Please Note:
Information Regarding Your Ability360 Prescription Drug Coverage and Medicare starts on page 30 of this document.
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Welcome

At Ability360, we believe that each and every employee plays an important role in our company’s success. That is the reason why we strive to provide you with a benefits program that rewards you for your hard work and dedication every day.

The comprehensive benefits program that the company offers you and your family is an important component of your total compensation package. We have prepared this Benefits Guide to help you understand the benefit plans available.

Included in this Benefits Guide are summaries of your benefit options regarding medical and voluntary dental plan options.

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.
Benefit Eligibility

Who is Eligible for Insurance?
You are eligible for benefits if you meet the criteria listed below.

Full-Time Caregivers
Full-time caregivers or HCS employees 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.

Part-Time Caregivers
To be eligible for medical benefits through BlueCross BlueShield of Arizona 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.

Dependents
Your dependents become eligible for coverage when you do, provided you have enrolled for coverage yourself. Eligible dependents include:

- Your legally married spouse
- Your eligible children up to age 26

Dependent Social Security Numbers
Employers are required by Medicare legislation to collect Social Security Numbers for your enrolled dependents. When enrolling or renewing your medical coverage, please have this information with you for your spouse and eligible children. Please submit Social Security Numbers for newborns once they are issued.
Enrollment

Annual Open Enrollment
Ability360 conducts its annual Open Enrollment during the month of November for a January 1st effective date. This is the time for employees to re-evaluate their needs and elect benefit options for the new plan year.

New Hire and Newly Eligible Employee
Newly hired or newly eligible employees must complete their enrollment no later than the last day of the month before their first day of eligibility.

How to Enroll
If you are newly eligible or making changes to your current coverage, you will need to complete a new enrollment form. If you are not making any changes to your benefit elections, your current elections will roll over to the new plan year.

Completed forms must be received by Human Resources no later than November 20, 2018.
**Between Enrollment Periods**

Generally, once you enroll, you cannot make changes to your enrollment selections until the next enrollment period. You may make changes to your benefit elections outside of the annual Open Enrollment ONLY if you experience a Qualifying Life Event (QLE), as defined by the IRS. Benefit changes must also be consistent with the QLE.

**Some Examples of QLEs**

**A legal marital status change:**

- Marriage
- Divorce, legal separation, or annulment
- Death of your spouse

**The number of eligible children changes:**

- Birth or adoption of a child
- Child gains or loses eligibility for coverage under the plan
- Death of a child

**You or an eligible family member’s benefits eligibility changes because:**

- A change in work schedule or status that causes you or your eligible family member to gain or lose eligibility.
- You or your eligible family member’s COBRA coverage from a prior employer expires.
- You or your eligible family member becomes eligible for or loses Medicare or Medicaid.
- You or your eligible family member loses coverage under a government’s or educational institution’s plan.

If a change in status does occur, contact Human Resources regarding eligible election changes within 30 days of the event.
Health Care Details

Section 125 Cafeteria Plan Guidelines

Pre-Tax Contributions
A Section 125 Cafeteria Plan enables you to save money by reducing your taxes and increases your take-home pay by using pre-tax dollars to pay for your portion of eligible insurance premiums.

Premiums offered on a pre-tax basis include the following benefit plans:
- Health
- Dental

Contributions made to the following account will also be paid on a pre-tax basis:
- Health savings accounts

The elections you make during the annual enrollment period will become effective on 1-1-2019.

To take advantage of the tax savings of pre-tax contributions, the IRS requires that the election(s) you make remain in effect for the entire benefit plan year. No changes in benefit elections can be made during the plan year unless you experience a qualifying event.

For example:
You choose to take your medical & dental premiums pre-tax during open enrollment. Several months later you decide that the medical and dental premiums are no longer affordable.

Unfortunately, you will be unable to stop the pre-tax premium deductions until the next annual open enrollment and the change will be effective January 1st of the next plan year.

There is an exception to this IRS rule. If you experience a change in family or employment status and the change qualifies under IRS rules, you may make a mid-year election change. The change requested, however, must be allowed under the plan and consistent with the event.

You must notify Human Resources of the qualifying event and complete the necessary paperwork within 30 days of the event in order to make a benefit election change. Requested benefit changes must be consistent with the qualifying event.

All eligible premiums will be deducted on a pre-tax basis. Contact Human Resources if you do not wish to have your deduction taken pre-tax.

Please refer to your Section 125 plan document for complete details, including eligible qualifying events.
Medical Coverage

Medical Allegiance Health Minimum Essential Coverage (M.E.C.)
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%; five doctor visits annually, as well as generic and preferred pharmacy.

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>In-Network Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective Date</strong></td>
<td>January 1, 2019 – December 31, 2019</td>
</tr>
<tr>
<td><strong>Doctor Visits (Limited to Five Annually)</strong></td>
<td></td>
</tr>
<tr>
<td>Convenience Clinic Care</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$35 copay</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>Immunizations (Child, Adult)</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Mammogram, Pap, PSA Tests</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Includes outpatient services</td>
<td>Excludes diagnostic services</td>
</tr>
<tr>
<td><strong>Colorectal Screening</strong></td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Includes outpatient services</td>
<td>Excludes diagnostic services</td>
</tr>
<tr>
<td><strong>Supplemental Care</strong></td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Urinalysis, EKG, Lab Tests covered as part of a routine exam</td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Contraception</strong></td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Devices and Sterilization</td>
<td></td>
</tr>
<tr>
<td><strong>Breast Feeding</strong></td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Equipment and Supplies</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Benefit</strong></td>
<td></td>
</tr>
<tr>
<td>Mandated Preventive Pharmacy</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td><strong>All Other Pharmacy</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Prescription</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Preferred Prescription</td>
<td>Covered at 50% of discounted pricing</td>
</tr>
<tr>
<td>Non-Preferred and Specialty Prescription</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>WEEKLY COST</strong></th>
<th>MEC Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$5.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$5.00</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$5.00</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$5.00</td>
</tr>
</tbody>
</table>

MEDICAL COVERAGE
Medical Coverage (continued)

At Ability360, we are pleased to offer quality BCBS of Arizona health insurance plans which emphasize the prevention of disease, while providing comprehensive coverage for major medical conditions. These plans are offered alongside the Allegiance plans. An overview of the plans in network benefits is provided below. More detailed benefit can be found in the Summary of Benefits and Coverage (SBC), available online at BCBS’s website or in the BCBS’s information packet. The website address can be found on the page 21 of this guide.

Medical Benefits

<table>
<thead>
<tr>
<th>BCBS</th>
<th>BCBS HSA $5,000 In-Network</th>
<th>BCBS HSA $3,000 In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$5,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$10,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>30%</td>
<td>0%</td>
</tr>
<tr>
<td>Out of Pocket</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,650</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$13,300</td>
<td>$6,000</td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>0% copay</td>
<td>0% copay</td>
</tr>
<tr>
<td>PCP / Convenience Clinic</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Laboratory</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>X-ray</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Advanced Imaging (CT,PET, MRI)</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Prescription Drugs Retail - 30 day</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Mail Order - 90 day</td>
<td>30% after deductible</td>
<td>0% after deductible</td>
</tr>
</tbody>
</table>

* The amount shown is the amount the member is responsible for.

Please refer to the information in the BCBS’s packet or certificate of coverage for out-of-network benefits.
**Prescription Drugs**

Go to the BCBS’s website to learn how much drugs cost before you go to the drugstore. The best way to know what your prescription cost will be or if the prescription requires a prior authorization is to log on to the website which can be found on page 21 of this guide. This will give you the drug cost specific to your plan. You can also go online to GoodRx.com to see the retail cost of your prescriptions.

**Please note that BCBS does provide 100% coverage for preventive drugs on their HSA plans.** Check BCBS’s formulary for covered medications as the coverage can vary between carriers.

**Mail Order**

BCBS makes getting your drugs simpler through BCBS’s mail order service where you can get up to a 90-day supply.

**Employee Cost Per Weekly Pay Period  (52 Pay Periods Per Year)**

<table>
<thead>
<tr>
<th></th>
<th>HSA $5,000</th>
<th>HSA $3,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$68.54</td>
<td>$98.31</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$201.26</td>
<td>$328.65</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$202.99</td>
<td>$287.88</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$362.55</td>
<td>$512.11</td>
</tr>
</tbody>
</table>
Which plan will work best for you?

Each medical plan option has differences as well as advantages. The plan that best meets your needs and the needs of your covered dependents will depend on your situation, specific health care requirements, and individual perspective.

Here are some questions you may consider:

• What matters most to me – keeping more of my paycheck or paying less when I receive services?
• How often do I or my covered dependents anticipate needing medical services during the upcoming year?
• Am I or a covered dependent considering planned surgery or service that may cause me to reach my out-of-pocket maximum?
• Should I cover a spouse or other dependents under my plan, or do my dependents have access to other coverage options that our family should consider?

It is important to analyze the plan details and share this information with any of your dependents who you are planning to enroll. By familiarizing yourself with the health plan coverage, limitations and rules, you can maximize the benefits of your plan, anticipate out-of-pocket costs and have more control over your medical expenses.

If you have questions about any of the plans, you can call Allegiance or BCBS or find answers on the BCBS’s website. The phone numbers and website addresses are listed on page 21 of this guide.
Money Saving Tips

A Doctor is Always In: Telemedicine

For minor ailments, you don’t have to wait in the emergency room or urgent care center for a diagnosis and treatment. You can access telehealth services from home, work or while traveling by phone, app or webcam. Most states have health care providers available 24 hours a day, 7 days a week, and 365 days a year!

BlueCare Anywhere – BCBSAZ is providing telehealth services through BlueCare Anywhere to all members enrolled in a BCBSAZ medical plan.

Individuals can access telehealth services for medical issues for a service fee of $49 regardless of the high deductible health plan selected. Individuals can use their HSA dollars to pay for their telehealth visit and these amounts go towards your deductible.

On Demand Doctor Visits

Telehealth enables virtual visits with board-certified physicians as well as with counselors and psychiatrists.

Sign up: Create a secure account and set up your medical profile.

Get treatment: To consult with a telemedicine provider licensed to practice in your state, simply call or go online to schedule an appointment and receive personalized treatment. When medically needed, providers can submit a prescription to the local pharmacy of your choice.

Types of Services offered:

MEDICAL - $49 contracted fee

Physicians provide care and prescription support for a range of common illnesses and injuries:

- Colds
- Bronchitis
- Diarrhea
- Earache/Ear Infections
- Respiratory infections
- Allergies, hives and skin infections
- Cough/Sore Throat
- Itchy Eyes and Pink Eye
- Nausea and Vomiting
- Sprains and Strains
- Abdominal pain
- Headaches/Migraines
- Flu and fever
- Sinus Infections/Sinus Symptoms
- Urinary Tract Infection

COUNSELING - $80-$95 contracted fee

Certified psychologists or counselors treat issues affecting emotional, Psychological and social well-being:

- Anxiety
- Stress management
- OCD
- Panic attacks
- PTSD trauma
- Insomnia
- Depression
- Bereavement/grief
- Life transitions

PSYCHIATRY - $175 contracted fee

Board-certified psychiatrists provide assessments, evaluations, treatment and prescription support:

- Anorexia
- Bulimia
- Social anxiety/anxiety disorders
- Cognitive disorder
- OCD
- PTSD, Panic attacks
- Bipolar disorder
- Insomnia
- Depression

Telemedicine is not a replacement for your primary care physician or annual doctor’s office visit, nor is it an online pharmacy and medications cannot be purchased or dispensed.
In-Network vs. Out-of-Network

Each PPO health plan provides two tiers of coverage— in-network and out-of-network services. This gives you the freedom to decide who will provide your care. Although you can choose to receive care from any licensed provider, you will save money by using in-network providers.

When you use an in-network provider, the plan pays benefits based on a negotiated rate. Any expense above this amount is not your responsibility. To determine which providers are considered in-network, you can log on to BCBS’s website and use the provider directory search tool. Because out-of-network providers are not contracted, not only does the plan pay less, but you are responsible for paying the difference between what the plan pays and what the out-of-network provider charges.

Decrease Out-Of-Pocket Healthcare Expenses

The cost of medical care continues to increase at a rapid rate each year. It is up to all of us to try to control costs and your efforts can make a difference. By making wise choices in your medical care, you help reduce the cost, which also helps to keep future rate increases to a minimum.

- Use In-Network Providers
- Consider using an Urgent Care facility when appropriate
- Obtain annual preventive exams and age-recommended screenings

Take Advantage of Free Preventive Services

Medical plans provide 100% preventive care coverage (subject to nationally-recognized age and gender guidelines) when services are performed by an in-network provider. Preventive care can help with early identification of certain illnesses which can prevent costly medical bills in the future. Preventive care services include:

- Annual preventive exam (physical)
- Screenings for:
  - Blood Pressure
  - Cholesterol
  - Colorectal Cancer
  - Diabetes (Type 2)
  - HIV (for everyone ages 15 to 65, and other ages at increased risk)
• Immunization vaccines  
• Well Child Care  
• Women’s Preventive Services

**24/7 Nurse Line**

You have access to the 24/7 Nurse Line whenever you have symptoms or health care concerns, even in the middle of the night. Registered nurses, who have an average of 15 years of clinical experience, are available 24 hours a day, seven days a week to help you whenever you need health care advice.

**CALL 1-866-422-2729**

When you call, a registered nurse can help you:

• Understand a wide range of symptoms  
• Determine if the Emergency Room, a doctor visit, or self-care is right for your needs  
• Learn more about diagnosis  
• Explore the risks, benefits and possible outcomes of treatment options  
• Get tips on how nutrition and exercise can help you maintain a healthy weight  
• Learn about important health screenings and immunizations

**On-line Services**

To make the most of your health care benefits, it pays to be involved, aware and in control. Blue Cross Blue Shield of AZ (BCBSAZ) offers a secure member website which helps you use your BCBSAZ benefits efficiently and to your best advantage. The website address can be found on page 21 of this guide.

By staying informed about your coverage and your responsibilities when using your health plan, you have the opportunity to save money and better predict your out-of-pocket costs.

Through the BCBS’s website you can:

• Find in-network doctors, hospitals and pharmacies near your home or work  
• Learn what your plan covers  
• Keep track of health care costs: check to see what a procedure may cost in your area  
• Look up claim information: what your doctor billed, how much your health plan paid and what you have to pay  
• Print temporary ID cards and/or order new ID cards

Download the BCBSAZ mobile app **AZBlue** to your iPhone or Android device to have instant mobile access to all of your healthcare information.
**Saving Money on Prescriptions**

**Ask about generic options**

Almost 80% of FDA-approved drugs have generic alternatives that cost an average of four times less than the brand-name versions. There is typically significant savings at big-box stores: Fry’s, Target and Walmart provide hundreds of generics for $4 for a 30-day supply and $10 for a 90-day supply.

Speak up when your Doctor is writing your script: Not all physicians automatically ask for generics, and a study found that doctors are generally unaware of the cost of the medicine they prescribe.

**Talk openly with your doctor**

Your healthcare provider may not know how much you’re paying for the drugs he or she prescribes. It also helps to review all your medications with your healthcare provider from time to time. If you’ve been taking a drug for a long time, it’s possible you no longer need it or could switch to something cheaper.

**Shop around**

Prices at pharmacies are flexible and you can try negotiating with your pharmacist. If one pharmacy has the best prices in town on all but one of the medications you’re taking, let the pharmacist know and see if she can give you a discount on that one drug. You can do your own price comparisons at www.goodrx.com. Additionally, a prescription filled in the hospital setting vs. retail is always going to be more expensive. Warehouse clubs often offer great savings, and you don’t always have to be a member to benefit. When you arrive, simply explain that you’re visiting the pharmacy.

**Look into patient assistance programs**

Many pharmaceutical companies have programs that provide their drugs at deep discounts or even free for people in need. If you have a prescription for a high-cost drug, check out the company’s web site to see if they offer assistance. You can also look up patient assistance programs on the NeedyMeds website (www.needymeds.org), which provides information on almost 6,000 programs.
Health Savings Account

What is a Health Savings Account?
A Health Savings Account (HSA) is a tax-advantaged savings account that belongs to you. All funds deposited into the account are tax free. It is not a “use-it-or-lose-it” type of account and if you leave your current employer, the funds and account go with you. The HSA account must be paired with a qualified high-deductible health plan (HDHP). The account helps pay for the expenses that are applied to deductibles and coinsurance which are not covered by your health plan. Qualified health care expenses such as medical, dental and vision paid from the account are never taxed.

Who is not eligible to open an HSA?
Anyone who is:
- Covered under any health plan that is not a qualified HDHP;
- Covered by a Flexible Spending Account (FSA), including a spouse’s FSA. A limited purpose FSA that covers dental and vision expenses only is acceptable.
- Entitled to (eligible for AND enrolled in) Medicare*, Medicaid or Tricare benefits or has received Indian Health Service (IHS) or VA** benefits in the last three months.
- Eligible to be claimed on another person’s tax return.

* If you are 65 and delay Medicare enrollment, please be aware that when you do apply, Medicare Part A coverage will be retroactive for 6 months. You will need to stop contributing before Medicare is effective to avoid potential penalties.
** Veterans with a service-connected disability may contribute to an HSA regardless of receiving VA benefits starting January 1, 2016.

Adult Children Covered Under Your HDHP
Your HSA funds cannot be used for adult children that are not qualified tax dependents.

Contributing to an HSA
Who can contribute?
Anyone can contribute to your HSA, you, your employer, a family member or anyone else.

Is there a limit as to how much can be contributed to an HSA?
The 2019 annual limits are:
- $3,500 for individual coverage
- $7,000 for family coverage (Employee and one or more eligible covered dependents)

If you are age 55 or older, but under the age of 65, you can make an additional $1,000 annual “catch-up” contribution to your HSA.

How HSA Funds Can Be Used
**Dental Coverage**

Ability360 offers HCS employees a DHMO dental plan through Cigna. This plan provides you with coverage for preventive and diagnostic care benefits, as well as, basic and major services.

Your provider must be in-network as there are no out-of-network benefits on this plan. To find in-network providers in your area, please visit Cigna’s website or call Cigna. The website address and phone number can be found on page 21 of this guide.

**Dental Benefits**

<table>
<thead>
<tr>
<th>Cigna</th>
<th>Cigna DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td><strong>In-Network Only</strong></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
</tr>
<tr>
<td><strong>Annual Benefit Maximum</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Deductible Waived for Preventive</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Class I-Preventive Exams, X-rays, Cleanings, Fluoride Treatments</strong></td>
<td>Scheduled Copays</td>
</tr>
<tr>
<td><strong>Class II-Basic Simple Extractions, Space Maintainers, Fillings, Periodontics, Endodontics, Oral Surgery</strong></td>
<td>Scheduled Copays</td>
</tr>
<tr>
<td><strong>Class III-Major Crowns, Inlays, Onlays, Denture Repairs</strong></td>
<td>Scheduled Copays</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Scheduled Copays</td>
</tr>
<tr>
<td>Orthodontic Lifetime Maximum</td>
<td>Scheduled Copays</td>
</tr>
<tr>
<td>Late Entrant Waiting Periods</td>
<td>None</td>
</tr>
</tbody>
</table>

**Employee Cost per Pay Period (52 Pay Periods per year)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Employee Only</td>
<td>$3.28</td>
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<tr>
<td>Employee + Spouse</td>
<td>$6.42</td>
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<tr>
<td>Employee + Child(ren)</td>
<td>$6.93</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$10.76</td>
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</table>

*The DHMO plan offers only in-network benefits; there is no coverage for out-of-network with this plan.*
**Additional Benefits**

**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. You must be employed for 60 days to participate. 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.

**Glossary**

**Glossary of Terms**

The following are terms commonly used when discussing benefits and insurance. This glossary contains terms used under our medical plan. These terms and definitions are intended to be educational and assist you in understanding how your medical plan works. For additional plan information, refer to your Summary of Benefits and Coverage (SBC).

**Allowed Amount**

Maximum amount on which payment is based for covered medical services. This may be called “eligible expense,” “payment allowance” or “negotiated rate”. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

**Balance Billing**

When an out-of-network provider bills you for the difference between the insurance company’s allowed amount and the provider’s charge. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

**Co-insurance**

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. For example, if the medical plan’s allowed amount for a medical service is $100 and you’ve met your deductible, and your co-insurance payment is 30%, then you would pay $30. The medical plan pays the rest of the allowed amount.

**Co-payment**

Co-pays are a fixed amount which you pay at time of service. Co-pays are most common for prescription drugs, office, urgent care and emergency room visits. In some cases you may be responsible for paying a co-pay as well as percentage of the remaining charges.

**Deductible**

The amount you must pay for eligible expenses before the plan begins to pay benefits. For example, if your individual deductible is $3,000; your plan will not pay anything for certain medical services until you have paid $3,000. A plan may also have separate deductibles that apply to specific services.
Medically Necessary
Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Explanation of Benefits
Your health plan sends you a record called an “Explanation of Benefits,” or EOB that explains how much you owe. The EOB also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other healthcare professional is allowed to charge a member (called the “allowed amount”).

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.

Non-Preferred Provider
A non-preferred provider is a provider who doesn’t have a service contract with your health insurance company or health plan to provide services to you. You’ll pay more to see a non-preferred provider.

Out-of-Pocket Maximum
The most you pay during a period specified in the policy or certificate of coverage before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Preauthorization
A determination by a health insurance carrier or a health plan that a medical service, treatment plan, prescription drug, prosthetic device durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification, our plans may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your medical plan will cover the cost.

Preferred Provider
A preferred provider is a provider who has a service contract with your health insurance company or health plan to provide services to you at a discount.

Premium
The amount that you are required to pay for your health insurance or plan.

Prescription Drug Coverage
Coverage that helps pay for prescription drugs and medications covered under the health insurance carrier’s formulary. A formulary is the list of FDA approved drugs covered under the medical plan. Each drug is classified into a tier and each tier determines the co-payment you will pay for the drug. Drug formularies typically have three or four tiers.

Primary Care Physician
A physician including a Medical Doctor, Doctors of Osteopathic Medicine, Internists, Family Practitioner, General Practitioner, OB/GYN and Pediatrician who directly provides or coordinates a range of medical services for a patient.
**Specialist**
A physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

**Urgent Care**
Care for an illness or injury serious enough that a reasonable person would seek care right away, but not as severe as to require emergency room care.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Carrier</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (MEC Plan)</td>
<td>Allegiance</td>
<td>800-877-1122</td>
<td><a href="http://www.askallegiance.com/preventive">www.askallegiance.com/preventive</a></td>
</tr>
<tr>
<td>Medical (HDHP’s w/HSA)</td>
<td>BlueCross BlueShield of Arizona</td>
<td>602-864-4197</td>
<td><a href="http://www.azblue.com">www.azblue.com</a></td>
</tr>
<tr>
<td>Mail Order Pharmacy</td>
<td>OptumRx</td>
<td>1-866-325-1794</td>
<td><a href="http://www.azblue.com">www.azblue.com</a></td>
</tr>
<tr>
<td>Telemedicine</td>
<td>BlueCare Anywhere</td>
<td></td>
<td><a href="http://www.azblue.com">www.azblue.com</a></td>
</tr>
<tr>
<td>Health Savings Account</td>
<td>HSA Bank</td>
<td>800-357-6246</td>
<td><a href="http://www.hsabank.com">www.hsabank.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Cigna</td>
<td>800-Cigna24 800-244-6224</td>
<td><a href="http://www.cigna.com">www.cigna.com</a> <a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>Ability360</td>
<td>Benefits</td>
<td>844-274-7284</td>
<td>ability360.org/hcs-employee-news</td>
</tr>
</tbody>
</table>

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

This benefit guide provides an overview of health and welfare benefits of Ability360. This guide overview does not provide comprehensive plan details, for such please refer to the plan documents, including without limitation, policies, certificates of coverage, coverage booklets, and/or contracts for complete coverage details. Copies of such documents may be obtained upon request to Ability360's human resources department. If any statement conflicts with the plan documents, the plan documents govern. This guide is not a contract, nor does it operate to create any legally enforceable obligations on the part of Ability360, its agents or its employees.
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](http://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](http://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](http://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 –

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
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<tbody>
<tr>
<td>Alabama</td>
<td>Medicaid</td>
<td><a href="http://myalhipp.com">http://myalhipp.com</a></td>
<td>1-855-692-5447</td>
</tr>
<tr>
<td>Alaska</td>
<td>Medicaid</td>
<td>The AK Health Insurance Premium Payment Program</td>
<td><a href="http://myakhipp.com">http://myakhipp.com</a></td>
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<tr>
<td></td>
<td></td>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
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<td>Medicaid Eligibility:</td>
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<td><a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<td>All other Medicaid</td>
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<td></td>
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<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
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<td>Colorado</td>
<td>Medicaid</td>
<td><a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a></td>
<td><a href="http://www.dhs.state.ia.us/hipp">http://www.dhs.state.ia.us/hipp</a></td>
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<td>Iowa</td>
<td>Medicaid</td>
<td>1-800-221-3943</td>
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<tr>
<td>Kansas</td>
<td>Medicaid</td>
<td><a href="http://www.kdheks.gov/hcf">http://www.kdheks.gov/hcf</a></td>
<td>1-785-296-3512</td>
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<td>State</td>
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<tr>
<td>Kentucky</td>
<td>Medicaid</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>1-800-635-2570</td>
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<td>Medicaid Website:</td>
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<tr>
<td></td>
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<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
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<td>Medicaid Phone: 609-631-2392</td>
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<td>CHIP Website:</td>
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<td><a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
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<tr>
<td></td>
<td></td>
<td>CHIP Phone: 1-800-701-0710</td>
<td></td>
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<tr>
<td>Louisiana</td>
<td>Medicaid</td>
<td>Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>1-888-695-2447</td>
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<td>Medicaid Website:</td>
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<td></td>
<td></td>
<td>Medicaid Phone: 1-800-541-2831</td>
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<td>Medicaid Website:</td>
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<tr>
<td></td>
<td></td>
<td><a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
<td>1-800-462-1120</td>
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<td>Massachusetts</td>
<td>Medicaid and CHIP</td>
<td>Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
<td>1-800-462-1120</td>
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<td></td>
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<td>Medicaid Website:</td>
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<td>North Carolina</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a></td>
<td>919-855-4100</td>
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<td>North Dakota</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
<td>1-844-854-4825</td>
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<td>Missouri</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.html">http://www.dss.mo.gov/mhd/participants/pages/hipp.html</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td>Oregon</td>
<td>Medicaid</td>
<td>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a></td>
<td>1-800-699-9075</td>
</tr>
<tr>
<td>Montana</td>
<td>Medicaid</td>
<td>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td>1-800-694-3084</td>
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<tr>
<td>Pennsylvania</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.dhs.pa.gov/hipp">http://www.dhs.pa.gov/hipp</a></td>
<td>1-800-692-7462</td>
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<td>Rhode Island</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
<td>401-462-5300</td>
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<td>State</td>
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<tr>
<td>WEST VIRGINIA – Medicaid</td>
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<tr>
<td>VIRGINIA – Medicaid and CHIP</td>
<td></td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>1-800-432-5924</td>
</tr>
</tbody>
</table>

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](http://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](http://www.cms.hhs.gov)
1-877-267-2323, Menu Option 4, Ext. 61565
**ANNUAL NOTICES**

**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**

**(BCBS of AZ HSA 3000 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 BCBS of AZ HSA 3000 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.

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**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 BCBS of AZ HSA 3000 plan currently offers participants pharmacy covered at 100% after the deductible is met; and the BCBS of AZ HSA 5000 plan currently offers participants pharmacy covered at 70% 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](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](http://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](http://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).**

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**Date:** January 1, 2019  
**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

(A llegiance plan)

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 Allegiance plan 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 Allegiance 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 Allegiance 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 Allegiance 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 Allegiance plans currently provides a limited prescription benefits. 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. 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](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](http://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](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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