March 4, 2016
Addendum #2
RFP 2016-001
Employee Benefits & Risk Management Consultant/Brokerage Services
Questions and Answers

Question #1
Is it possible to get a copy of the Benefits Guide/Brochure or something similar that provides greater detail of the current level of benefits and carriers? It would be helpful to better understand the level of benefits employees are currently receiving (down to co-pays, deductibles, etc).

Answer #1
Digital Benefit Information Guide (BIG) attached. Medical plan comparisons begin on page 10.

Question #2
How many employees are enrolled in each of the medical plans?

Answer #2
As of March 1, 2016
Anthem – Select = 291
Anthem – Full = 18
Kaiser = 290
SIMNSA = 35

Question #3
What is the NHA's current contribution strategy?

Answer #3
Originally based on a percentage contribution, holding costs for employees after several years has shifted the percentage strategy. See page 33 in BIG for actual costs/contributions.

Question #4
Please describe the extent of NHA's current wellness programs or initiatives.

Answer #4
NHA has had a Wellness Program in place for 3 years. It includes monthly challenges, company events, and individual site and department wellness events.
NHA also partners with Live Well San Diego and offers fitness classes at several worksites.
Each year NHA has a Health Fair where employees can attend booths by vendors offering information and assistance in the areas of health and wellness.

Question #5
Describe NHA's HRIS system and how it supports the Benefits plan administration.

Answer #5
Currently, our HRMS handles benefits manually.

Question #6
What are the planned major benefits activities for 2016?

Answer #6
We are moving towards online enrollment through an Employee Self Service portal and setting up automatic carrier file feeds.

Question #7
If we are willing to elect commissions developed from the P & C lines of coverage as compensation for the program, may we respond to Addendum I "Request Response Submittal Cover Sheet" stating that we will accept the commission in lieu of fees or in the alternative.

Answer #7
Not applicable for RFP purposes

Question #8
Will NHA be providing us with the premium basis for each line of coverage requested in order to develop a cost basis and thus appropriate fee?

Answer #8
See page 33 of the BIG for premium costs of medical, dental and vision plans.

Neighborhood House Association

"A neighbor you can count on... since 1914"

EMPLOYEE BENEFIT INFORMATION GUIDE 2015 – 2016

Senior Services

Health & Nutrition Services

Community Services

Early Childhood Development

Training & Organizational Development

CONTENTS

Neighborhood House Association

"A neighbor you can count on... since 1914"

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

WE'VE GOT YOU COVERED

Welcome to your 2015 – 2016 Benefits Information Guide!

At Neighborhood House Association, we care about the whole you. This is why we developed a benefits program that will meet the broad needs of our employees and your families. The programs referenced in this booklet are meant to keep you healthy and productive, while also giving you options to plan for and protect yourself in the future. This Benefits Information Guide is a great tool to help you understand the plans and programs that you and your family will be enrolled in for the plan year. Enclosed you will find details about:

- Who is eligible to participate
- How to enroll and how to make changes during the year, if applicable
- Each benefit and a summary of what is covered under the plan
- The Insurance Companies who administer our benefits and how to contact them if you need assistance
- And much more!

Offering competitive and cost effective benefits to Neighborhood House Association employees is important. It is a way for us to say "thank you" for contributing to the underlying success of the agency.

If you have any questions about the employee benefits described herein or would like more information, please refer to your plan documents and insurance booklets or contact the Benefits Department.

Sincerely,

Duke F. Sobek
Senior Director, Human Resources

ELIGIBILITY & ENROLLMENT

If you are a new employee or you are re-evaluating your choices as a continuing participant, the benefits program offers a variety of coverage options that are available to you.

Who Can Enroll

Regular Full-time and Regular Part-time employees working a minimum of 20 hours per week are eligible to participate in the benefits program. Eligible employees may also choose to enroll eligible family members, including a legal spouse / registered/unregistered domestic partner and/or children.

Children are considered eligible if they are:

- Your or your spouse's / registered/unregistered domestic partner's biological children, stepchildren, adopted child or foster child up to age 26 *(Affidavit may be required, please contact Benefits)*
- Your or your spouse's / registered/unregistered domestic partner's children of any age if they are incapable of self-support due to a physical or mental disability

When Coverage Begins

Your enrollment choices remain in effect for the benefits plan year, July 1, 2015 through June 30, 2016. Benefits for eligible **new hires** will commence as outlined below:

Eligibility Date	Benefit Plan
The first day of the month following 30 days of employment (you must enroll within 30 days of becoming eligible)	• Medical • Dental
Variable Hour Employees are eligible the first day of the month following a consecutive 6-month period of averaging 20 service hours per week	• Voluntary Vision • Voluntary Worksite Plans • Voluntary / Supplemental Life/AD&D
You will automatically be enrolled in Group Life / AD&D, LTD and EAP when you are first eligible. Please be sure to complete a Beneficiary Designation Form available from your Human Resources Department.	• Group Life / AD&D • Long-term Disability • EAP Plan

Please note: If you miss the enrollment deadline, you may not enroll in the benefits program unless you have a qualified change in status during the plan year. See page 5 for details.

ELIGIBILITY & ENROLLMENT

When Coverage Begins (Continued)

This year is a "passive" Open Enrollment, meaning you are only required to complete a form if your want to make changes to your current elections and/or your dependents. If you make you no changes, your current elections will remain in place for the 2015-2016 Plan Year. This includes your medical, dental, vision, however, you do have to elect for your Flexible Spending Account.

If you miss your opportunity to enroll in benefits, you will not be able to enroll until the next Open Enrollment, July 1, 2016, unless you experience a Qualifying Life Event. See page 5 for details.

Changes during the Year

You are permitted to make changes to your benefits outside of the Open Enrollment period if you have a qualified change in status as defined by the IRS.

Generally, you may add or remove dependents from your benefits, as well as add, drop or change coverage if you submit your request for change within 30 days of the event. Examples include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Death of a dependent
- You or your spouse's / state registered domestic partner's loss or gain of coverage through our organization or another employer
- Change in residence affecting eligibility or access

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days.

For a complete explanation of qualified status changes, please refer to the Legal Information Regarding Your Plan found on page 36 of this guide.

Paying for Coverage

NHA strives to provide you with a valuable benefits package at a reasonable cost. Based on your benefit selections and coverage level, you may be required to pay for a portion of the cost. The Cost of Coverage section in this guide outlines the rates and frequency of payroll deduction for each benefit.

Waive-Out Provision

To waive all coverage offered, you must complete a Waiver Form; or check I decline participation on the Universal Enrollment Form to waive only medical or dental coverage.

Please note that if you waive coverage, the next opportunity to enroll in your benefits will be July 1, 2016, or when a Qualifying Status Change occurs.

Things to know!

Need to make a change to your coverage or add/drop dependents?

- If you wish to make changes including Adding/Dropping Dependents complete and sign the Enrollment Form available in Human Resources

Considering SIMSA this year?

- Be sure to consult with your tax professional to confirm SIMNSA coverage meets the coverage standards as required by the individual mandate
- Plans that fail to meet the requirements could result in you paying a penalty for tax year 2015

Have covered dependents or considering adding a dependent?

- Keep in mind NHA has the right to audit dependents at any time and may ask for information demonstrating your enrolled dependent is eligible for coverage
- Dependents that are found to be ineligible can find support or alterive plan options by contacting Insurance Advocate (See Resources at the end of the Guide)
- To define an eligible dpendent refer to page 4 of your Guide

Questions:

- Gail Taylor Benefits Manager
- Phone 858 244 8145
- Email gtaylor@neighborhoodhouse org

MEDICAL COVERAGE

Whether you have a common cold or will be undergoing surgery, medical benefits cover a range of services and can provide peace of mind to help you offset health care costs.

Your Medical Plan Options

NHA offers a total of four HMO plans to choose from – two HMO plans administered by Anthem; an HMO plan administered by Kaiser Permanente; and a cross-border HMO plan administered by SIMNSA.

To help guide your plan selection, the following pages include details concerning how the plans will operate, as well as plan highlights and features. For your reference, an illustration of rates is listed in The Cost of Coverage section of this guide.

Using an HMO Plan

A Health Maintenance Organization (HMO) plan requires you and enrolled dependents to select a Primary Care Physician (PCP) who will direct the majority of your health care needs. Generally, an HMO operates as follows:

- ✓ With the exception of an OB/GYN specialist who is affiliated with your selected medical group, you must receive a referral from your PCP before receiving services from a specialist
- ✓ You and any enrolled dependent(s) are not required to see the same PCP, and you may change your PCP at any time
- ✓ Services may require a fixed-dollar payment up front, referred to as a copayment
- ✓ You do not have to submit claim forms to your insurance company
- ✓ Any services rendered out-of-network without the proper referral from your PCP will not be covered

Anthem, Kaiser, and SIMNSA administer the HMO plans and a summary of covered services is listed on the following pages. For a complete listing of covered services for each plan, please refer to your Summary Plan Description (SPD).

Anthem provides a dual network HMO which provides you the option of selecting either the Anthem Select Network, with a smaller network of doctors, or the Anthem Full Network plan, which may provide access to more physicians. Regardless of your selection, you will be required to use the HMO in the same manner as outlined above by selecting a Primary Care Physician. Listed in The Cost of Coverage section of this guide, you will find the cost differences between these plans.

MEDICAL COVERAGE

Your Medical Plan Options (Continued)

Using the Kaiser HMO Plan

As a member of the Kaiser Permanente Health Maintenance Organization (HMO) plan, you will receive your medical care from an integrated network of physicians and specialists at a medical office, medical center, or affiliated hospital near you. Additional information regarding the Kaiser Permanente HMO is outlined below:

- You may choose a primary care doctor for yourself or your family members by reviewing physician's profiles at kp.org/chooseyourdoctor or receive assistance in selecting a physician and scheduling your first appointment by calling 888.956.1616
- Initial referrals for most specialty care services will be coordinated by a Kaiser Permanente physician. However, many departments such as OB/GYN, Optometry, Psychiatry & Addiction Medicine are self-referred
- There are no deductibles with the Kaiser Permanente HMO and no claim forms to submit unless you receive emergency services outside of a plan facility
- Preventive services are covered at 100%

A summary of covered services under the Kaiser Permanente HMO plan is listed on the following pages. For a complete listing of covered services for each plan, please refer to your Summary Plan Description (SPD).

Using the SIMNSA HMO Plan

SIMNSA provides a great opportunity for participants, both English and Spanish speaking, to receive qualify health care at an affordable cost.

SIMSNA provides medical and services in Mexico and operates in the same manner an HMO plan in the United States. When you select the SIMNSA Health Maintenance Organization (HMO) plan, you must receive all of your care in Mexico by a SIMNSA provider. Generally, the SIMNA HMO will function as follows:

- A Primary Care Physician (PCP) will direct the majority of your health care needs and is responsible for referring you to Specialists
- Services may require no copayment or fixed-dollar payment up front, referred to as a copayment
- You do not have to submit claim forms to your insurance company
- The only services that may be covered in the U.S. are true medical emergencies and urgent care as described in your plan documents
- There are no deductibles
- Preventive services are covered at 100%

For a complete listing of covered services for each plan, please refer to your Summary Plan Description (SPD).

MEDICAL COVERAGE

Using Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Regardless of the plan you have, you may save money by filling prescription requests at participating pharmacies. Additional important information regarding your prescription drug coverage is outlined below:

- Kaiser and Anthem have drug formularies, or a list of prescription drugs including both generic and brand-name medications, that are preferred
- The Kaiser plan covers generic items for a $10 Copayment and brand-name items for a $20 Copayment, at Plan Pharmacies or through mail-order service
- Anthem utilizes a tiered prescription drug plan which requires varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number
- The Anthem plan has four tiers:
  - Tier 1 – Lowest copayment – Drugs offering the greatest value within a therapeutic class; some are generic
  - Tier 2 – Medium copayment – Drugs on this tier are generally the more affordable brand-name drugs. Other drugs are on this tier because they are "preferred" within their therapeutic classes, based on clinical effectiveness and value
  - Tier 3 – Highest copayment – These are the higher cost brand-name drugs. Some Tier 3 drugs may have generics or equivalents in Tier 1. In addition some drugs on this tier may have been evaluated to be less cost-effective than an equivalent drug on lower tiers
  - Tier 4 – May have a higher cost share than Tier 3 drugs. This tier includes non-preferred drugs or specialty drugs
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list
- Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring

For a current version of the prescription drug lists go to www.kp.org, or www.anthem.com/ca. The summary charts listed on the following pages contain plan coverage information.

Watching Your Wallet?

There are a few ways you might save money through the Prescription Drug plan

- **Generic Drugs:** Talk to your doctor or pharmacist about trying generic drugs which contain the same active ingredients as the brand-name equivalent and may reduce your pharmacy expenses
- **Mail Order:** Save time and money by utilizing your mail order service for your medications A 90-day supply of your medication will be shipped directly to the address on file instead of purchasing a typical 30-day supply at a walk-in pharmacy Visit the Kaiser or Anthem website for more information about the mail order service
- **Price Compare:** Some pharmacies such as those at warehouse clubs or discount stores may offer less expensive prescriptions than others By calling ahead you may determine which pharmacy provides the most competitive price

MEDICAL COVERAGE

Selecting a Plan that's Right for You

As you evaluate your health plan options and insurance needs, consider the following factors:

- **Choice:** If you prefer to render services from specific physicians, specialists or facilities, check to see if the medical plan option will cover services from those providers. While some health plans restrict your provider selection, others provide greater flexibility and choice
- **Coverage:** Whether routine, surgical, prescription or another type of coverage, determine if the plan covers the services and medical treatments you value most. Plan exclusions, restrictions and limitations may also guide your selection process, which are detailed in the Summary Plan Descriptions
- **Cost:** Cost may be a large determining factor in your selection and each plan may contain a variety of cost components. Consider the amount of your payroll deduction, as well as other plan expenses such as deductibles, copayments or coinsurance

Free Preventive Health Care

The Federal Health Care Reform law now requires insurance companies to cover preventive care services in full, saving you money and helping you maintain your health. Such preventive services include:

- Routine doctor's visits
- Annual checkups
- Well-baby and child visits
- Several types of immunizations and screenings

To confirm that your preventive care services are covered, refer to your plan documentation.

You are encouraged to review The Cost of Coverage section of this guide, along with the complete Summary Plan Descriptions (SPD) of each plan.

Do you have questions regarding a plan? To correspond with a plan representative refer to the Directory & Resources section for important contact information.

ANTHEM HMOS

Plan Highlights	Anthem Premier HMO 20 Full Network	Anthem Premier HMO 20 Select Network
Annual Deductible		
Individual	None	None
Family	None	None
Maximum Out-of-pocket [1]		
Individual	$1,500	$1,500
Family	$3,000	$3,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP)	$20 Copay	$20 Copay
Specialist	$20 Copay	$20 Copay
Preventive Care Exam	No Copay	No Copay
Well-baby Care	No Copay	No Copay
Diagnostic X-ray and Lab	No Copay	No Copay
Complex Diagnostics (MRI / CT Scan)	$100 per Test	$100 per Test
Chiropractic (20 visits per calendar year)	$15 / Visit	$15 / Visit
Hospital Services		
Inpatient	$200 / Admit	$200 / Admit
Outpatient Surgery	$100 / Admit	$100 / Admit
Emergency Room (waived if admitted)	$100 Copay	$100 Copay
Urgent Care (out of service area; waived if admitted)	$20 / Visit	$20 / Visit
Maternity Care		
Physician Services (prenatal or postnatal)	$20 / Visit	$20 / Visit
Hospital Services	No Copay	No Copay
Mental Health & Substance Abuse		
Inpatient	No Copay	No Copay
Outpatient	$20 / Visit	$20 / Visit
Retail Prescription Drugs (30-day supply)		
Tier 1	$10 Copay	$10 Copay
Tier 2	$20 Copay	$20 Copay
Tier 3	$40 Copay	$40 Copay
Tier 4	20% (max. $150 copay per fill)	20% (max. $150 copay per fill)
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$10 Copay	$10 Copay
Tier 2	$40 Copay	$40 Copay
Tier 3	$80 Copay	$80 Copay
Tier 4	N/A	N/A

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

KAISER HMO

Plan Highlights	HMO In-network Only
Annual Deductible	
Individual	None
Family	None
Maximum Out-of-pocket [1]	
Individual	$1,500
Family	$3,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$20 Copay
Specialist	$20 Copay
Preventive Care Exam	No Copay
Well-baby Care	No Copay
Diagnostic X-ray and Lab	No Copay
Complex Diagnostics (MRI / CT Scan)	No Copay
Chiropractic (20 visits per calendar year)	$15 / Visit
Hospital Services	
Inpatient	No Charge
Outpatient Surgery	$20 per Procedure
Emergency Room (waived if admitted)	$50 / Visit
Urgent Care	$20 / Visit
Maternity Care	
Physician Services (prenatal or postnatal)	No Charge
Hospital Services	No Charge
Mental Health & Substance Abuse	
Inpatient	No Charge
Outpatient	$20 / Visit
Retail Prescription Drugs (100-day supply)	
Generic	$10 Copay
Brand-name	$20 Copay
Mail Order Prescription Drugs (100-day supply)	
Generic	$10 Copay
Brand-name	$20 Copay

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

SIMNSA HMO – (SEE PAGE 5 FOR 2015 TAX YEAR CONSIDERATIONS)

Plan Highlights	HMO In-network Only
Calendar Year Deductible	
Individual	None
Family	None
Calendar Year Out-of-pocket Maximum [1]	
Individual	None
Family	None
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$7 Copay
Specialist	$7 Copay
Preventive Care Exam	No Charge
Well-baby Care	No Charge
Diagnostic X-ray and Lab	No Charge
Complex Diagnostics (MRI / CT Scan)	No Charge
Therapy, including Physical, Occupational and Speech	$10 Copay
Hospital Services	
Inpatient	No Charge
Outpatient Surgery Hospital Surgery	No Charge
Emergency Room	In-area: $25 / Out-of-area: $100
Urgent Care	In-area: $25 / Out-of-area: $50
Maternity Care	
Physician Services (prenatal or postnatal)	$7 Copay
Hospital Services	No Charge
Mental Health & Substance Abuse	
Inpatient	No Charge
Outpatient	$7 Copay
Retail Prescription Drugs (30-day supply)	
Generic	$10 Copay
Brand	$10 Copay
Non-formulary	$10 Copay
Mail Order Prescription Drugs (90-day supply)	
Generic	N/A
Brand	N/A
Non-formulary	N/A

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

ANTHEM WELLNESS & DISCOUNT PROGRAMS

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. Because we care about your total well-being, we're encouraging all employees to engage in our Wellness Program at no-cost to you.

Good Nutrition Basics – Anthem

Words like "refined", "saturated" and "solid" are great to hear if they're describing jewelry, paint colors or the foundation of a house. The same isn't true if you're trying to follow a healthy eating plan. Refined sugar and flour in breads add empty calories and no fiber; and large amounts of saturated fat are not heart-friendly, especially solid fats like butter and lard. The result: too many calories and not enough nutrients.

A healthy eating plan should include a variety of foods from the basic food groups that provide the most nutrients from the calories we consume. The basic food groups are these:

- Grains
- Vegetables
- Fruits
- Fats
- Milk
- Meats & beans

Following a healthy eating plan helps your body guard itself against serious conditions including heart disease, stroke, diabetes, high blood pressure, osteoporosis and certain cancers. Combine this good habit with 30–60 minutes of physical activity most days of the week and you can also help keep your weight at a normal level.

This is excellent news for all of us. It means that, one meal at a time, we have the power to potentially control the course of disease based on the lifestyle choices we make. Understanding good nutrition basics can help us make better food selections now. Consistently making better food selections over time can become a habit. And a habit of nutritious eating and exercising can add up to a lot of time spent enjoying a better quality of life.

Learn more about what's in your food and why eating a variety of essential nutrients is vital to your good health and wellness. Check out the Fitness and Nutrition articles and tools by visiting www.anthem.com/ca.

ANTHEM WELLNESS & DISCOUNT PROGRAMS

Preventive Care – Anthem

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans and policies cover 100% of preventive services. When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket.

Preventive Versus Diagnostic Care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses.

For example, say your doctor suggests you have a colonoscopy because of your age. That's preventive care. On the other hand, say your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care and you may need to pay part of the cost.

Overview of Preventive Services Offered

For a full listing see your benefits summary to learn more.

- Preventive Physical Exams & Screening Tests (depending on your age)
- Immunizations
- Breastfeeding support, Supplies & Counseling
- Contraceptive Birth Control Counseling & FDA-approved Birth Control Methods that need a Prescription (female)

Always consult with your doctor about what's right for you.

24/7 NurseLine – Anthem

Health concerns can happen when you least expect them. You might be on vacation or even on a business trip. Or your child may have a fever in the middle of the night. But there's somewhere you can turn for help any time of the day or night.

Call the **24/7 NurseLine** to talk with a registered nurse about your health concern. Whether it's a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. And, if you want, a nurse will call you later to see how you're doing.

Our nurses can help you choose the right place for care if your doctor isn't available and you aren't sure what to do. Do you need to head straight to the emergency room? Is urgent care best? Or do you need to see your doctor? Making the right call can save you time and money – and give you access to the best possible care.

Do you speak Spanish or another language other than English? We have Spanish-speaking nurses and translators on call. TTY/TDD services are available, too.

If you'd prefer not to talk about your health concern over the phone, the AudioHealth Library might be for you. These helpful prerecorded messages cover more than 300 health topics in English and Spanish. Just call the 24/7 NurseLine number and choose the AudioHealth Library option.

Health questions?

24/7 NurseLine is always here for you. Call toll free at the customer service number on your ID card.

85% of members like you would recommend 24/7 NurseLine to others.

ANTHEM WELLNESS & DISCOUNT PROGRAMS

Discount Programs – Anthem

Fitness & Health

LivingLean – Save 40%. LivingLean is not a diet. It is a program that has you point out your main problem foods and your main munchies, then it teaches you how to get rid of your emotional cravings for them. LivingLean is a five-week program.

GlobalFit™ – Get up to 60% off fitness club memberships. With GlobalFit, you can get in shape and save. Join your choice of over 10,000 fitness centers across the country – including Curves, Bally's, Gold's, Anytime Fitness and many more – all at some of the lowest available rates! Save big on home fitness with videos and equipment. NutriSystem's 28-Day Favorites Package is also offered through GlobalFit, and you'll save $30 off the retail of their order.

GlobalFit™ offers special pricing on exercise videos and an extra 5% off of the already low prices at Smooth Fitness™.

ChooseHealthy™ – Take the alternative path with discounts on health and wellness products, fitness club memberships and more.

Puritan's Pride – Save 20% and get free shipping on the vast selection of vitamins, minerals, herbs, supplements and much more.

Vision, Hearing & Dental

Eyewear Discount – Save 30% on eyeglasses, 20% on most nonprescription sunglasses and discounted prices on accessories.

Premier LASIK – Save 15% on LASIK with all their in-network providers and prices as low as $695 per eye with select providers. Call a Premier LASIK representative at 866.767.2179 to learn more.

TruVision™ – Members receive 10% off vision correction procedures. Their network of highly trained optometrists, ophthalmologists and surgeons are committed to providing you with high-quality care. Also, get 20% off your first order of your favorite brands of contact lenses. Free shipping on orders of $99 or more.

Vision, Hearing & Dental (Continued)

HearPO – Get a low price guarantee on the seven top companies that work with HearPO. Call 888.HEARING.

Beltone™ – Hearing screening and in-home service at no additional cost, and up to 50% off all Beltone hearing aids.

drugstore.com™ – Save 5% on dental and vision products, along with free shipping on orders of $49 or more.

Medicine & Treatment

SelfHelpWorks – Join a SelfHelpWorks online program to help you lose weight, stop smoking, manage stress or cut back on alcohol or quit drinking completely and get a 30-day guest pass at no additional cost and a 40% discount. Call 877.719.9860.

ChooseHealthy™ – Take the alternative path with discounts on visits to massage therapists, acupuncturists and more.

Murad® – Save $25 plus a free gift with any purchase of $100 or more on skin care.

Allergy Control Products – Save 25% on Allergy Control encasings for your bed. Plus, save 20% on a variety of doctor recommended products for a healthier home.

National Allergy Supply – Save 15% on mattress encasings, air filtration products, compressors and other products that can help relieve your allergy, asthma and sinus symptoms. Call 800.522.1448.

drugstore.com™ – Save 5% on health, beauty, wellness and personal care products, along with free shipping on orders of $49 or more.

To find the discounts that are available to you, log in to www.anthem.com/ca today. Not registered? Sign up now for access to personalized service and resources. It's fast, easy – and secure.

KAISER WELLNESS PROGRAMS

The advantages of being a Kaiser Permanente member start now. Get online programs, special rates, and classes offered at our medical centers to help you live healthier.

Programs & Classes

Classes, Coaching and more

- Classes, Support Groups and Programs
- Wellness Coaching

Healthy Lifestyle Programs

- Total Health Assessment
- Eat Healthy
- Lose Weight
- Manage Back Pain
- Manage Chronic Conditions
- Manage Diabetes
- Manage Pain
- Overcoming Depression
- Overcoming Insomnia
- Quit Smoking
- Reduce Stress

Special Rates for Members

- Fitness Club Discounts
- Acupuncture, Chiropractic and Other Complementary Care
- 10,000 Steps®

Be the Next Success Story

Give yourself the winning edge with a Total Health Assessment and free healthy lifestyle programs for Kaiser Permanente members 18 years and older, offered in partnership with HealthMedia®. Use these customized online programs to get the clear steps and ongoing encouragement it takes to reach your health goals.

After you've answered an in-depth questionnaire, you'll have access to tools such as:

- A Personalized Action Plan
- Follow-up Emails to Help you Track your Progress
- Tools to Monitor your Progress
- Exercise and Stretching Videos
- Guided Imagery Podcasts
- Health News

DENTAL COVERAGE

Dental benefits are another important element of your overall health. With proper care, your teeth can and should last a lifetime.

Your Dental Plan Options

This year, you and your eligible dependents will have the opportunity to enroll in a Dental Exclusive Provider Organization plan (EPO) offered by Principal , a Dental Point of Service plan (POS) also offered by Principal, or a cross-border Dental HMO plan administered by SIMNSA. We encourage you to review the coverage details and select the option that best suits your needs.

Helpful Dental Hints

- Don t forget about your semi-annual Dental Cleanings! Review your plan information to learn more about what is covered under the plan
- To find an in-network dentist go to www.principal.com and search the Provider Network or call 800 247 4695

Using the Principal Dental Plans

In order to receive benefits while enrolled in the Dental EPO plan, you and your enrolled eligible dependents must obtain services from a primary care dentist who participates in the Dental Exclusive Provider Organization network. If you receive services from a provider outside of the approved network, you would be responsible for paying the entire dental bill yourself.

A Dental POS plan combines characteristics of traditional Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans, providing members the option to select which plan method to utilize at the time service is rendered.

The POS plan has a network of providers, including providers in Mexico (PPO tier only), and provides you flexibility to use the plan as a PPO, or you may choose to use the plan in a similar fashion as a traditional HMO. In this first tier option (DHMO) , you will generally have to select a Primary Care Dentist from within the insurance company's network who will manage your dental treatments and refer to you Specialists as needed.

When using your PPO tier, you may decide to see a provider who is not in the network, however, if care is self-referred or received by out-of-network dental providers, you may be subject to out-of-pocket costs including fixed-dollar payments at the time of service (copayments), a percentage of payment towards the entire bill (coinsurance) and an annual deductible. This tier of the plan operates more like a traditional PPO.

Using the SIMNSA Dental Plan

The SIMNSA Dental plan requires that you receive care from a contracted SIMNSA provider in Mexico. Coverage is available at the Mexicali dental office, and you must work in San Diego County to participate.

There are no deductibles and no claim forms for you to submit.

You will be covered for emergency services in the United States as well as anywhere in the world.

For a list of providers, please contact SIMNSA directly at 800.424.4652 or visit the website: www.simnsa.com

DENTAL COVERAGE – PRINCIPAL EPO

Plan Highlights	Principal Dental EPO In-network Only
Calendar Year Deductible	
Per Person	None
Family Maximum	None
Calendar Year Maximum	$1,000 per Person
Preventive	
Office Visit	100%
X-rays	100%
Cleanings (2 per year)	100%
Sealants (per tooth)	100%
Restorative	
Amalgam Fillings	100%
Composite Fillings	100%
Periodontics (gum treatment)	
Scaling & Root Planing	50%
Gingivectomy	50%
Endodontics (root canal therapy)	
Pulpotomy	50%
Root Canal (anterior and bicuspid)	50%
Root Canal (molar teeth)	50%
Oral Surgery	
General Anesthesia	50%
Simple Extraction	50%
Soft Tissue Impaction	50%
Complete or Partial Bony Impaction	50%
Crowns & Bridges	
Inlay / Onlay (2 surfaces)	50%
Crowns	50%
Prosthetics (dentures)	
Denture Adjustment	50%
Complete or Partial Denture	50%
Other	
Implants	Not Covered
Orthodontia Services	
Deductible	None
Children Only- up to age 19	50%
Lifetime Maximum	$1,000

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions

DENTAL COVERAGE – PRINCIPAL POS

Plan Highlights	Principal Dental EPO	Principal Dental PPO	
	In-network Only	In-network	Out-of-network
Calendar Deductible			
Per Person	None	$50	$50
Family Maximum	None	$150	$150
Deductible Waived for Preventive Services	N/A	Yes	No
Calendar Year Maximum	$1,500 per Person	$1,000 per Person	$1,000 per Person
Preventive			
Office Visit	100%	100%	50%
X-rays	100%	100%	50%
Cleanings (4 per year)	100%	100%	50%
Sealants (per tooth)	90%	80%	50%
Restorative			
Amalgam Fillings	90%	80%	50%
Composite Fillings	90%	80%	50%
Periodontics (gum treatment)			
Scaling & Root Planing	90%	80%	50%
Gingivectomy	90%	80%	50%
Endodontics (root canal therapy)			
Pulpotomy	90%	80%	50%
Root Canal (anterior and bicuspid)	90%	80%	50%
Root Canal (molar teeth)	90%	80%	50%
Oral Surgery			
General Anesthesia	60%	50%	50%
Simple Extraction	90%	80%	50%
Soft Tissue Impaction	90%	80%	50%
Complete or Partial Bony Impaction	90%	80%	50%
Crowns & Bridges			
Inlay / Onlay (2 surfaces)	60%	50%	50%
Crowns	60%	50%	50%
Prosthetics (dentures)			
Denture Adjustment	60%	50%	50%
Complete or Partial Denture	60%	50%	50%
Other			
Implants	50%	50%	50%
Lifetime Maximum (comined)	$1,000	$1,000	$1,000
Orthodontia Services			
Child(ren) only – up to Age 19	50%	50%	50%
Lifetime Maximum (combined)	$1,000	$1,000	$1,000

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

DENTAL COVERAGE – SIMNSA DHMO

Plan Highlights	SIMNSA Dental HMO In-network Only
Annual Deductible	
Per Person	None
Family Maximum	None
Annual Plan Maximum	Unlimited
Preventive	
Office Visit	No Charge
X-rays	No Charge
Cleanings	No Charge
Sealants (per tooth)	No Charge
Restorative	
Amalgam Fillings, Primary Teeth	$5 – $10 Copay
Amalgam Fillings, Permanent Teeth	$5 – $15 Copay
Periodontics (gum treatment)	
Gingivoplasty (per tooth)	$8 Copay
Gingivectomy (per quadrant)	$25 Copay
Endodontics (root canal therapy)	
Pulpotomy	$10 Copay
Root Canal (anterior and bicuspid)	$50 Copay
Root Canal (molar teeth)	$50 Copay
Oral Surgery	
Local / Sedative Base Anesthesia	No Charge
Simple Extraction	$8 Copay
Soft Tissue Impaction	$30 Copay
Complete or Partial Bony Impaction	$50 Copay
Crowns & Bridges (plus additional cost of noble metal)	
Pontic (resin, cast, or porcelain)	$60 – $70 Copay
Crowns	$15 – $50 Copay
Prosthetics (dentures)	
Denture Adjustment	$10 Copay
Complete or Partial Denture	$63 Copay
Other	
Implants	Not Covered
Orthodontia Services	
Deductible	None
Adult	$50 Copay / Visit
Child(ren)	$50 Copay / Visit
Length of Treatment	24 Months

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

VISION COVERAGE

By practicing healthy eye habits, you and your family members can work towards preserving your vision for the long haul.

Your Vision Plan Option

Vision coverage is offered by VSP as a Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

Any questions pertaining to your vision coverage can be directed to VSP by calling 800.877.7195 or visiting their website, www.vsp.com.

Plan Highlights	VSP Vision PPO	
	In-network	Out-of-network
Copays	$10 Exam / $25 Materials	
Exam Every 12 months	100% after Copay	Up to $43 Reimbursement
Lenses Every 12 months		
Single	100% after Copay	Up to $34 Reimbursement
Bifocal	100% after Copay	Up to $51 Reimbursement
Trifocal	100% after Copay	Up to $68 Reimbursement
Frames Every 24 months	$150 Allowance, then 20% discount	Up to $40 Reimbursement
Contacts Every 12 months, in lieu of lenses & frames		
Medically Necessary	100% after Copay	Up to $210 Reimbursement
Elective (instead of glasses)	$100 allowance for contacts & exam	Up to $100 Reimbursement
Additional Pairs of Glasses	20% Discount from any VSP Doctor within in 12 months of exam	
LASIK	Average 15% off the regular price or 5% off the promotional price; Discounts only available from contracted facilities	

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

VISION COVERAGE

At VSP® Vision Care, we care about the overall health of our members, and we're committed to helping them experience life to the fullest.

Like vision loss, hearing loss can have a huge impact on both workplace productivity and home life. In fact, the largest hearing impaired group in the United States is comprised of those under the age of 65 – many of whom are still in the workforce and leading active lives. With the average cost of a pair of hearing aids topping $5,000, it's no wonder that 70% of the more than 30 million Americans who need hearing aids don't have them because they can't afford them.

Discounts on Hearing Aids through TruHearing®

TruHearing is offering all VSP members and their covered dependents free access to the TruHearing MemberPlus® Program to enjoy deep discounts on some of the most popular digital hearing aids on the market.

The TruHearing MemberPlus Program includes:

- Savings of up to 50% on hearing aids
- Yearly comprehensive hearing exams for $75
- 3 Visits with a hearing professional after purchase (fitting, programming and/or adjustments)
- Manufacturer's coverage for a one-time loss or damage for three years (replacement fee paid to manufacturer)
- 3-year repair warranty
- 48 batteries per purchased hearing aid

VSP members may also add up to four guest members (parents, grandparents, siblings) for a VSP-exclusive rate of $71 each.

TruHearing Discounts

Simple as 1-2-3!

Taking advantage of the TruHearing discounts is easy

All a VSP member has to do is

1. Sign up at vsp truhearing com and choose whether to enroll dependents and guest members as well
2. Call TruHearing at 877 396 7194 to schedule an appointment
3. Visit hearing aid center receive exam and purchase discounted aids

That's it!

All transactions are between the VSP member and TruHearing

Best of all, if a member already has a hearing aid benefit from their health plan or employer they can combine it with this program to maximize the benefit and reduce their out-of-pocket expense.

Notes: Through December 15, 2013.
Savings over national average retail prices; vary based on hearing aid model purchased.

Learn more about this VSP member offer at vsp.truhearing.com

DISABILITY COVERAGE

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation

Long Term Disability (LTD)

If your disability extends beyond 180 days, the LTD coverage through Unum can replace 60% of your earnings, up to maximum of $10,000 per month.

Duration of benefits is based on your age when the disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability for 2 years.

If your disability occurs at or after age 68, benefits would be paid for a reduced period of time.

Defining Disability Coverage

Beneficiaries are individuals or entities that you select to receive benefits from your policy

- Benefit Period: Maximum amount of time you may receive proceeds for a continuous disability
- Commencement Date: The first day your disability is covered, which immediately follows the completion of the waiting period
- Elimination or Waiting Period: Period beginning when you become eligible to receive payments and ending when payments start to be paid

Taxation of Disability Coverage

Because disability coverage is an employer paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.

Please note: Consult your tax advisor for additional taxation information or advice.

Worldwide Emergency Travel Assistance Services

Whether your travel is for business or pleasure, Unum's worldwide emergency travel assistance program, provided by Assist America, is there to help you when an unexpected emergency occurs. With one phone call anytime of the day or night, you , your spouse and dependent children can get immediate assistance anywhere in the world. Emergency travel assistance is available to you when you travel to any foreign country, including neighboring Canada or Mexico. It is also available anywhere in the United States for those traveling more than 100 miles from home. Your spouse and dependent children do not have to be traveling with you to be eligible; however, spouses traveling on business for their employer are not covered by this program.

Unum through Assist America

Witnin the U.S. 800.872.1414
Outside the U.S. (U.S. access code) + 609.986.1234
Reference Number: 01-AA-UN-762490
medservices@assistamerica.com

LIFE AND AD&D COVERAGE

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Employer Paid Basic Life and AD&D

Paid for in full by Neighborhood House Association, the benefits outlined below are provided by Unum:

- Eligible employees include those who work at least 20 hours each week
- Your Basic Life / AD&D coverage amount is $25,000

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

TIPS & Reminders

- To Enroll in Optional Life contact your HR Department for an Enrollment Application
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the amount you specify
- You can change your beneficiary at any time
- You may be subject to EOI is you waive your opportunity to enroll after your initial eligibility period

Voluntary Employee Paid Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase through Unum.

- **For employees**: Increments of $10,000 up to the lesser of 5x annual earnings or $495,000 (Base coverage and additional combined)
- **For your spouse / state registered domestic partner**: Increments of $5,000 up to $235,000
- **For your child(ren):** $2,500 to $10,000. Dependent amounts cannot exceed 50% of employee coverage

EMPLOYEE / SPOUSE AGE	RATES PER $1,000 / NON-TOBACCO	RATES PER $1,000 / TOBACCO	ADD RATE
Less than 25	$0.076	$0.118	Employee: $0.025
25 - 29	$0.068	$0.101	Spouse: $0.030
30 - 34	$0.068	$0.101	Child: $0.030
35 - 39	$0.084	$0.144	
40 - 44	$0.127	$0.219	
45 - 49	$0.219	$0.354	
50 - 54	$0.388	$0.625	
55 - 59	$0.700	$1.148	
60 - 64	$0.912	$1.494	
65 - 69	$1.308	$2.169	
70 - 74	$2.262	$3.738	
75 and over	$3.848	$6.379	
Child per $2,500	**$0.300**		

LIFE AND AD&D COVERAGE

Worksite Benefits thru UNUM

To enhance your benefit offerings, Neighborhood House Association has made additional benefits available through UNUM. These benefit options are a valuable addition to your current coverage, and provide you additional peace of mind and financial support when you need it most. To learn more about or to enroll in one of the following:

- Accident
- Individual Short Term Disability
- Critical Illness

Please note:

- Your premiums may increase if you experience a salary increase and/or move age bands as of the start of the new Plan Year
- Enrollment into the Worksite Benefits are only available once per year, during Open Enrollment. If you are a newly hired employee, and it is outside the Open Enrollment period, your next opportunity to enroll in these benefits will be July 1, 2016

Contact UNUM directly at 800.635.5597 to enroll!

EMPLOYEE ASSISTANCE PROGRAM (EAP)

NHA understands that you and your family members might experience a variety of personal or work related challenges. Through the EAP, you have access to resources, information and counseling in order to address situations affecting your work-life balance.

Your EAP Option

Provided by Unum, the Employee Assistance Program (EAP) is available to all employees and your dependents, as well as any member of your household. The purpose of the program is to provide confidential assistance at no-cost for a wide range of personal topics.

Consultations are available for subjects such as:

- Child and eldercare assistance
- Identity theft
- Marital, relationship, parenting and family problems
- Depression, stress and anxiety
- Bereavement or grief counseling
- Substance abuse and recovery

Access Support Today!

- **By Phone: 800.854.1446**
- **Online:** www.lifebalance.net
- **User ID & password:** lifebalance

Using the Program

When you're faced with a troubling situation, the EAP will provide:

- 3 face-to-face sessions per member/dependent/household member per incident
- 24-hour Crisis Hotline & Telephone Counseling
- Financial Counseling
- Legal Referrals
- Online Behavioral Health Services, such as: Self-Assessments, Library of Information & Education Materials, Online Magazine, Health & Wellness Information, etc.
- Work / Life Services (telephone or website) for important matters such as Childbirth & Adoption, Educational Resources & Referrals, Personal Enrichment, amongst other subjects

FLEXIBLE SPENDING ACCOUNT (FSA)

Stretch your health care spending by using pre-tax dollars for qualified medical and/or dependent care costs by participating in the Flexible Spending Account program.

FSA Overview

You may have the option to enroll in and contribute towards one of the following types of Flexible Spending Accounts (FSA), helping to reduce your taxable income and pay for eligible expenses for yourself, spouse and eligible dependents on a tax-free basis. The FSA plan operates on a plan year basis from July 1, 2015 – June 30, 2016. You may participate in one or all of the following accounts:

- A Health Care FSA can reimburse for health care expenses that are not covered, or are only partially covered, by your medical, dental and vision insurance plans including other eligible expenses. You will have immediate access to the entire annual contribution amount from the first day of the benefit year, before all scheduled contributions have been made
- The Dependent Care FSA can be used to pay for qualified child care and/or caregivers for a disabled family member living in the household who is unable to care for themselves. Unlike the Health Care FSA, you can only access the money that is currently in the account

With regards to the FSA:

- The plan administrator is IGOE
- Contributions are deducted from your paycheck in equal amounts during the year before federal, state and social security taxes are taken out
- Since you are not paying federal, state or social security taxes on the contributions, your taxable income is reduced and your spendable income actually increases

Enrolling in an FSA

To participate in the FSA program, enrollment must be completed each year during the Open Enrollment period for both new and active employees up to the maximum amounts allowed. An annual contribution amount must be determined at the time of enrollment.

Once enrolled, you will have online access to view your FSA balance(s), check on a reimbursement status and more. If you're a first time enrollee, register as a new user. Visit www.goigoe.com to access IGOE's online portal.

The following sections provide additional information on contributing towards the FSA and using funds, as well as how reimbursements are completed.

FLEXIBLE SPENDING ACCOUNT (FSA)

Contributing to Your Accounts

Each account allows participants to contribute a set annual amount, as outlined in the chart below.

Account Type	Contribution Limit
Health Care FSA	• You can contributed up to $2,550 pre-tax in 2015
Dependent Care FSA	• You may contributed up to $5,000 per year

Please note: Consult your tax advisor for additional taxation information or advice.

Not sure how much to contribute? By estimating the eligible expenses you and your family might incur during the plan year, you will have a better sense of how much your annual contribution towards the FSA should be. The Planning Worksheets may help you determine an amount to contribute to the Health Care FSA and/or Dependent Care FSA.

FLEXIBLE SPENDING ACCOUNT (FSA)

Eligible Expenses

The types of expenses reimbursable by your spending accounts are determined by the IRS. Examples of eligible expenses and additional information are below.

Account Type	Eligible Expenses
Health Care FSA	• Deductibles, copays and coinsurance, as well as out-of-pocket costs for medical, dental and vision services, including chiropractic and acupuncture services • Prescription drugs and over-the-counter medications with a prescription are considered eligible • Explicit guidelines for determining eligible expenses have yet to be provided by the Internal Revenue Service (IRS); for a list of potential eligible expenses that may be covered by a Flexible Spending Account (FSA), review Internal Revenue Code (IRC) section 213 (d). IRS Publication 502 (Medical and Dental Expenses) may be used as a guide for what expenses may be considered by the IRS to be for medical care; however, the guidelines should be used with caution when trying to determine what expenses are reimbursable under an FSA [1]
Dependent Care FSA	• Eligible child care, nanny services or residential disabled adult daycare for your dependents • Dependents claimed on your federal income tax return, including those under age 13 and those of any age who are unable to care for themselves, who live with you for more than half of the taxable year and do not provide more than half of his/her own support would be considered eligible dependents for this FSA • To determine potential eligible employment-related expenses view IRC sections 129 and 21. IRS Publication 503 (Child and Dependent Care Expenses) may also be used as a guide for what expenses that may be considered employment-related; however, Publication 503 should be used with caution when trying to determine what expenses are reimbursable under a Dependent Care FSA [1]

Keep itemized receipts in a safe place. The IRS or IGOE may request a copy to substantiate a claim. If you are required to submit a receipt or some form of claim documentation and fail to comply, reimbursement may be denied.

Receiving Reimbursements

Reimbursements will be made to you in a separate check included with your paycheck for each applicable pay period in which a reimbursement was filed.

Use It – Don't Lose It

With an FSA **funds do not roll over**

- So long as you are benefit eligible at the time you incur a claim any qualified expenses incurred between July 1 2015 June 30 2016 can be submitted for reimbursement through September 30 2016
- Any leftover amount from July 1 2015 to June 30 2016 that is not spent will be forfeited

RETIREMENT / 401K

Whether you're just a few years away from retirement or you're in the early planning stages for your future, NHA offers choices to help you live comfortably at your desired retirement age.

Your 401(k) Plan Option

Administered by TRI-AD, the 401(k) plan allows you to plan for your future by saving a portion of each paycheck today. Your contributions to the plan are made through the convenience of automatic payroll deductions. You may contribute from 3% to 100% of your pay as a pre-tax contribution. You may enroll in the 401(k) plan immediately upon being hired.

You become eligible to share in company matching contributions after 6 months of service. For every dollar that you put into the plan, Neighborhood House Association will match it with $2.00 up to 3%. When you contribute 3%, Neighborhood House Association will contribute 6%.

Enrollment & Account Access

To help with your retirement planning, 401(k) Participant Services call center is accessible Monday – Friday, 5:00 a.m. – 6:00 p.m. PT at 877.690.4015 or by email at 401kmail@tri-ad.com However, you may contact the Benefits Office if you have any questions about using this service.

Additional 401(k) Information

Contribution Limits: For 2015 the IRS annual contribution limits are $18,000 for everyone under age 50 or $24,000 for anyone that is age 50 or over prior to December 31, 2015. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year.

Contribution Changes: You may change the amount of your contribution each pay period. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website.

Employer Contributions: Discretionary match is offered to all eligible participants of 6% up to 3% of your eligible compensation. The match is contributed each pay period subject to company approval each year and may change in the future.

Additional 401(k) Information (Continued)

Loans & Hardship Withdrawals: Our 401(k) plan allows for both Loans and Hardship withdrawals to be taken from your account while still employed with our company. Please see the Benefits Office for information and requirements for either option.

Rollovers Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact TRI-AD or the Benefits Office for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

Vesting

Employee deferrals and employee rollover contributions are always 100% vested. Any employer contributions are subject to the following vesting schedule, **retroactive to date of hire:**

Years Of Service [1]	Percentage
Less than 1 year	0%
1 but less than 2 years	35%
2 but less than 3 years	65%
3 years or more	100%

[1] 1,000 hours worked in a calendar year = 1 year of service

VACATION, SICK DAYS, PTO & HOLIDAYS

To round out your health and welfare coverage, we offer these additional benefits to support both your personal and professional needs.

Vacation Time Off

Vacation time off with pay is available to eligible employees to provide opportunities for rest, relaxation, and personal pursuits. Regular full-time employees are eligible to earn and use vacation time as described below. Part-time employees will be prorated based on the percentage of full-time hours worked.

Years of Eligible Service	Vacation Hours Earned per Month	Vacation Days Each Year
Year 1–5	6.67	10 Days
Year 6–10	10	15 Days
Year 11+	13.33	20 Days

Union Employees: Accrual begin as of the date-of-hire, for use at the conclusion of the introductory period.

Non-union Employees: Accrual begins immediately and can be used after 6 months.

There is a 300 hour cap on accrued time off for both Union and Non-union employees. If you reach the 300 hour cap on accrued time off, you will not accrue hours until you are once again below that cap.

Sick Leave

Sick Hours Earned per Month	Sick Days Each Year
5.33	8 Days

Union Employees: Accrual begins after 6 months of full-time service

Non-union Employees: Accrual begins immediately and can be used after 6 months

Variable Hour Employees (VHE): After satisfying 30 days of service in a 12-month period, the employee will receive 24 hours of sick leave, which may be used upon the 90th day of employment. VHEs are not subject to the accrual schedule.

Sick leave is capped at 360 hours or 45 days.

Personal Days

- Neighborhood House Association offers 2 personal days per year
- Union Employees are eligible after 6 months of employment
- Non-union Employees are eligible immediately upon hire
- Use it or lose it by December 31 of each year

Paid Holidays

Neighborhood House Association provides the following paid holidays each year:

2015 Holidays		
July 3	Friday	Independence Day
September 7	Monday	Labor Day
November 11	Wednesday	Veterans' Day Holiday
November 26	Thursday	Thanksgiving
November 27	Friday	Day after Thanksgiving
December 25	Friday	Christmas
December 31	Thursday	New Year's Eve

2016 Holidays		
January 1	Friday	New Year's Day
January 18	Monday	Martin Luther King, Jr. Day
February 12	Friday	Lincoln's Birthday
February 15	Monday	President's Day
March 31	Thursday	Cesar Chavez Day
May 30	Monday	Memorial Day

MEMBER SUPPORT

Understanding your employee benefits options can be confusing and complicated. Member Support through Barney & Barney provides answers and information at your fingertips.

You're Not Alone

Plan options, copays and deductibles...

Planning for you and your family's health and welfare needs can be an overwhelming task. Member Support is your resource for guidance when navigating your benefits plan, from open enrollment to handling life's many changes.

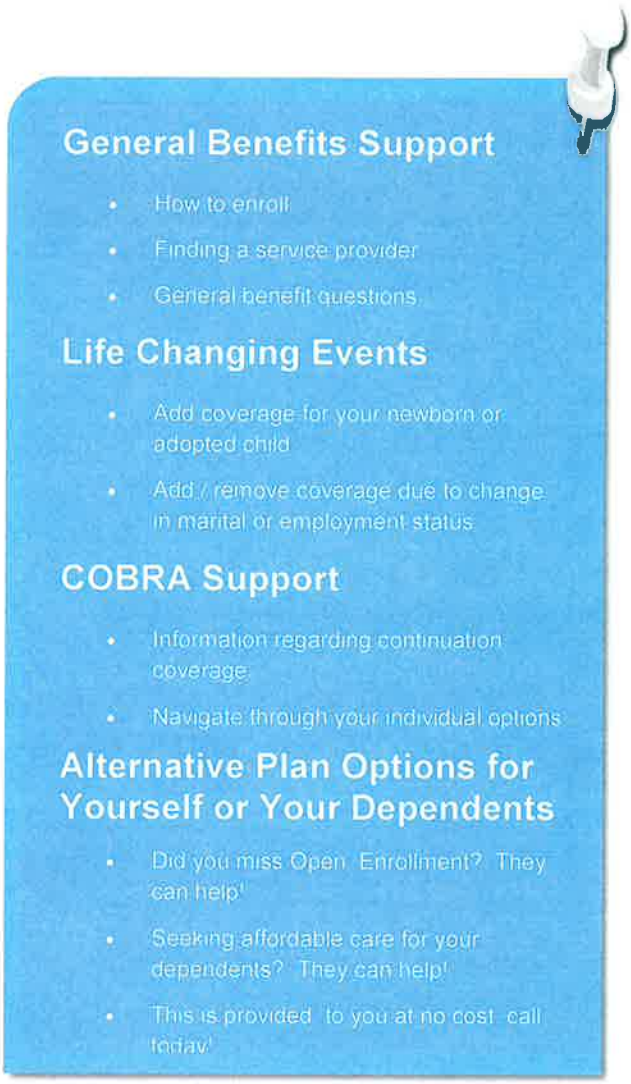
Just a Call or Click Away

Bilingual Member Support is available Monday through Friday, 8:00 a.m. – 5:00 p.m. Pacific Time.

- **Toll-free:** 844-779-1866
- **Email:** membersupport@barneyandbarney.com

Dedicated Benefits Resource

As a company-sponsored benefit, Member Support gives you unlimited direct access to insurance professionals who are dedicated to knowing our plan options inside and out. Whether you're a new employee, looking for information on how to continue your coverage or your insurance needs are changing, you're bound to have questions on your plan options and programs.



THE COST OF COVERAGE

The rates below are effective July 1, 2015 – June 30, 2016.

Coverage Level	Monthly Cost	NHA Monthly Cost	Employee Monthly Cost	Employee Pay Period Deduction
Anthem Premier HMO 20 Select Network				
Employee Only	$617.47	$587.47	$30.00	$13.85
Employee and 1 Dependent	$1,296.72	$972.72	$324.00	$149.54
Employee and 2 or more Dependents	$1,852.44	$1,280.44	$572.00	$264.00
Anthem Premier HMO 20 Full Network				
Employee Only	$847.58	$686.58	$161.00	$74.31
Employee and 1 Dependent	$1,779.90	$1,229.90	$550.00	$253.85
Employee and 2 or more Dependents	$2,542.73	$1,640.73	$902.00	$416.31
Kaiser Permanente HMO				
Employee Only	$549.56	$519.56	$30.00	$13.85
Employee and 1 Dependent	$1,044.16	$748.16	$296.00	$136.62
Employee and 2 or more Dependents	$1,406.86	$872.86	$534.00	$246.46
SIMNSA HMO				
Employee Only	$160.53	$140.53	$20.00	$9.23
Employee and 1 Dependent	$308.40	$200.40	$108.00	$49.85
Employee and 2 or more Dependents	$476.98	$268.98	$208.00	$96.00
Principal Dental EPO				
Employee Only	$19.89	$14.89	$5.00	$2.31
Employee and 1 Dependent	$38.10	$17.10	$21.00	$9.69
Employee and 2 or more Dependents	$68.78	$21.78	$47.00	$21.69
Principal Dental POS				
Employee Only	$32.29	$16.29	$16.00	$7.38
Employee and 1 Dependent	$61.03	$21.03	$40.00	$18.46
Employee and 2 or more Dependents	$104.68	$27.68	$77.00	$35.54
SIMNSA Dental				
Employee Only	$17.04	$12.04	$5.00	$2.31
Employee and 1 Dependent	$28.39	$18.39	$10.00	$4.62
Employee and 2 or more Dependents	$47.13	$27.13	$20.00	$9.23
VSP Vision PPO				
Employee Only	$9.66	$0.00	$9.66	$4.46
Employee and 1 Dependent	$13.74	$0.00	$13.74	$6.34
Employee and 2 or more Dependents	$24.63	$0.00	$24.63	$11.37

PLAN GUIDELINES AND EVIDENCE OF COVERAGE

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

MEDICARE PART D NOTICE

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure (for use on or after 04/01/2011)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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).**

LEGAL INFORMATION REGARDING YOUR PLANS

Required Notices

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your state registered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your state registered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

HIPAA Privacy Notice

Notice of Health Information 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.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

Our Pledge regarding Health Information

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by Law to

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that are currently in effect.

The Plan will use Your Health Information for

Treatment: The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Workers' Compensation: We may release health information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement: We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

Public Health: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the plan privacy officer;
- Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal health information within 60 days or 5 days if conducting business in California;
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice.

The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

LEGAL INFORMATION REGARDING YOUR PLANS

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Important Information on how Health Care Reform Affects Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

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

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

Important Information about COBRA Continuation Coverage and other Health Coverage Alternatives

Note: For use by single employer group health plans.

This notice has important information about your right to continue your health care coverage in your company's plan, as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.healthcare.gov or call 800.318.2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the plan will end on the last day of the month in which the following "qualifying events" occur:

- Termination of employment (18 months of COBRA)
- Reduction in hours of employment (18 months of COBRA)
- Death of employee (36 months of COBRA for the spouse and dependents)

Why am I getting this notice? (Continued)

- Divorce or legal separation (36 months of COBRA for the ex-spouse)
- Entitlement to Medicare (36 months of COBRA for the spouse and dependents)
- Loss of dependent child status (36 months of COBRA for the dependent)

Federal law requires that most group health plans (including this plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") from the list below may qualify to elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the plan because he or she is no longer a dependent under the plan

Contact your Human Resources Representative to determine eligibility for spouse and dependents.

Are there other coverage options besides COBRA Continuation Coverage?

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

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries. Contact your Human Resources Representative for specific start and end dates for COBRA coverage.

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify Human Resources of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit http://www.dol.gov/ebsa/publications/cobraemployee.html.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

Other coverage options may cost less. If you choose to elect continuation coverage, additional information about payment will be provided to you after your election is received by the plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from **Medicaid** or the **Children's Health Insurance Program (CHIP)**. You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

LEGAL INFORMATION REGARDING YOUR PLANS

When can I enroll in the Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Important Information about Payment

First payment for continuation coverage. You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the plan. You're responsible for making sure that the amount of your first payment is correct. You may contact Human Resources to confirm the correct amount of your first payment.

Important Information about Payment (Continued)

Periodic payments for continuation coverage. After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary may be obtained by contacting Human Resources. The periodic payments can be made on a monthly basis. Under the plan, each of these periodic payments for continuation coverage is due on a specified date for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the plan will continue for that coverage period without any break. The plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments. Although periodic payments are due on specified dates (contact Human Resources for this information), you'll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period.

If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the plan.

Contact your Plan Administrator for information for where your first payment and all periodic payments for continuation coverage should be sent.

Separate USERRA Rights for Military Service: The COBRA health care coverage continuation rights discussed above are separate from USERRA health care coverage continuation rights for qualifying military service.

If you leave employment to enter military service, you should contact Human Resources to determine whether you also have USERRA health care coverage continuation rights.

OMB Control Number 1210-0123 (expires 10/31/2016)

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [1]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [2], and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

[1] The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

[2] Special hours of service eligibility requirements apply to airline flight crew employees

LEGAL INFORMATION REGARDING YOUR PLANS

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627 www.wagehour.dol.gov

Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

We will not provide advance notice to you when your continuation coverage terminates.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) PREMIUM ASSISTANCE SUBSIDY NOTICE

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can contact your State Medicaid or CHIP office or dial **(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, you can contact the Department of Labor at www.askebsa.dol.gov or call (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 January 31, 2015. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**MINNESOTA – Medicaid**	**PENNSYLVANIA – Medicaid**
Website: www.myalhipp.com Phone: (855) 692-5447	Website: www.dhs.state.mn.us/ Click on Healthcare, then Medical Assistance Phone: (800) 657-3629	Website: www.dpw.state.pa.us/hipp Phone: (800) 692-7462
ALASKA – Medicaid	**MISSOURI – Medicaid**	**RHODE ISLAND – Medicaid**
Website: health.hss.state.ak.us/dpa/programs/medicaid/ Phone (outside of Anchorage): (888) 318-8890 Phone (Anchorage): (907) 269-6529	Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005	Website: www.ohhs.ri.gov Phone: (401) 462-5300
COLORADO – Medicaid	**MONTANA– Medicaid**	**SOUTH CAROLINA – Medicaid**
Website: www.colorado.gov/hcpf Phone (in-state): (800) 866-3513 Phone (out-of-state): (800) 221-3943	Website: Medicaid.mt.gov/member Phone: (800) 694-3084	Website: www.scdhhs.gov Phone: (888) 549-0820
FLORIDA – Medicaid	**NEBRASKA – Medicaid**	**SOUTH DAKOTA – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: (877) 357-3268	Website: www.accessnebraska.ne.gov Phone: (855) 632-7633	Website: dss.sd.gov Phone: (888) 828-0059
GEORGIA – Medicaid	**NEVADA – Medicaid**	**TEXAS – Medicaid**
Website: dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: (800) 869-1150	Medicaid Website: dwss.nv.gov/ Medicaid Phone: (800) 992-0900	Website: https://www.gethipptexas.com/ Phone: (800) 440-0493
INDIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**	**UTAH – Medicaid and CHIP**
Website: www.in.gov/fssa Phone: (800) 889-9949	Website: www.dhhs.nh.gov/oii/documens/hippapp.pdf Phone: (603) 271-5218	Medicaid Website: health.utah.gov/upp CHIP Website: health.utah.gov/chip Phone: (866) 435-7414
IOWA – Medicaid	**NEW JERSEY – Medicaid and CHIP**	**VERMONT– Medicaid**
Website: www.dhs.state.ia.us/hipp/ Phone: (888) 346-9562	Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: (609) 631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: (800) 701-0710	Website: www.greenmountaincare.org/ Phone: (800) 250-8427
KANSAS – Medicaid	**NEW YORK – Medicaid**	**VIRGINIA – Medicaid and CHIP**
Website: www.kdheks.gov/hcf/ Phone: (800) 792-4884	Website: www.nyhealth.gov/health_care/medicaid/ Phone: (800) 541-2831	Medicaid Website: www.dmas.virginia.gov/rcp-hipp.htm Medicaid Phone: (800) 432-5924 CHIP Website: http://www.covera.org/programs_premium_assistance.cfm CHIP Phone: (855) 242-8282
KENTUCKY – Medicaid	**NORTH CAROLINA – Medicaid**	**WASHINGTON – Medicaid**
Website: chfs.ky.gov/dms/default.htm Phone: (800) 635-2570	Website: www.ncdhhs.gov/dma Phone: (919) 855-4100	Website: www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: (800) 562-3022 ext. 15473
LOUISIANA – Medicaid	**NORTH DAKOTA – Medicaid**	**WEST VIRGINIA – Medicaid**
Website: www.lahipp.dhh.louisiana.gov Phone: (888) 695-2447	Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: (800) 755-2604	Website: www.dhhr.wv.gov/bms/ Phone: (877) 598-5820, HMS Third Party Liability
MAINE – Medicaid	**OKLAHOMA – Medicaid and CHIP**	**WISCONSIN – Medicaid**
Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: (800) 977-6740 TTY: (800) 977-6741	Website: www.insureoklahoma.org Phone: (888) 365-3742	Website: www.badgercareplus.org/pubs/p-10095.htm Phone: (800) 362-3002
MASSACHUSETTS – Medicaid and CHIP	**OREGON – Medicaid**	**WYOMING – Medicaid**
Website: www.mass.gov/masshealth Phone: (800) 462-1120	Website: www.oregonhealthykids.gov www.hijossaludablesoregon.gov Phone: (800) 699-9075	Website: health.wyo.gov/healthcarefin/equalitycare Phone: (307) 777-7531

To see if any other States have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

DIRECTORY & RESOURCES

Below, please find important contact information and resources for NHA.

Information Regarding	Group# / Contact		Phone / Email / Website Information	
Enrollment & Eligibility				
• Enroll or view health plan selections • Add / delete dependents, change address, etc.	Benefits Office	Gail Taylor	858.244.8145	gtaylor@neighborhoodhouse.org
Medical Coverage				
• Verify eligibility of a particular medical service / procedure • Check the status of a claim • Request an ID card • Change Primary Care Physician • Confirm your eligibility or coverage	276559H001/ 276559H008	Anthem Blue Cross	800.888.8288	www.anthem.com/ca
	121155	Kaiser Permanente	800.464.4000	www.kp.org
	398	SIMNSA (Mexico)	800.424.4652	www.simnsa.com
Dental Coverage				
• How do I find a provider • Verify coverage for procedure • Check status of claim	1019848	Principal Dental	800.247.4695	www.principal.com
	398	SIMNSA (Mexico)	800.424.4652	www.simnsa.com
Vision Coverage				
• How do I use the plan • What is covered	12241692	VSP Member Services	800.877.7195	www.vsp.com
Life, AD&D and Disability				
• Group Life / AD&D • Long-Term Disability • Supplemental Life	Unum	Life / AD&D Services LTD Services	800.445.0402 800.431.0344	www.unum.com
Flexible Spending Account				
What is eligible for reimbursement • Claim Status • Account Balance • Flex System Claim Card	IGOE	Member Services	800.633.8818 Opt. #1	www.goigoe.com
401(k) Retirement Plan Adviser				
• Investment Options • Contributions, Loans	TRI-AD	Member Services	877.690.4015	www.tri-ad.com
Employee Assistance Plan				
• 24-hour crisis hotline • Get referrals for face-to-face counseling sessions	Unum	Ceridian Member Services Spanish Line	800.854.1446	www.lifebalance.net User ID & Password: lifebalance
Travel Assistance				
Emergency Travel Assistance	Unum Assist America Reference # 01-AA-UN-762490	Within the U.S. Outside the U.S.	800.872.1414 (U.S. access code) + 609.986.1234	medservices@assitamerica.com
Benefits Broker & Member Support				
Barney & Barney Insurance Services LLC, a division of Marsh & McLennan Agency LLC 9171 Towne Centre Dr., Ste. 500 San Diego, CA 92122	Main Office Susan Loomis, Client Service Executive Todd Bennett, Principal Laico Cook, Client Manager Insurance Advocates **Member Support**		800.321.4696 858.587.7536 858.587.7157 858.587-7451 855.298.6588 **1.844.779.1866**	www.barneyandbarney.com susanl@barneyandbarney.com todd.bennett@barneyandbarney.com laico.cook@barneyandbarney.com **membersupport@barneyandbarney.com**

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