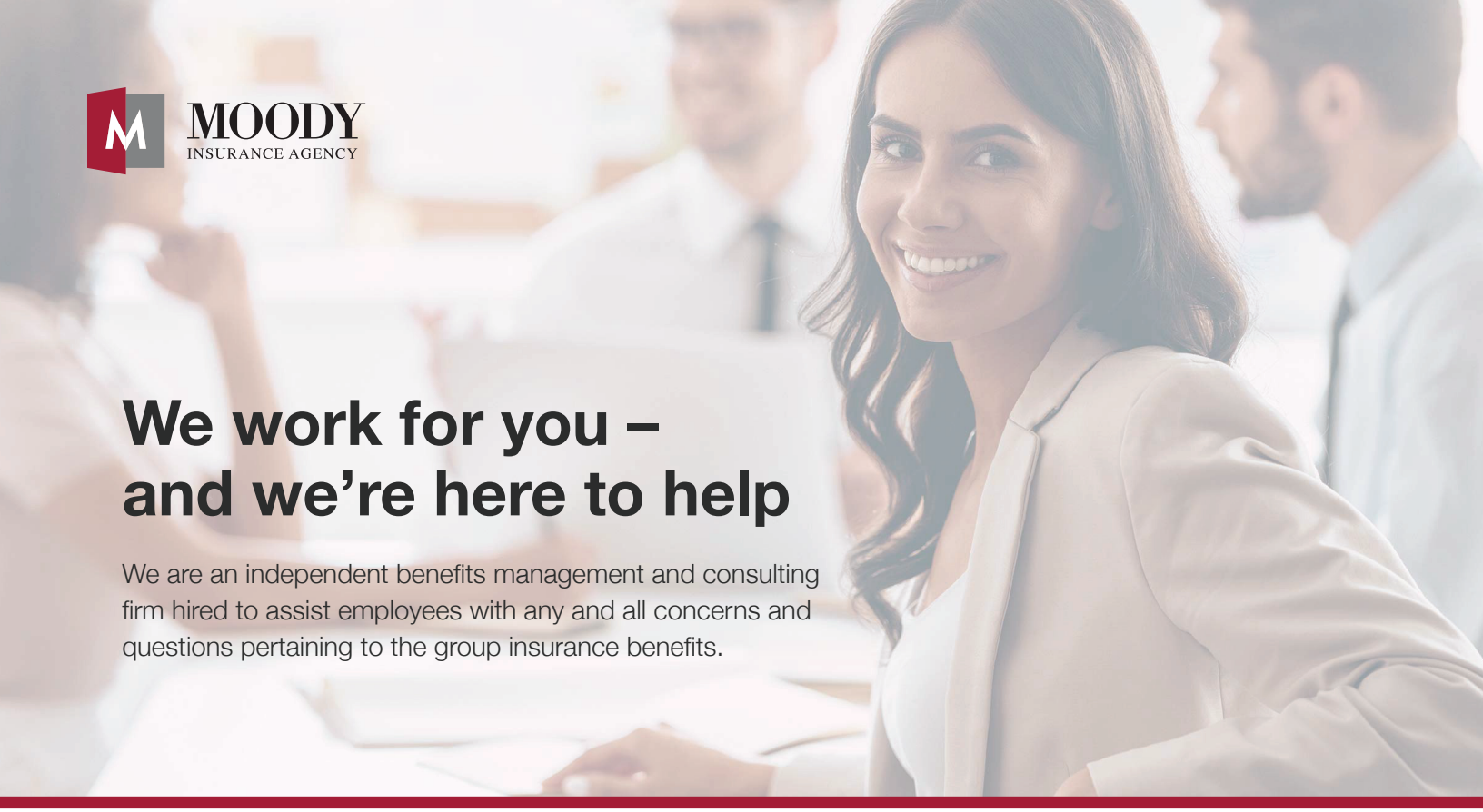
CHEYENNE VILLAGE

SERVING ADULTS WITH DEVELOPMENTAL DISABILITIES

January 1, 2020 – December 31, 2020

Employee Benefits Enrollment Guide

MOODY
INSURANCE AGENCY



We work for you – and we're here to help

We are an independent benefits management and consulting firm hired to assist employees with any and all concerns and questions pertaining to the group insurance benefits.

Benefits Inquiries

POLICY QUESTIONS

Our Account Managers can answer questions about renewals, compliance and healthcare reform, escalated service issues, employee meetings, and wellness discussions.

CLAIMS

Come to our Account Specialist with your benefit inquiries, claim issues, carrier questions, billing issues, and provider searches.

ADMINISTRATION CONCERNS

Your Account Admin can help with enrollment issues, questions about qualifying events, employees address changes, and ID card requests.

Benefits Contact

Amy Conger, GBDS, PPACA
Account Manager
(719) 533-3103
amy.conger@moodyins.com

Lisa Pearce, PPACA
Account Specialist
(719) 533-3102
lisa.pearce@moodyins.com

Molly Artes
Account Administrator
(719) 533-3104
molly.artes@moodyins.com

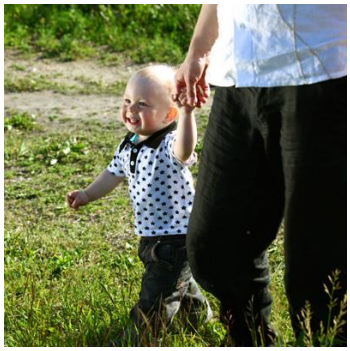
Welcome to Open Enrollment for your 2020 Benefits!

Dear Employee,

Cheyenne Village offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family, keeping in mind the following factors:

- Elections you make during open enrollment will become effective January 1, 2020.
- This is the only time during the year that you have an opportunity to add, delete or make changes to your existing coverage.
- The only exception to this rule is a Qualifying Event (QE) such as marriage, divorce, birth/adoption or loss of other coverage. If you have a QE during the course of the year, you may be able to make changes to your plan outside of open enrollment but will need to notify HR immediately and complete the appropriate enrollment/change forms within 30 days of that event, otherwise you will not be able to make changes until open enrollment 2020.

****Please note the tables in this document are not a complete listing of benefits. Please see the summaries of each benefit for more details****



Who is Eligible?

- All full-time regular employees are eligible to enroll.
- Benefits eligibility begins **first of the month following 60 days from your date of hire.**
- Dependents are defined as Spouse and/or Child(ren).
- Children are defined as less than 26 years of age regardless of financial or student status.

How to Enroll & Make Changes

- The first step is to review your benefits package offerings.
- You must complete the necessary forms and return them to HR as soon as possible.
- ***All employees must fill out an enrollment form either electing or waiving coverage for all benefits.***
- Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

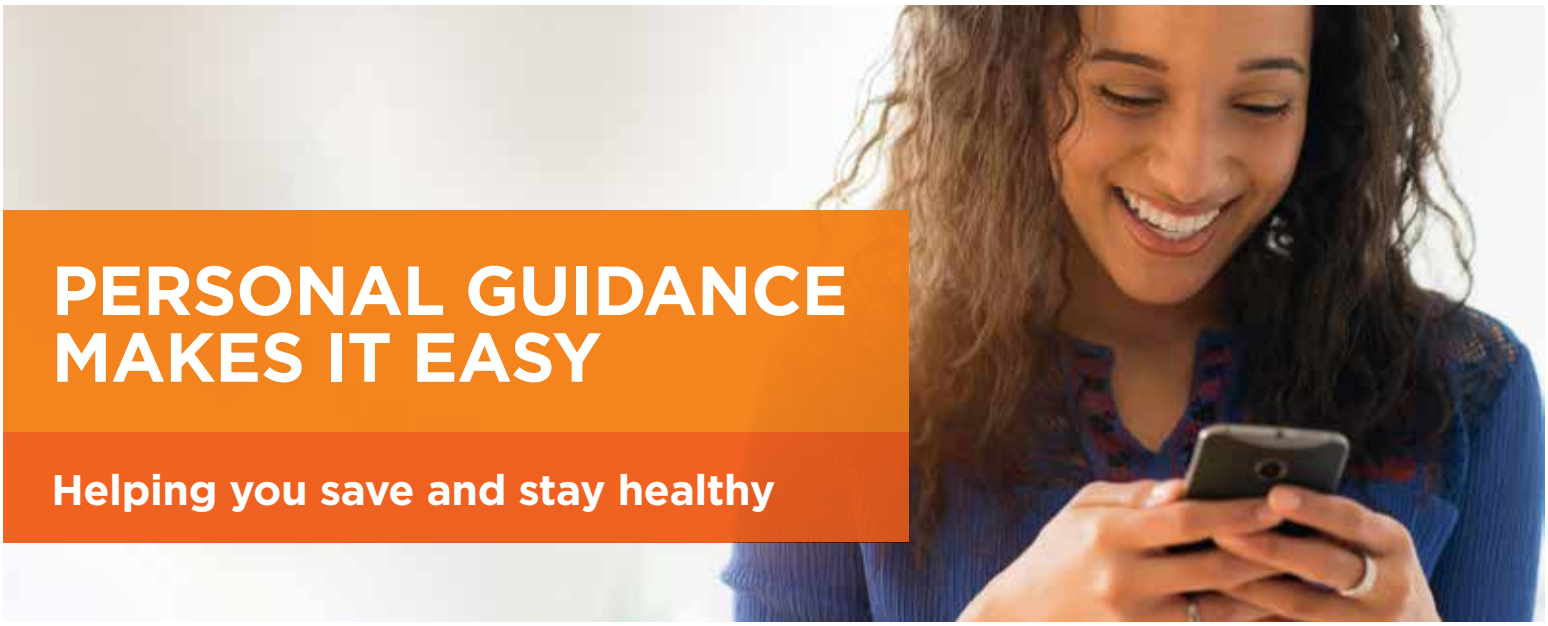
When to Enroll for Open Enrollment

- The benefits you elect during open enrollment will be effective from January **1, 2020 – December 31, 2020**
- All Election/Changes Forms should be returned to HR.

How to Make Future Changes

- Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period.
- Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status.
- If you experience one of these status changes, please notify HR within 30 days of the event to obtain the appropriate forms for enrollment.

Service	HDHP with HSA OAP $3500 Base Plan In Network	OAP HMO $3500 Buy Up In Network
Plan Year Deductible	Individual $3,500 Family $7,000	Individual $3,500 Family $7,000
Out of Pocket Maximum (Includes Deductible, Coinsurance, and Copays)	Individual $6,500 Family $13,000	Individual $6,000 Family $12,000
Telehealth (Virtual Visits)	You pay 30% after deductible	$30 Copay
Preventive Care	Covered at 100%	Covered at 100%
Office Visits / Specialty Visits	You pay 30% after deductible	$30 copay / $50 copay
Lab & X-ray	You pay 30% after deductible	Covered at 100%
MRI, CT & PET Scan	You pay 30% after deductible	$250 copay at an outpatient facility You pay 30% after deductible for in office facilities
Outpatient Services/Surgery	You pay 30% after deductible	$500 copay per admission plus 30% after deductible
Hospital Inpatient	You pay 30% after deductible	You pay 30% after deductible
Emergency Room	You pay 30% after deductible	$350 Copay (waived if admitted)
Urgent Care	You pay 30% after deductible	$100 Copay
Ambulance Service (Ground or Air)	You pay 30% after deductible	You pay 30% after deductible
Prescription	**After deductible is met:** Generic: $20 copay Preferred Brand: $40 copay Non-Preferred Brand: $60copay **Up to a 30 day supply** Please see SBC for Specialty, retail and home delivery	Generic: $15 copay Preferred Brand: $40 copay Non-Preferred Brand: $75 copay Specialty: 20% up to $250 **Up to a 30 day supply** Please see SBC for Specialty, retail and home delivery
Website/Network/Phone Number	www.mycigna.com / OAP IN / 866-494-2111	



PERSONAL GUIDANCE MAKES IT EASY

Helping you save and stay healthy

Now it's easier for you to take control of your health and health spending.

Cigna One Guide service can help you make smarter, informed choices and get the most from your plan. It's our highest level of support that combines the ease of a powerful app with the personal touch of live service. One Guide personal support, tools and reminders can help you stay healthy and save money.

Your One Guide team is a click or call away to help you:

Understand your plan

- Know your coverage and how it works
- Get answers to all your health care or plan questions

Get care

- Find an in-network doctor, lab or urgent care center
- Connect to health coaches, pharmacists and more
- Stay on track with appointments and preventive care
- Take advantage of dedicated one-on-one support for complex health situations

Save on care

- Learn ways to save and get the most value from your plan
- Get cost estimates and service comparisons to avoid surprises

Start using the Cigna One Guide service today – by app, chat or phone.

Download the myCigna℠ app* or call the number on the back of your ID card to talk with your personal guide.

GET IT ON Google play | BlackBerry World | Available on kindle fire | Download on the App Store

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company.

KNOW BEFORE YOU GO

Your guide for where to go when you need medical care.

Lower — Cost and time — Greater

	Cigna Telehealth Connection	Convenience Care clinic	Doctor's office	Urgent care center	Emergency room
	Access telehealth services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when where and how it works best for you. Visit the website or call to register.[1] AmwellforCigna.com 855-667-9722 MDLIVEforCigna.com 888-726-3171	Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The best place to go for routine or preventive care, to keep track of medications, or for a referral to see a specialist.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to the nearest emergency room. "Freestanding" emergency room (ER) locations are becoming more common in many areas. Because these ERs are not inside hospitals, they may look like urgent care centers. When you receive care at an ER, you're billed at a much higher cost than at other health care facilities.
Conditions treated[2]	› Colds and flu › Rashes › Sore throats › Headaches › Stomachaches › Fever › Allergies › Acne › UTIs and more	› Colds and flu › Rashes or skin conditions › Sore throats, earaches, sinus pain › Minor cuts or burns › Pregnancy testing › Vaccines	› General health issues › Preventive care › Routine checkups › Immunizations and screenings	› Fever and flu symptoms › Minor cuts, sprains, burns, rashes › Headaches › Lower back pain › Joint pain › Minor respiratory symptoms › Urinary tract infections	› Sudden numbness, weakness › Uncontrolled bleeding › Seizure or loss of consciousness › Shortness of breath › Chest pain › Head injury/major trauma › Blurry or loss of vision › Severe cuts or burns › Overdose
Your cost and time	› Costs the same or less than a visit with your primary care provider › Appointments typically in an hour or less › No need to leave home or work	› Same or lower than doctor's office › No appointment needed	› May charge copay/ coinsurance and/ or deductible › Usually need appointment › Short wait times	› Costs lower than ER › No appointment needed › Wait times vary	› Highest cost › No appointment needed › Wait times may be long, averaging over 4 hours[3]

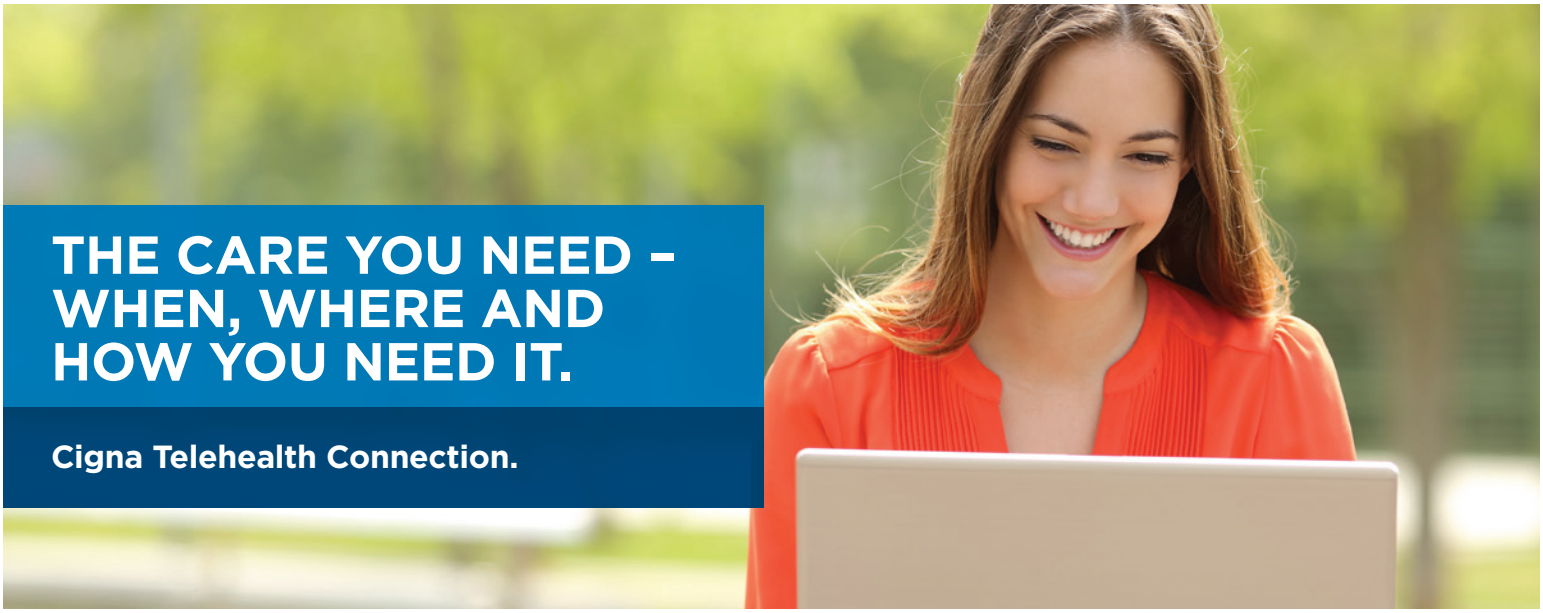
Cigna Health Information Line

A telephone service staffed by nurses that helps you understand and make informed decisions about health issues you are experiencing, at no extra cost. It can help you choose the right care in the right setting at the right time, whether it's reviewing home treatment options, following up on a doctor's appointment, or finding the nearest urgent care center. Just call the number on your Cigna ID card. Open 24/7.

To find a specific health care facility or doctor, go to myCigna.com or use the myCigna Mobile App.[4]

Together, all the way.®

Cigna®



THE CARE YOU NEED – WHEN, WHERE AND HOW YOU NEED IT.

Cigna Telehealth Connection.

Choice is good. More choice is even better.

Cigna provides access to **two** telehealth services as part of your medical plan – **Amwell** and **MDLIVE**.

Cigna Telehealth Connection lets you get the care you need – including most prescriptions (when appropriate) – for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office. When, where and how it works best for you!

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: Amwell or MDLIVE doctors.

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register on both Amwell and MDLIVE, you can speak with a doctor for help with:

- Sore throats
- Headaches
- Stomachaches
- Fevers
- Colds and flu
- Allergies
- Rashes
- Acne
- Shingles
- Bronchitis
- Urinary tract infections and more

The cost savings are clear.

Televisits with Amwell and MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, your telehealth services are only available for minor, non-life-threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

Amwell and MDLIVE are only available for medical visits. For covered services related to mental health and substance use disorder, you have access to the **Cigna Behavioral Health** network of providers.

- Go to **myCigna.com** to search for a telehealth provider under Specialty in the Behavioral Directory link
- Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

Together, all the way.®

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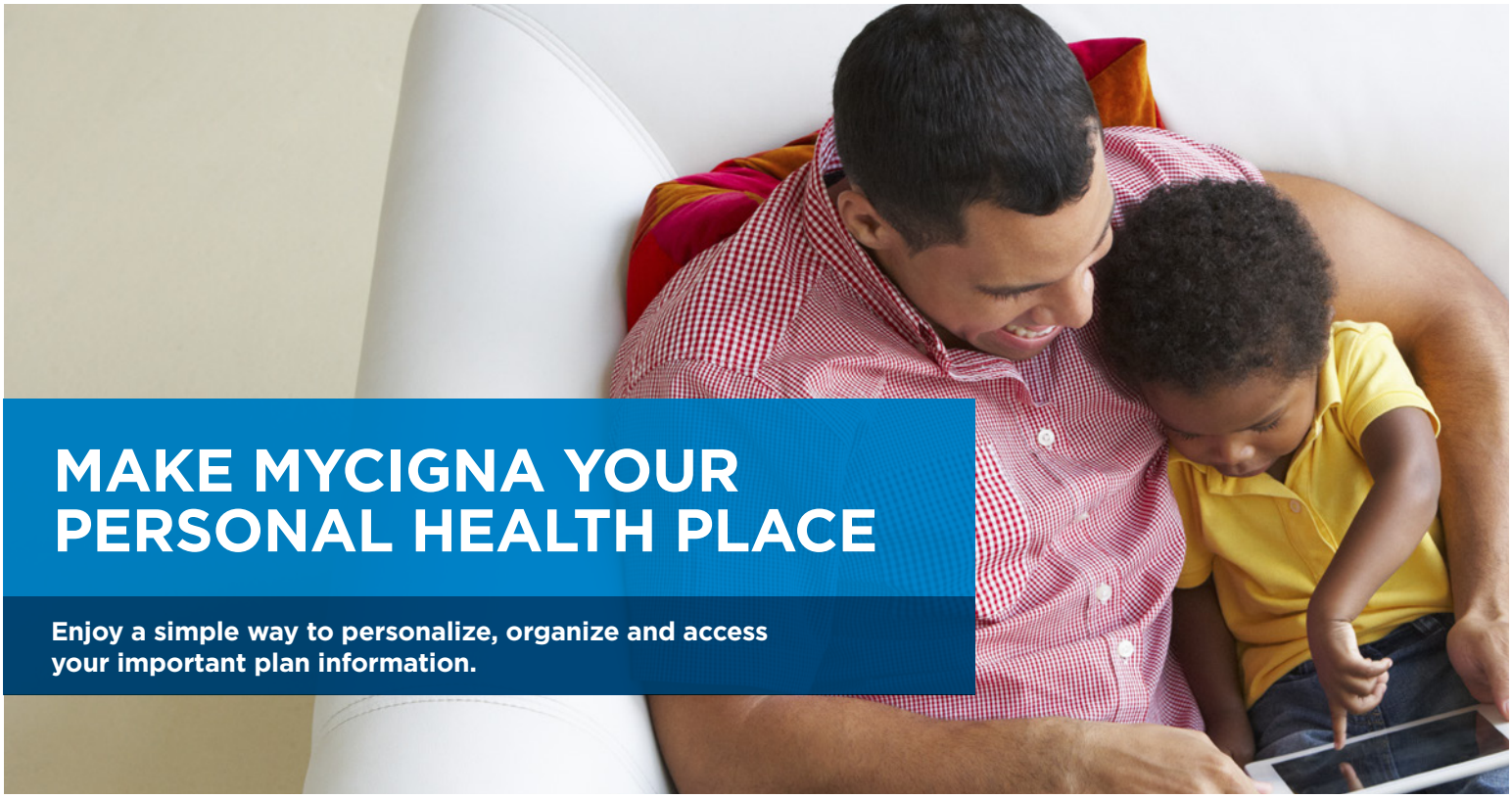
Offered by Cigna Health and Life Insurance Company or its affiliates.



MAKE MYCIGNA YOUR PERSONAL HEALTH PLACE

Enjoy a simple way to personalize, organize and access your important plan information.

Register on myCigna.com

Once you do, you can log in anytime, anywhere to:

- **Manage** and track claims
- **View** ID card information
- **Find** doctors and compare cost and quality ratings
- **Review** your coverage
- **Track** your account balances and deductibles
- **Compare** prescription drug prices at thousands of pharmacies in our network

Register today! Visit **myCigna.com** or download the myCigna Mobile App*.

Download on the App Store | GET IT ON Google play | Available on amazon apps kindle fire | Get it at BlackBerry World

Go to myCigna.com to go paperless!
After you register, you can set up paperless communications. Just log in to myCigna.com and select "Go Paperless".

Cigna®

dispatch HEALTH

BRINGING BACK THE HOUSE CALL

DISPATCHHEALTH BRINGS COMFORTABLE HEALTHCARE TO YOUR HOME.

WHAT WE TREAT

COMMON AILMENTS
- Fever - Flu - Nausea
- Headaches - Migraines
- Urinary tract infection

+ More

SKIN
- Hives - Allergic reactions
- Skin abscess (boil)
- Cuts that need stitches
- Rashes

+ More

GASTROINTESTINAL
- Diarrhea
- Heartburn
- Constipation
- Nausea and vomiting

+ More

EAR, NOSE & THROAT
- Sore throat
- Ear infection or pain
- Sinus infection
- Nosebleeds

+ More

EYE
- Eye infection
- Object in the eye

+ More

NEUROLOGICAL
- Vertigo (dizziness)
- Weakness

+ More

MUSCULOSKELETAL
- Joint or back pain
- Strains or sprains
- Minor bone breaks

+ More

RESPIRATORY
- Asthma attacks
- Bronchitis

+ More

PROCEDURES WE PERFORM
- IV placement
- IV fluids
- Stitches
- Splinting
- Advanced on-site blood testing
- Lancing of abscess (boil)
- Urinary catheter insertion
- Infectious disease testing (flu, strep, mono)

+ More

A TEAM YOU CAN TRUST

For every house call we send a physician assistant or nurse practitioner along with a medical technician. An on-call physician is also available at all times via phone.

WE'VE GOT YOU COVERED

QUICK. EFFICIENT. AFFORDABLE.

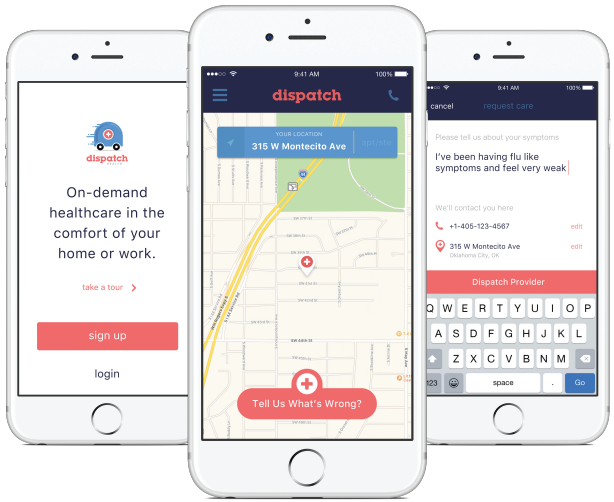
We accept most insurance. Please contact DispatchHealth for more information about your specific insurance plan. In addition, an affordable flat fee is available for uninsured patients.

We accept credit card, debit card, health savings account (HSA), health reimbursement account (HRA) and flexible spending account (FSA) payments.

ON-DEMAND HEALTHCARE 7 DAYS A WEEK 365 DAYS A YEAR | **8AM-10PM**

DISPATCHHEALTH.COM OR **719-270-0805**

NO MEMBERSHIPS NEEDED | ACCEPTED BY MOST INSURANCE



Download on the App Store

ANDROID APP ON Google Play

FOLLOW US FOR UPDATES:

Cigna Healthcare Financial Exhibit for:

Cheyenne Village, Inc.

Effective Date: January 01, 2020

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Cigna DPPO Advantage	Out-of-Network
Calendar Year Maximum		
(Class II, III Expenses)	$1000, Class I Does Not Apply	$1000, Class I Does Not Apply
Calendar Year Deductible		
Per Individual	$50	$50
Per Family	$150	$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays Brush Biopsy	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Stainless Steel/Resin Crowns	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care		
Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Crowns/Inlays/Onlays Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
	Not Covered	Not Covered
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on Maximum Allowable Charge Standard schedule (for location of service rendered).
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

P0002 (NS001) Network. Prepared by Underwriting. 08/29/2019 08:12 AM

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Prosthesis over Implants	1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment. No frequency limit for participants under age 19.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for a specified time period; thereafter, considered a Class III expens
Late Entrant Limit	50% coverage on Class III and IV (if applicable), for 12 months
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within five years following the date of its original installation
* Replacement of a bridge or denture which can be made useable according to accepted dental standards
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
* Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type
* Instruction for plaque control, oral hygiene and diet
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pay
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profit
* Any sickness covered under any workers' compensation or similar law
* Charges in excess of the reasonable and customary allowances
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

*** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.*

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

EyeMed VISION CARE®

CHEYENNE VILLAGE, INC

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $35
Contact Lens Fit and Follow-Up *(Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)*		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail price	N/A
Frames	$120 allowance; 20% off retail price over $120	Up to $48
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $25
Bifocal	$25 Copay	Up to $40
Trifocal	$25 Copay	Up to $60
Standard Progressive Lens	$90	Up to $40
Premium Progressive	$90, 80% of charge less $120 Allowance	Up to $40
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses		
Conventional	$135 allowance; 15% off retail price over $135	Up to $95
Disposable	$135 Allowance; plus balance over $135	Up to $95
Medically Necessary	$0 Copay; Paid in Full	Up to $200
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

Want to learn more?

- For a complete list of providers near you, use our Provider Locator on www.eyemedvisioncare.com and choose the ACCESS network or call 1-866-723-0596.
- For Lasik providers, call 1-877-5LASER6.

Additional Discounts and Features:

- 40% off additional eyewear purchases.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.
- Laser vision correction - 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.

LensCrafters Pearle Vision Sears Optical OPTICAL JCPenney Optical Private Practitioners

Save on eye exams, eyeglasses, contact lenses and time.

Because vision care should be simple.

Everyone needs proper vision care. But you've got a job to do and a life to live. That's why at EyeMed Vision Care, we design our benefits to fit the way you live, work and play.

Balancing eye health and vision wellness with overall health care.

- Besides measuring your vision, regular eye exams can help identify early signs of serious health conditions like diabetes, heart disease and high blood pressure.

See well, look great and save!

- Enjoy the freedom to choose from top brand-name frames that fit your lifestyle.
- Select the latest in contact lens technology.
- Receive value above and beyond the benefit, including unlimited 40 percent off additional complete pairs of eyewear. You never have to pay full price for eyewear needs.

It's vision care, on your terms.

- Find the eye care professional that's right for you, with access to thousands of independent eye doctors and top optical retailers across the country.
- Schedule appointment times that fit your schedule; weekdays, plus evenings and weekends.
- Find answers when you need them—our customer care agents are available seven days a week to assist you.

Visit EyeMedVisionCare.com to learn more and to find an eye doctor near you.

LensCrafters Pearle Vision Sears Optical Target Optical JCPenney Optical Private Practitioners

EyeMed Vision Care®

Benefits are not provided for services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical and/or surgical treatment of the eye, eyes or supporting structures; Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses and/or contact lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy; or Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive Lens not covered - fund as a Bifocal Lens. Standard Progressive Lens covered - fund Premium Progressive as a Standard.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Basic Enhanced Employee Assistance Program

Mutual of Omaha

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life.

Your Employee Assistance Program (EAP) can be the answer for you and your family.

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

EAP BENEFITS

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)

  *Face-to-face visits can also be used toward legal consultations

  *California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period per person.
- Legal assistance and financial services
  - *Online will preparation*
  - *Legal library & online forms*
  - *Telephonic financial consultation*
- Resources for:
  - *Financial tools & resources*
  - *Substance abuse and other addictions*
  - *Dependent and elder care assistance & referral services*
- Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

WHAT TO EXPECT

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. There is ***no cost*** to you for utilizing EAP services. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help. Visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

Benefits that work™

› Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Cheyenne Village, Inc, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Life Insurance Benefit Amount	For You: An amount equal to 1 times your annual salary, but in no event less than $10,000 or more than $50,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.
FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $40,000.

Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag - Common Carrier
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep	We work with Willing® to offer employees discounted online will preparation tools. In just a few clicks you can complete a customized plan to protect your family and property (valid in all 50 states). To get started visit www.willing.com/mutualofomaha

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 50%

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

Please contact your employer if you have questions prior to enrolling.

› Short-Term Disability Insurance

How Would You Pay Your Bills if You Were Sick or Injured Temporarily?

Even a short illness or injury could seriously impact your paycheck. Sick time will get you by while it lasts, but what happens when your sick days run out? A short-term disability policy provides you with cash benefits when you need it.

We've Got You Covered

As an active employee of Cheyenne Village, Inc, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A disability income insurance policy can help provide security when you need it, plus give you peace of mind so you can recover faster and get back on the job sooner.

Coverage guidelines and benefits are outlined below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the day of your disabling injury. • On the 8th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources.
Maximum Benefit Period	Up to 13 weeks
Maximum Weekly Benefit	$600
Minimum Weekly Benefit	None
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.

DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

› Long-Term Disability Insurance

Your Ability to Earn an Income May Be Your Most Important Asset

Most people don't think twice about insuring their home, automobile or health. However, many people don't recognize just how important it is to insure their income.

We've Got You Covered

As an active employee of Cheyenne Village, Inc, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A lengthy disability can be devastating, and is more common than you might think. It may lead to a loss of income, independence and financial security.

A disability income insurance policy can help provide security when you need it most. It pays you cash benefits when you're sick or hurt and can't work.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 90 calendar days after the onset of your disabling injury or illness or the date your short term disability ends.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$6,000
Minimum Monthly Benefit	$100
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.

DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99%
Definition of Monthly Earnings	Monthly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 12. Monthly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, monthly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
SERVICES	
Employee Assistance Program (EAP)	The EAP program provides you and your loved ones access to trained professionals and resources for assistance with personal and workplace issues.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

› Voluntary Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Cheyenne Village, Inc, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 21, or 25 if a student. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES			
	Minimum	**Guarantee Issue**	**Maximum**
For You	$10,000	7 times annual salary, up to $100,000	$500,000, in increments of $10,000, but no more than 7 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $20,000	100% of employee's benefit, up to $150,000
Children	$2,000	100% of employee's benefit	100% of employee's benefit, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent children. Children include those, up to age 21 (25 if a full-time student). In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $100,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $20,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (information about your health).
Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep	We work with Willing® to offer employees discounted online will preparation tools. In just a few clicks you can complete a customized plan to protect your family and property (valid in all 50 states). To get started visit www.willing.com/mutualofomaha

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 50%

Spouse coverage terminates when you reach age 70.

Life insurance benefits will not be paid if the insured's death is the result of suicide within one year from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

Please contact your employer if you have questions prior to enrolling.

Voluntary Term Life Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 29	$0.69	$1.38	$2.07	$2.76	$3.45	$4.14	$4.83	$5.52	$6.21	$6.90
30 - 34	$0.91	$1.82	$2.73	$3.64	$4.55	$5.46	$6.37	$7.28	$8.19	$9.10
35 - 39	$1.11	$2.22	$3.33	$4.44	$5.55	$6.66	$7.77	$8.88	$9.99	$11.10
40 - 44	$1.60	$3.20	$4.80	$6.40	$8.00	$9.60	$11.20	$12.80	$14.40	$16.00
45 - 49	$2.90	$5.80	$8.70	$11.60	$14.50	$17.40	$20.30	$23.20	$26.10	$29.00
50 - 54	$4.70	$9.40	$14.10	$18.80	$23.50	$28.20	$32.90	$37.60	$42.30	$47.00
55 - 59	$7.41	$14.82	$22.23	$29.64	$37.05	$44.46	$51.87	$59.28	$66.69	$74.10
60 - 64	$11.51	$23.02	$34.53	$46.04	$57.55	$69.06	$80.57	$92.08	$103.59	$115.10
65 - 69	$20.69	$41.38	$62.07	$82.76	$103.45	$124.14	$144.83	$165.52	$186.21	$206.90
70 - 74	$37.09	$74.18	$111.27	$148.36	$185.45	$222.54	$259.63	$296.72	$333.81	$370.90
75+	$61.10	$122.20	$183.30	$244.40	$305.50	$366.60	$427.70	$488.80	$549.90	$611.00

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.35	$0.69	$1.04	$1.38	$1.73	$2.07	$2.42	$2.76	$3.11	$3.45
30 - 34	$0.46	$0.91	$1.37	$1.82	$2.28	$2.73	$3.19	$3.64	$4.10	$4.55
35 - 39	$0.56	$1.11	$1.67	$2.22	$2.78	$3.33	$3.89	$4.44	$5.00	$5.55
40 - 44	$0.80	$1.60	$2.40	$3.20	$4.00	$4.80	$5.60	$6.40	$7.20	$8.00
45 - 49	$1.45	$2.90	$4.35	$5.80	$7.25	$8.70	$10.15	$11.60	$13.05	$14.50
50 - 54	$2.35	$4.70	$7.05	$9.40	$11.75	$14.10	$16.45	$18.80	$21.15	$23.50
55 - 59	$3.71	$7.41	$11.12	$14.82	$18.53	$22.23	$25.94	$29.64	$33.35	$37.05
60 - 64	$5.76	$11.51	$17.27	$23.02	$28.78	$34.53	$40.29	$46.04	$51.80	$57.55
65 - 69	$10.35	$20.69	$31.04	$41.38	$51.73	$62.07	$72.42	$82.76	$93.11	$103.45

ALL CHILDREN PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)*

$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$8,000	$9,000	$10,000
$0.20	$0.30	$0.40	$0.50	$0.60	$0.70	$0.80	$0.90	$1.00

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)

DON'T LOSE BETWEEN $500 TO $1,000 PER YEAR ON MEDICAL, DENTAL AND VISION EXPENSES!

OPEN A MEDICAL FSA DURING OPEN ENROLLMENT THIS YEAR

How Do Medical FSAs Work?

The purpose of a Medical FSA is to pay for expenses related to the prevention, treatment, diagnosis, or mitigation of a disease or illness.

Sign up during open enrollment, choosing an annual dollar amount you want taken out of your paycheck **before** taxes and put into your Medical FSA. Use the expense worksheet on the second page to help you choose your election amount so you know you will use all of your funds by the end of the plan year.

Use your Medical FSA money to pay for eligible medical, dental, or vision expenses incurred during your organization's plan year. You can also pay for expenses for your spouse and any of your qualified tax dependents, even if they are covered under a different insurance plan. Your entire annual election is available the **first day** of your plan year.

By not paying taxes on these expenses, you avoid losing up to $1,000 (20% to 40% of your annual Medical FSA election). Use this hard–earned money on something else you value and enjoy!

Visit **www.24hourflex.com/tax-savings-calculator/** to estimate your tax savings by using a Medical FSA.

Why You Should Sign Up

To avoid losing hard–earned money each time you pay for medical, dental or vision expenses.

To have access to money at the start of the plan year to pay for medical, dental or vision expenses for you and your family. Your annual election is fully available the first day of the plan year.

How Do You Pay For Expenses?

Use the 24HourFlex Benny card, a stored value VISA card loaded with your annual Medical FSA election amount, to pay providers directly.

Pay expenses yourself and then submit an itemized receipt to 24HourFlex to be reimbursed from your Medical FSA.

Important: You must save itemized receipts for all your expenses that include:

- The date of service
- Service performed or product provided
- Name of the merchant
- The cost of the service

How Do You Manage Your Account?

The easiest way to mange your account is online at www.24hourflex.com/newuser

You can also use the 24HourFlex mobile app available for Android and Apple (iOS).

Make sure you read your Plan's Summary Plan Description (SPD), available from your employer, to understand the deadlines and rules that govern your rights and benefits.

CUSTOMER SERVICE

7:00 a.m. to 6:00 p.m. (Mountain Time)
MONDAY – FRIDAY

VISIT: WWW.24HOURFLEX.COM

CALL: 800-651-4855

EMAIL: INFO@24HOURFLEX.COM

LIVE CHAT ONLINE

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

DON'T LOSE BETWEEN $1,250 TO $2,000 PER YEAR ON CHILD CARE EXPENSES!

OPEN A DEPENDENT CARE FSA DURING OPEN ENROLLMENT THIS YEAR

How Do Dependent Care (Child Care) FSAs Work?

The purpose of a Dependent Care FSA is to pay for dependent care services for a dependent child or adult, allowing you and your spouse (if applicable) to work or to look for work.

You choose an annual dollar amount, up to $5,000 per family, that you want taken out of your paycheck **before** taxes and put into your Dependent Care FSA. **Use the expense worksheet on the second page to help you choose your election amount** so you know you will use all of your funds by the end of the plan year.

As the Dependent Care money is deducted from your paycheck, you can then **use it to pay for eligible dependent care expenses** incurred during your organization's plan year.

Common eligible Dependent Care expenses include day care and before/after school expenses for a dependent child up to 12 years old or pre-school expenses.

Common ineligible expenses include kindergarten tuition, overnight camps, and care for a child 13 or older who isn't physically or mentally disabled.

By not paying taxes on these expenses, you avoid losing up to $2,000 in taxes (25% to 40% of your annual Dependent Care FSA election). Use this hard-earned money on something else you value and enjoy!

Why You Should Sign Up

To avoid losing hard-earned money each time you pay for dependent care expenses.

How Do You Pay For Expenses?

You can use the 24HourFlex Benny card, a stored value VISA card loaded with your current Dependent Care balance, to pay providers directly if they accept cards AND are set up with a credit card merchant account tied to being a dependent care provider.

You can also incur expenses and then submit an itemized invoice to 24HourFlex to be reimbursed from your Dependent Care FSA.

Important: You must have an itemized invoice from your provider that includes:

- The dates or date range of care provided
- Name of the dependent care provider
- The cost of the care
- A description of the care provided

How Do You Manage Your Account?

The easiest way to mange your account is online at www.24hourflex.com/newuser

Through the 24HourFlex Mobile App available for Android and Apple (iOS).

Make sure you read your Plan's Summary Plan Description (SPD), available from your employer, to understand the deadlines and rules that govern your rights and benefits.

CUSTOMER SERVICE

7:00 a.m. to 6:00 p.m. (Mountain Time)
MONDAY – FRIDAY

VISIT: WWW.24HOURFLEX.COM

CALL: 800-651-4855

EMAIL: INFO@24HOURFLEX.COM

LIVE CHAT ONLINE

Annual Notices:

Newborns' and Mothers' Health Protection Act (NMHPA)

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

Women's Health and Cancer Rights Act (WHCRA)

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

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

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

If you would like more information on WHCRA benefits, call your plan administrator.

Patient Protection Choice of Providers

In cases where the Group Health Plan allows or required a participant to designate a primary care provider, the participant has the right to designate any primary care provider who participates in the network and who is available to accept the participant or participant's family members.

Until you make this designation, the Group Health may designate a primary care provider automatically. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact your Employer Representative.

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

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

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

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

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

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

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

Living in Colorado, you may be eligible for assistance paying your employer health plan premiums. You may contact the State for further information on eligibility –

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711

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

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

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

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the *Notice of Privacy Practices,* describing how protected health information about you may be used and disclosed and how you can get access to the information, contact your plan administrator.

Special Enrollment Notice

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

Loss of Other Coverage

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

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

Marriage, Birth or Adoption

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

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

Medicaid or CHIP

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

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

For More Information or Assistance

For more information about your coverage offered by your employer or to request special enrollment, please check your summary plan description or contact:

Name	Barb Kitchen
Address	6275 Lehman Drive
City, State	Colorado Springs, CO 80918
Telephone	719-572-7489

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2020 open enrollment period for health insurance coverage through the Marketplace runs from Nov. 15, 2019, through Jan. 31, 2020. Individuals must enroll or change plans prior to Dec. 15, 2019, for coverage starting as early as Jan. 1, 2020. After Jan. 31, 2020, you can get coverage through the Marketplace for 20120 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78 percent of your household income for the year or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact HR.