your eligible dependents) coverage for medical benefit plans will terminate at the end of the month in which your employment ends. Coverage also may be affected by a leave of absence. If any of your family members cease to be eligible (whether by reason of divorce, age or otherwise), coverage for that dependent only will end at the end of the month.

If you are enrolled in the **Cigna** medical plan and your hours drop to an average of 20 to 29 hours per week, you will be able to enroll in an **Optimed** medical plan. You can receive information regarding those benefits and enrollment by calling the Ability360 Benefits line *at 1-844-274-7284, or email: Benefits@Ability360.org*

COBRA

Allegiance MEC Plan or Cigna Plans

When your Allegiance or Cigna medical or Cigna Dental coverage ends, "continuation coverage" may be available under a federal law commonly referred to as COBRA. You are required to notify us of certain events (e.g. divorce or legal separation). Please see Human Resources for more details. Payment for any lines of coverage elected will be the member's full responsibility and will not be subsidized by Ability360.

Optimed

Your OptiMed medical plans are COBRA eligible. Please note that the OptiMed medical plans are not major medical plans. These plans are administered by UnitedGroup Programs.

Important Notice

On June 26, 2013, the U.S. Supreme Court ruled that the federal ban on recognizing same-sex marriages was unconstitutional. As a result, same-sex married partners are legally considered married and are to be treated the same as opposite-sex married partners in all respects under Federal law, which means they may now be eligible for benefits to which they were not previously entitled—for example, payment of health insurance premiums on a pre-tax basis, COBRA continuation rights, and other benefits for which spouses are eligible. Any legally married same-sex partner should review his or her employee benefits elections to ensure that he or she is maximizing what is now available to same-sex marriage partners. The law has not changed with respect to same-sex domestic partners who are not married.

Health Care Reform: What You Should Know

- The Health Care Exchange Marketplace was developed to allow consumers to shop and compare health insurance plans for coverage. You can find more information at www.healthcare.gov.
- Costs for Marketplace plans vary depending on income, number of dependents, and plan design. Payment for these plans is on a post-tax basis and is not payroll deducted by your employer. You will be responsible for 100% of the premium cost with no contribution from Ability360.
- Subsidies are available for employees whose group health plan is **not** affordable, accessible, or acceptable (actuarially equivalent to the "minimum value" health coverage). Healthcare reform defines this coverage based on the following criteria:
  - **Affordable** = Cost of coverage does not exceed 9.69% of employee's annual income
  - **Accessible** = Employee has reasonable and fair opportunity to enroll in benefits
  - **Acceptable** =Meets IRS guidelines of the health plan's share of total costs of benefits provided to the employee is at least 60% of the overall, average cost of services. This is determined by the IRS. Members enrolled in the health plan cannot pay more than $7,150 for individual medical expenses not including premium and $14,300 for families.
- The high deductible HSA plans offered by Ability360 have been tested and are considered affordable, accessible, and meets the minimum requirements; therefore you may not qualify for a subsidy in the Marketplace exchange.

ACA Individual Mandate

The tax penalty for not having health coverage is calculated one of two ways. If you or your dependents do not have insurance that qualifies as **M**inimum **E**ssential **C**overage (**MEC**) you'll pay either a percentage of your household income or a flat fee -- whichever is higher.

If you did not have coverage in 2016, you will pay the **higher** of these two amounts:

- **2.5% of your yearly household income up to a maximum for the national average price of a Bronze plan sold through the Marketplace, or;**
- **$695 per person for the year ($347.50 per child under 18) up to maximum of $2,085**

The Individual Mandate amounts for 2017 can be found at www.healthcare.gov .

It is important you understand that because you are offered a MEC plan, if you do not accept this coverage, you will be subject to the IRS penalty when you file your income tax return.

Your Options:

- Enroll in your employer's plan with pre-tax dollars
- Purchase individual coverage through the Marketplace or directly from an insurance company using post-tax dollars and paying for coverage at "retail" prices
- Pay the tax penalty

Medical

ALLEGIANCE HEALTH MINIMUM ESSENTIAL COVERAGE (M.E.C.)PLAN

To be eligible for Allegiance MEC Plan medical benefits, you must be working an average of at least 30 hours per week. Premium deductions are pre-tax.

This plan is a **Minimum Essential Coverage (MEC) Plan** and covers **preventive** prescriptions and care at 100% as well as five doctor visits annually as well as generic and preferred pharmacy.

Schedule of Benefits	In-Network Only
Effective Date	January 1, 2017 – December 31, 2017
Doctor Visits (Limited to Five Annually)	
Convenience Clinic Care	$10 copay
Primary Care Physician	$25 copay
Specialist	$35 copay
Preventive Care	
Immunizations (Child, Adult)	Covered at 100%
Mammogram, Pap, PSA Tests Includes outpatient services Excludes diagnostic services	Covered at 100%
Colorectal Screening Includes outpatient services Excludes diagnostic services	Covered at 100%
Supplemental Care Urinalysis, EKG, Lab Tests covered as part of a routine exam	Covered at 100%
Women's Contraception Devices and Sterilization	Covered at 100%
Breast Feeding Equipment and Supplies	Covered at 100%
Pharmacy Benefit	
Mandated Preventive Pharmacy	Covered at 100%
All Other Pharmacy	
Generic Prescription	$10 copay
Preferred Prescription	Covered at 50% of discounted pricing
Non-Preferred and Specialty Prescription	Not covered

All costs represent **WEEKLY payroll** deductions. All tiers cost the same

WEEKLY COST				MEC Plan
Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	$5.00

CIGNA HSA MEDICAL PLANS

To be eligible for Cigna Plan medical benefits, you must be working an average of at least 30 hours per week. These plans meet **minimum value**. They are both high deductible health plans. **You must meet your deductible before the insurance company begins to pay for services.** The percentage listed for services is the portion you will need to pay for your claims **after your deductible is met**. Once you pay the out of pocket maximum, including your deductible, your claims will be paid at 100% for the plan year (Jan-Dec). Premium deductions are pre-tax.

Schedule of Benefits	CIGNA HSA $5,000		CIGNA HSA $2,600	
	In Network	Out of Network	In network	Out of Network
Effective Date	January 1, 2017 – December 31, 2017			
Annual Plan Deductible				
Individual	$5,000	$5,000	$2,600	$2,600
Family	$10,000	$12,700	$5,200	$5,200
Annual Out of Pocket Maximum				
Individual	$6,350	$12,700	$2,600	$10,000
Family	$12,700	$25,400	$5,200	$20,000
Lifetime Maximum Benefit	No lifetime maximums. Some services have visit or benefit limits.			
Co-Insurance	30%	50%	0%	50%
Office Visit (PCP & Specialist)	30% (^)	50% (^)	0% (^)	50% (^)
Preventive Services & Routine Vision Exam	Covered at 100%	Not covered	Covered at 100%	Not covered
Laboratory & Radiology Services	30% (^)	50% (^)	0% (^)	50% (^)
Emergency Room	30% (^)	30% (^)	0% (^)	50% (^)
Hospitalization / Outpatient Services / Urgent Care	30% (^)	50% (^)	0% (^)	50% (^)
Pharmacy Benefits				
Generic / Brand / Non-preferred / Specialty	10% (^)	50% (^)	0% (^)	50% (^)
Mail Order (90 day supply)	10% (^)	Not covered	0% (^)	Not covered
Preventive Medications (Generic & Preferred Brand*)	Covered at 100%	50% (^)	Covered at 100%	50% (^)

Note: Services where plan deductible applies is denoted with (^).
*Non-Preferred Brand Preventive Medications are subject to deductible & coinsurance.

All costs represent **WEEKLY payroll** deductions.

Cigna Medical Plans	HSA $5,000	HSA $2,600
Employee Only	$68.54	$98.31
Employee + Spouse	$219.45	$309.39
Employee + Child(ren)	$192.01	$271.01
Employee + Family	$342.93	$482.10

Health Savings Account (HSA)

Ability360 has two high deductible health plans to choose from and participation is suggested in the Health Savings Account (HSA) through HSA Bank. HSA Bank is a preferred partner for Ability360. You can find more information about HSAs at www.hsabank.com. You can perform the following transactions online:

- Check Account Balance
- Pay providers
- Funding options
- Cost Estimator tools

If you participate in either high deductible health plan, you can set aside pre-tax money in an HSA. This is an account funded to help you save for future medical expenses. **There are certain advantages to putting money into these accounts, including favorable tax treatment!** The 2017 maximum amount that can be contributed to an HSA is $3,400 for individual coverage and $6,750 for family coverage. Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000 annually.

Who Can Have an HSA?

Any adult can have an HSA if you:

- Have coverage under an HSA-qualified, high-deductible health plan (HDHP)
- Have no other first-dollar medical coverage (other types of insurance such as specific injury or accident, disability, dental care, vision care, or long-term care are permitted)
- Cannot be claimed as a dependent on someone else's tax return
- Or your spouse have a flexible spending account (FSA) that is not a limited purpose account
- Not entitled to (eligible for AND enrolled in) Medicare, Medicaid or Tricare benefits or has received VA benefits in the last three months

Contributions to your HSA can be made by you, the employee, through payroll deductions on a pre-tax basis. If you make a contribution post-tax, you can deduct the contributions (even if you do not itemize deductions) when completing your federal income tax return. Contributions to the account must stop once you are enrolled in Medicare, Medicaid, receive VA benefit or enroll in a plan with first dollar coverage. However, you still have the option to use your HSA funds to pay for qualified medical expenses if you meet any of these criteria. Contributions roll over year after year and are not subject to the "use it or lose it" provisions of a flexible spending account. **This is your money no matter where you work!**

Advantages of HSAs

Security – Your HSA can provide a buffer for unexpected medical bills.

Affordability – In most cases, you can lower your health insurance premiums by switching to health insurance coverage with a higher deductible.

Flexibility– You can use your HSA to pay for current medical expenses, including expenses that your insurance may not cover, or save your funds for future needs, such as:

- Health insurance or medical expenses if unemployed
- Medical expenses after retirement (before Medicare), long-term care expenses and insurance
- Out-of-pocket expenses when covered by Medicare

Savings – You can save the money in your HSA for future medical expenses and grow your account through investment earnings.

Control – You make the decisions regarding:

- How much money you will put in the account
- Whether to save the account for future expenses or pay current medical expenses
- Which medical expenses to pay from the account
- Which financial institution will hold the account
- Whether to invest any of the money in your account and what investments to make

Portability – Accounts are completely portable, meaning you can keep your HSA even if you:

- Change jobs
- Change your medical coverage
- Become unemployed
- Move to another state
- Change your marital status

Tax Savings – An HSA provides you triple tax savings:

1. Tax deductions when you contribute to your account
2. Tax-free earnings through investment
3. Tax-free withdrawals for qualified medical expenses

What are the steps in using an HSA?

1. First open your HSA and fund through payroll deductions. Your Ability360 Benefit team can assist you with this.
2. Next you or your tax dependent seeks medical, pharmacy, dental, vision care or an IRS approved service. A complete listing can be found at http://www.irs.gov/pub/irs-pdf/p502.pdf. You can use your HSA funds to pay for any tax dependents health care expenses even if they are not enrolled in an Ability360 plan.
3. Lastly, claims are filed through the insurance company and appropriate discounts applied. Amounts are applied to deductible and coinsurance where applicable. Employee then uses their HSA account to pay the member responsibility as billed or if payment is due at time of service.

HSA funds can only be used to pay health care expenses that were incurred after the account was opened and initially funded. Be sure to keep all your receipts in case you are ever audited by the IRS.

Optimed Limited Benefit Plan

Preferred Care Plus Plan

To be eligible for the Optimed limited medical plan you must be working an average of at least 20 hours but less than 30 hours per week. Enrollment in OptiMed is 60 days after hire and during open enrollment. **This plan does not meet the requirements of a Minimum Essential Coverage (MEC) required by the Affordable Care Act (A.C.A.).** By enrolling in this plan you will still be subject to the Individual Mandate Penalty. If you are **NOT eligible** to enroll in the Allegiance or Cigna medical plans, you **CAN** enroll in the OptiMed medical plan. If you **ARE eligible** to enroll in the Allegiance or Cigna plan, you **CANNOT** enroll in either OptiMed medical plan.

Schedule of Benefits	Calendar Year Maximum		Benefit Amounts
Effective Date	January 1, 2017 – December 31, 2017		
Calendar Year Overall Maximum Medical Benefit	**$100,000**		
Outpatient Physicians Office Visit Benefit	$700		$70 per visit
Emergency Room Benefit for Sickness	Included in office visit maximum		$70 per visit
Wellness Care Benefit	$150		$50 per visit
Outpatient X-Ray & Lab	$300		$40 per visit
Hearing Exam Benefit	Paid once per 24 months per member & spouse; once per 12 months per child		$70 per exam
Emergency Room Benefit for Accident	Only paid if treated with 72 hours of the accident		$1,000 per visit
Surgical Schedule			
Outpatient Surgical Schedule	$1,000		$500
Anesthesiology – Inpatient and Outpatient			20% of surgical benefit paid
Hospital Indemnity Benefit for sickness or accidents; requires a 24 hour stay			
Inpatient Hospitalization	Included in overall maximum		$500 per day
Intensive Care Hospitalization *paid in addition to Inpatient Hospitalization Benefit*	Included in overall maximum; 30 days calendar year maximum		$500 per day
Skilled Nursing Facility *after a 3+ day hospital stay*	Included in overall maximum; 60 days calendar year maximum		$250 per day
Employee Term Life Insurance / AD&D			$10,000/$10,000
Dependent Term Life Insurance			
Spouse			$5,000
Children 6 months to 19 (25 for full time students)			$2,500
Infants 14 days to 6 months			$250
Outpatient Prescription Drugs			
Prescription drug formulary applies. Drugs not on the formulary receive discounts only. Limitations and exclusions apply.	Employee Only	$2,500	$10 generic copay $50 brand copay
	Employee + One	$4,000	
	Family	$5,000	

PLEASE SEE WEEKLY RATES FOR THIS PLAN ON PAGE 14.

Optimed Limited Benefit Plan

Premier Care Plan

To be eligible for the Optimed limited medical plan you must be working an average of at least 20 hours but less than 30 hours per week. Enrollment in OptiMed is 60 days after hire and during open enrollment.
This plan does not meet the requirements of a Minimum Essential Coverage (MEC) required by the Affordable Care Act (A.C.A.). By enrolling in this plan you will still be subject to the Individual Mandate Penalty. If you are **NOT eligible** to enroll in the Allegiance or Cigna medical plans, you **CAN** enroll in the OptiMed medical plan. If you **ARE eligible** to enroll in the Allegiance or Cigna plan, you **CANNOT** enroll in either OptiMed medical plan.

Schedule of Benefits	Calendar Year Maximum		Benefit Amounts
Effective Date	January 1, 2017 – December 31, 2017		
Calendar Year Overall Maximum Medical Benefit	**$100,000**		
Outpatient Physicians Office Visit Benefit	$900		$75 per visit
Emergency Room Benefit for Sickness	Included in office visit maximum		$75 per visit
Wellness Care Benefit	$150		$150 per visit
Outpatient X-Ray & Lab	$300		$60 per visit
Hearing Exam Benefit	Paid once per 24 months per member & spouse; once per 12 months per child		$70 per exam
Emergency Room Benefit for Accident	Only paid if treated with 72 hours of the accident		$1,000 per visit
Surgical Schedule			
Outpatient Surgical Schedule	$3,000		$1,500
Anesthesiology – Inpatient and Outpatient			20% of surgical benefit paid
Hospital Indemnity Benefit for sickness or accidents; requires a 24 hour stay			
Inpatient Hospitalization	Included in overall maximum		$1,000 per day
Intensive Care Hospitalization *paid in addition to Inpatient Hospitalization Benefit*	Included in overall maximum; 30 days calendar year maximum		$1,000 per day
Skilled Nursing Facility *after a 3+ day hospital stay*	Included in overall maximum; 60 days calendar year maximum		$500 per day
Employee Term Life Insurance / AD&D			$20,000/$20,000
Dependent Term Life Insurance			
Spouse			$10,000
Children 6 months to 19 (25 for full time students)			$5,000
Infants 14 days to 6 months			$500
Outpatient Prescription Drugs			
Prescription drug formulary applies. Drugs not on the formulary receive discounts only. Limitations and exclusions apply.	Employee Only	$2,500	$10 generic copay $50 brand copay
	Employee + One	$4,000	
	Family	$5,000	

PLEASE SEE WEEKLY RATES FOR THIS PLAN ON PAGE 14.

Dental – Cigna Dental HMO

The Cigna HMO dental plan is available to ALL caregivers working an average of 20 or more hours per week. You can also enroll your spouse and your eligible dependent(s).

Dental Plan At-A-Glance

Schedule of Benefits	Cigna DHMO
Effective Date	**January 1, 2017 – December 31, 2017**
	DHMO
	In-Network Only
Annual Deductible (Individual / Family)	**None**
Annual Plan Maximum per person per year	**None**
Office Visit Copay	**$6 (Observation Only)** **$40 (Emergency After Hours)**
Preventive and Diagnostic Dental Services	
Exams / Cleanings / Sealants / X-rays	See Schedule*
Basic Dental Services	
Amalgam & Composite Fillings	See Schedule
Periodontal Surgery & Maintenance	See Schedule
Simple & Surgical Extractions	See Schedule
Endodontics (Root Canals)	See Schedule
Major Dental Services	
Repairs (Crowns)	See Schedule
General Anesthesia	See Schedule
Implants/Crowns/Bridges/Dentures	See Schedule

PLEASE SEE WEEKLY RATES FOR THIS PLAN ON PAGE 14.

*Fee schedule can be found on our benefits webpage: http://ability360.org/hcs-employee-news

Mutual of America –Tax Deferred Annuity (TDA)

Annuities are flexible, tax-deferred investment plans that you can use to help you achieve your long-term financial goals and provide a source of retirement income.

Note: Ability360 does not contribute to this plan.

Contact: Mutual of America at (602) 224-8080 to arrange for payroll deductions for this annuity.

Mutual of America will notify our payroll department of your election.

Cost of Benefits

All costs below represent **WEEKLY payroll** deductions.

Allegiance MEC Plan	MEC Plan
Employee Only	$5.00
Employee + Spouse	$5.00
Employee + Child(ren)	$5.00
Employee + Family	$5.00

Cigna Medical Plan	HSA $5,000	HSA $2,600
Employee Only	$68.54	$98.31
Employee + Spouse	$219.45	$309.39
Employee + Child(ren)	$192.01	$271.01
Employee + Family	$342.93	$482.10

OptiMed Limited Medical Plan*	Preferred Care Plus*	Premier Care*
Employee Only	$23.72	$35.83
Employee + One	$47.46	$73.70
Employee + Family	$67.07	$104.74

Cigna Dental Plan	DHMO
Employee Only	$3.28
Employee + Spouse	$6.42
Employee + Child(ren)	$6.93
Employee + Family	8.31

*** This plan does not meet the requirements of a Minimum Essential Coverage (MEC) required by the Affordable Care Act (A.C.A.). By enrolling in this plan you will still be subject to the Individual Mandate Penalty.**

Please note that premium for the OptiMed Medical plans medical are taken on a post-tax basis. Premiums on the Allegiance and Cigna Medical and Cigna Dental plans are taken on a pre-tax basis.

If you are **not eligible** to enroll the Allegiance or Cigna medical plans, you **can** enroll in the OptiMed medical plan. If you **are eligible** to enroll in the Allegiance or Cigna plan, you are **not** eligible to enroll in either OptiMed medical plan.

Where do I find a list of network providers?

Carrier	Phone Number	Website
Allegiance MEC Plan	(800) 877-1122	www.askallegiance.com/preventive
Cigna HSA Plans	Please call the number on the back of your ID card	www.cigna.com
OptiMed Limited Medical Plan	(800) 482-8770	www.optimedhealth.com
Cigna Dental Plan	Please call the number on the back of your ID card	www.cigna.com

Glossary of Terms

AD&D – Accidental Death and Dismemberment is an additional benefit should an eligible participant pass away in an accident (rather than natural causes). The beneficiary gets an additional benefit of 2 times their face amount. Also includes dismemberment which includes loss of the use of certain body parts (including limbs or eyesight).

COBRA – Consolidated Omnibus Reconciliation Act. A health, dental and vision plan which allows an employee and their eligible beneficiaries who leaves a company to continue to be covered under the company's health plan, for certain time period and under certain conditions.

Coinsurance – A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount has been paid.

Deductible – A fixed dollar amount during the annual benefit period (1/1/2017 – 12/31/2017) that an insured person pays before the insurer starts to make payments for covered medical services.

Embedded Deductible – Your plan contains two components, an individual deductible and a family deductible. Having two components to the deductible allows each member of your family the opportunity to have your insurance policy cover their medical bills prior to the entire dollar amount of the family deductible being met. The individual deductible is embedded in the family deductible. For example, if you, your wife and daughter are on a family plan with a $5,200 family embedded deductible, and the individual deductible is $2,600, and your daughter incurs $2,600 in medical bills, her deductible is met and any subsequent medical bills for your daughter that year will be covered at 90% until the out of pocket maximum is met. This occurs even though the family deductible of $5,200 has not been met.

Explanation of Benefits (EOB) - Written, formal statement sent to PPO enrollees that lists the services provided, amounts paid and costs billed by the health plan.

Formulary - A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost-effective for members. The formulary is updated periodically.

Generic Drug - FDA-approved prescription drugs that are a therapeutic equivalent to the brand-name drug, contain the same active ingredient as the brand-name drug, and cost less that the brand-name drug equivalent.

Health Savings Account (HSA) - A tax-advantaged medical savings account available to those are enrolled in a high-deductible health plan (HDHP). Funds can be used to pay for qualified healthcare expenses per the IRS guidelines. The funds contributed to an account are not subject to federal income tax at the time of deposit.

In-network – A provider that is contracted or participating in the plan.

Out-of-network – A provider that is not contracted or participating in the plan.

Out-of-pocket maximum – The maximum dollar amount a group member is required to pay out of pocket during a year. After the maximum is reached, the insurance carrier pays all covered expenses.

Carriers & Vendors Contact Information

Benefit / Provider	Department	Phone Number	Website
Medical			
Cigna HSA Plans	If you've lost your ID card	800-Cigna24 800-244-6224	www.mycigna.com
	Home Delivery Pharmacy	800-285-4812	www.mycigna.com
	Customer Service	877-484-5967	http://www.optimedfamily.com/ability360/
MEC Plan	Customer Service	800-877-1122	www.askallegiance.com/preventive
Health Savings Account			
HSA Bank	Customer Service	800-357-6246	www.hsabank.com
Limited Medical Benefit Plan			
Optimed	Customer Service	800-482-8770	
Dental			
Cigna	Customer Service	877-484-5967	www.mycigna.com
Day to Day Benefits Assistance			
Ability360	Benefits	844-274-7284	ability360.org/hcs-employee-news

http://ability360.org/hcs-employee-news

ALL CARRIER INFORMATION AND ENROLLMENT MATERIALS ARE AVAILABLE ONLINE AT THE ABOVE LISTED WEBSITE OR CAN BE REQUESTED THROUGH HUMAN RESOURCES AT BENEFITS@ABILITY360.ORG

1-844-274-7284, or email: Benefits@Ability360.org

HIPAA Notice of Privacy Practices

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Obtain Access To This Information

Please Review It Carefully.

INTRODUCTION
This is the HIPAA Notice of Privacy Practices for Ability360 Health Care Plan (the "Group Health Care Plan"). Throughout this notice, the terms "we," "us" and "our" refer to the Group Health Care Plan.

The Group Health Care Plan is required by law to maintain the privacy of protected medical information and to provide covered individuals with notice of its legal duties and privacy practices with respect to protected medical information. However, the Plan is permitted to use and disclose this information under the circumstances described in this notice.

This Notice describes how we protect any personal health information that we have about you ("Personal Health Information"), and how we may use and disclose this information. Personal Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. This Notice also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide this Notice to you by federal law known as the Health Insurance Portability and Accountability Act ("HIPAA"). For additional information regarding the privacy policies described in this Notice or to obtain a copy of the Privacy Policies and Procedures of the Group Health Care Plan, you may contact us through the HR Department.

The Group Health Care Plan is required to abide by the terms of this notice until it is amended. The Plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. All individuals covered under the Group Health Care Plan will receive a revised notice of a material revision to the notice.

PERMITTED USES AND DISCLOSURES
In order for the Employer's Group Health Care Plan to pay for your eligible medical expenses, the Plan and those administering the Plan must create or receive certain medical information about you. This information may involve:

- **Payment activities** such as billing and collection activities, eligibility determinations, adjudication of claims, pre-certification and utilization review, and coordination of benefits, or
- **Health care operation activities** such as quality assessment, case management, subrogation or business management and general administrative activities, or
- **Treatment activities** by your health care provider, such as providing information about other treatments you have received.

By your enrolling in the Group Health Care Plan, you have agreed to allow the Plan and its administrators to create or use your medical information in order to perform these duties without your express authorization. The Plan may also disclose medical information about you without your authorization to business associates of the plan, such as actuaries who price the cost of coverage, the claims administrator who pays the claims or other professionals who perform services on behalf of the Plan. All disclosures made by the Plan of medical information for purposes of payment or health care operation activities shall be the minimum necessary to accomplish the intended purpose of the disclosure, and any business associate who receives the information must agree to keep it confidential.
The law requires the Group Health Care Plan to make certain disclosures. These include disclosures:

- As necessary to comply with workers' compensation or other similar programs.

- As necessary for courts and law enforcement agencies. Disclosures to a law enforcement agency may occur if required by law (such as the occurrence of certain types of wounds) or if required by a court order other legal process. The Plan may also disclose medical information: for the purpose of identifying or locating a suspect, witness, fugitive or missing person; about a crime victim, if the victim agrees or emergency circumstances require disclosure without consent; about a person who has died if the nature of the death suggests that it may be the result of criminal conducts; or if there is evidence to suggest that a crime occurred on the premises.
- As necessary for public health research and disclosure, including reporting of communicable diseases to the applicable authorities (who may contact exposed individuals) and workforce medical investigations.
- As necessary to health oversight activities authorized by law. However, this will generally not include an investigation of a particular individual unless it involves receipt of health care, public health benefits or public benefits contingent on the individual's health.
- As necessary if disclosure is required by another law.

The Plan may also be permitted or required to disclose medical information without your authorization under the following circumstances:

- If authorized by law, to proper authorities for purpose of reporting child abuse or domestic violence. Subject to certain restrictions, the Plan may also report this information to social services, but must generally inform the victim of the abuse for which it is making the disclosure.
- To state insurance departments, U.S. Department of Labor and other government agencies that may regulate us.
- Upon your death, to a coroner, funeral director or to tissue or organ services, as necessary to permit them to perform their functions.
- Under certain circumstances, for research purposes.
- To prevent or lessen a serious threat to the health or safety of a person or the public.
- If authorized by law, in connection with military matters or matters of national security and intelligence.

In addition, the Plan may disclose medical information to the Plan Sponsor (ABILITY360 Health Care Plan) under the following conditions:

- Employer may not use any such information for employment-related decisions.
- Employer may receive such information as the Plan documents allow.
- You have the right to inspect the Plan documents allowing disclosures.

SPECIAL SITUATIONS

We may disclose Personal Health Information about you to a relative, a friend, the subscriber of your health benefits plan or any other person you identify, provided the information is directly relevant to that person's involvement with your health care. For example, if a family member of a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by contacting the Benefits Administrator.

If you are a minor, you also may have the right to block parental access to your Personal Health Information in certain circumstances, if permitted by law. You should contact the Benefits Administrator to obtain further information about this right.

If necessary, under certain circumstances, we may also use your Personal Health Information to notify a family member, or another person responsible for your care, of your location, general condition, or death.

Other uses and disclosures of your medical information will be made only with your written authorization and you may revoke the authorization at any time, upon request.

MINIMUM NECESSARY STANDARDS

When using or disclosing Personal Health Information or when requesting Personal Health Information from another entity covered by HIPAA, we will make reasonable efforts not to use, disclose or request more than the minimum amount of Personal Health Information necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

However, the minimum necessary standards will not apply to disclosure to or requests by a health care provider for treatment, uses or disclosures made by you, disclosures made to the Secretary of Health and Human Services, uses or disclosures that are required by law, and uses or disclosures that are required for the Group Health Plan's compliance with law.

You have the right:

- To request restrictions on certain uses and disclosures of your medical information. The Plan does not have to agree with a requested restriction, but if the Plan does agree, the Plan will abide by that restriction.
- To receive your own confidential health information by alternative means or at alternative locations, if receipt of the information in the usual manner could endanger you. You should contact Employer to request the alternative delivery. You must include a statement that disclosure of the information in the usual manner could endanger you.
- To inspect and copy your own health information, but exceptions apply to certain types of information. If you request to see or copy your own health information at that time, including the circumstances under which you may challenge the exception.
- To amend your own health information when that information is incorrect.
- To obtain an accounting of any disclosure of your confidential health information, other than disclosures for purpose of payment, health care operations or treatment, or disclosures made in accordance with your written authorization.
- To obtain a paper copy of this notice upon request.

In each case, you must make your request to the Employer in writing. Depending upon the nature of the request, you will be given more information at that time, including any exceptions to the rules that may apply to your case.

Individuals may complain to the Plan sponsor and/or to the Secretary of Health and Human Services if they believe their privacy rights have been violated. If you wish to file such a complaint, please contact Employer and you will be given information on how to proceed. You will not be retaliated against by the Plan or Plan sponsor for the complaint. The Department of Health and Human Services may be contacted in Washington D.C. or listings may be found in local telephone directories.

For further information, contact Employer.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm 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: http://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: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ 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/hipp Phone: 1-800-692-7462

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: 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, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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.

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 Human Resources.

Newborns' Act Disclosure

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).

Women's Health and Cancer Rights Act Disclosure

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Contact Cigna services for more information. The phone number is on the back of your ID card.

Preventive Care Services for Women

Effective for plan years beginning on or after August 1, 2012, your non-grandfathered plan must cover specific preventive care services for women without cost-sharing requirements. The covered preventive care services for women include: well-woman visits; gestational diabetes screening; human papillomavirus (HPV) testing; sexually transmitted infection (STD) counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling. Exceptions to the contraceptives requirement apply to certain religious employers. The preventive care guidelines for women are available at: www.hrsa.gov/womensguidelines/.

Notice of Extension of Adult Child Coverage to age 26 (medical plan)

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 Ability360's Health Care Plan. Individuals may request enrollment for such children for 30 days from the date of notice.

Patient Protection Disclosure (choice of providers)

Ability360's Health Care Plan does not require the designation of a primary care provider. You do not need prior authorization from Cigna 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.

Medicare Part D Notices

Important Notice from Ability360 About Your Prescription Drug Coverage and Medicare

(Allegiance and Cigna HSA 2600 and HSA 5000 plans)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ability360 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. Ability360 has determined that the prescription drug coverage offered by the Allegiance and Cigna HSA 2600 and HSA 5000 plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Ability360 coverage will not be affected. The Allegiance plan currently offers participants a 2 tier pharmacy plan: Tier 1 for generics at a $10 copay and Tier 2 for preferred brand prescriptions are covered at 50%, non-preferred prescriptions are not covered; the Cigna HSA 2600 plan currently offers participants pharmacy covered at 100% after the deductible is met; and the Cigna HSA 5000 plan currently offers participants pharmacy covered at 90% after the deductible is met. You can compare this coverage to the Medicare Prescription Drug plan offerings by reviewing a summary of the plans **https://www.medicare.gov/find-a-plan/questions/home.aspx**. In addition, your current coverage pays for other health expenses in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Ability360 coverage, be aware that you and your dependents may be able to get this coverage back at the next open enrollment.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Ability360 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Arizona Bridge for Independent Living changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

- Visit 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).

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

Date:	January 1, 2017
Name of Entity/Sender:	Ability360
Contact--Position/Office:	Melody Forbes
Address:	5025 E Washington Street, Suite 200 Phoenix, AZ 85034
Phone Number:	1-844-274-7284

Important Notice from Ability360 About Your Prescription Drug Coverage and Medicare
(OptiMed plans)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ability360 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. 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. Ability360 has determined that the prescription drug coverage offered by the OptiMed plans are, 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 the OptiMed plans. 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 the OptiMed plans. 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 to December 7th.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the prescription coverage under the OptiMed plans are 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's 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 Ability360 coverage will not be affected. The OptiMed plans currently provides a limited prescription benefits: $10 for generics, $50 for brand not to exceed a benefit of $2,500 per insured for the calendar year . You can compare this coverage to the Medicare Prescription Drug

plan offerings by reviewing a summary of the plans https://www.medicare.gov/find-a-plan/questions/home.aspx. In addition, your current coverage pays for other health expenses in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Ability360 coverage, be aware that you and your dependents may be able to get this coverage back at the next open enrollment.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Ability360 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

- Visit 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:	January 1, 2017
Name of Entity/Sender:	Ability360
Contact--Position/Office:	Melody Forbes
Address:	5025 E Washington Street, Suite 200 Phoenix, AZ 85034
Phone Number:	1-844-274-7284

CMS Form 10182-NC **Updated April 1, 2011**