2018 Annual Benefits Enrollment

Legal Notices

Transamerica reserves the right to change, amend or terminate any benefits plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.

This benefits guide, combined with these legal notices, provides an overview of the benefits available to employees and their dependents. In all cases, the official plan documents govern and this guide is not and should not be relied upon as a governing document. In the event of a discrepancy between the information presented in this guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS (ERISA PLANS)

This enrollment website constitutes a Summary of Material Modifications (SMM) and a notice of applicable changes to the Component Plans of the Transamerica Welfare Benefits Program. It is meant to supplement and/or replace certain information in the 2017 Summary Plan Description for the Transamerica Welfare Benefits Program, until such time that a new SPD is distributed to you, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available through the Mercer Marketplace website. There are two ways to access the Mercer Marketplace website:

1. If you're on the network, click the "2018 Benefits Enrollment" link via the Benefits Enrollment menu on Employee Central, or
2. If you're not connected to the network, log on **to benefits.transamerica.com** using your network username and password. Enter "US" as the domain (AAM and Corporate Center use "DS").

   Note: If you're part of the Transamerica Agency Network:

   - Log in to **www.tapremier.com** and go to the Links page.
   - Click "2018 Benefits Enrollment."
   - Enter the same ID and password you use for Employee Central and Integrity Ed, and enter "US" as the domain.

Beginning November 1, you may also request a paper copy by calling Mercer Marketplace's dedicated Transamerica Benefits Center at **866-891-4274**.

IMPORTANT NOTICE FROM TRANSAMERICA CORPORATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Transamerica Medical Plans and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including covered drugs and their costs 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 obtain 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. Transamerica Corporation determined that on average for all Medical Plan participants, the prescription drug coverage offered by all the Transamerica Medical Plans is expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, neither you nor your dependents may continue your medical, including prescription drug coverage under the Transamerica Medical Plans. You and your dependents will permanently lose medical and prescription drug coverage under the Transamerica Medical Plans and will not be able to get this coverage back.

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 under the Transamerica Medical Plans and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

For more information, contact Employee Services at **866-558-5560**. NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if your coverage under the Transamerica Medical Plans 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 **800-MEDICARE** or **800-633-4227**. TTY users should call **877-486-2048**.

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

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

Date: October 15, 2017
Name of Entity/Sender: Transamerica Medical Plans
Contact: Employee Services
Address: 4333 Edgewood Rd NE, MS 3830
Cedar Rapids, IA 52499

Phone Number: **866-558-5560**

HIPAA SPECIAL ENROLLMENT NOTICE

Notice of special enrollment right for health plan coverage

If you decline enrollment in a Transamerica health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a Transamerica health plan without waiting for the next Annual Benefits Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. Your dependents may be able to enroll provided you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in a Tech International medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another medical plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

To request a HIPAA special enrollment based on the events described above or obtain more information, contact Employee Services at **866-558-5560**.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

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.
- Treatment of prostheses and physical complications of the mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

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 medical carrier at the phone number listed on the back of your ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA OR "NEWBORNS' ACT") NOTICE

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). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

MICHELLE'S LAW NOTICE

Extended dependent medical coverage during student medical leaves

Transamerica plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, call Mercer Marketplace at **866-891-4274** as soon as the need for the leave is recognized by Transamerica. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

CHIP/MEDICAID 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, contact your state Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your state for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: www.myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid eligibility: www.dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: www.myarhipp.com Phone: 1-855-MyARHIPP (1-855-692-7447)	Health First Colorado website: 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
FLORIDA – Medicaid	**GEORGIA – Medicaid**
Website: www.flmedicaidtplrecovery.com/hipp Phone: 1-877-357-3268	Website: www.dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone:1- 404-656-4507
INDIANA – Medicaid	**IOWA – Medicaid**
Healthy Indiana Plan for low-income adults 19–64: Website: www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid: Website: www.indianamedicaid.com Phone 1-800-403-0864	Website: www.dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: www.kdheks.gov/hcf Phone: 1-785-296-3512	Website: www.chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
LOUISIANA – Medicaid	**MAINE – Medicaid**
Website: www.dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP	MINNESOTA – Medicaid
Website: www.mass.gov/eohhs/gov/departments/masshealth Phone: 1-800-862-4840	Website: www.mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005	Website: www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1-603-271-5218	Medicaid website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid phone: 1-609-631-2392 CHIP website: www.njfamilycare.org/index.html CHIP phone: 1-800-701-0710
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: www.dma.ncdhhs.gov Phone: 1-919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid**
Websites: www.healthcare.oregon.gov/Pages/index.aspx www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: www.eohhs.ri.gov/ Phone: 1-855-697-4347	Website: www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: www.dss.sd.gov Phone: 1-888-828-0059	Website: www.gethipptexas.com Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Medicaid website: www.medicaid.utah.gov CHIP website: www.health.utah.gov/chip Phone: 1-877-543-7669	Website: www.greenmountaincare.org Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Medicaid website: www.coverva.org/programs_premium_assistance.cfm Medicaid phone: 1-800-432-5924 CHIP website: www.coverva.org/programs_premium_assistance.cfm CHIP phone: 1-855-242-8282	Website: www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022, ext. 15473
WEST VIRGINIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: www.mywvhipp.com Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://wyequalitycare.acs-inc.com Phone: 1-307-777-7531	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

TRANSAMERICA HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Transamerica health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes the privacy practices of these plans: medical, dental and vision. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the plan in this notice, unless specified otherwise.

The plan's duties with respect to health information about you

The plan is required by law to maintain the privacy of your health information and to provide you with this notice of the plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the plan, not Transamerica as an employer — that's the way the HIPAA rules work. Different policies may apply to other Transamerica programs or to data unrelated to the plan.

How the plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the plan may share your health information with physicians who are treating you.
- Payment includes activities by this plan, other plans or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection or reinsurance. For example, the plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Health care operations include activities by this plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the plan may use information about your claims to audit the third parties that approve payment for plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the plan uses or discloses PHI for underwriting purposes, the plan will not use or disclose PHI that is your genetic information for such purposes.

How the plan may share your health information with Transamerica

The plan, or its health insurer or HMO, may disclose your health information without your written authorization to Transamerica for plan administration purposes. Transamerica may need your health information to administer benefits under the plan. Transamerica agrees not to use or disclose your health information other than as permitted or required by the plan documents and by law. The Plan Administrator, including any authorized delegates (including Employee Services), are the only Transamerica employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the plan and Transamerica, as allowed under the HIPAA rules:

- The plan, or its insurer or HMO, may disclose "summary health information" to Transamerica, if requested, for purposes of obtaining premium bids to provide coverage under the plan or for modifying, amending or terminating the plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The plan, or its insurer or HMO, may disclose to Transamerica information on whether an individual is participating in the plan or has enrolled or disenrolled in an insurance option or HMO offered by the plan.

In addition, you should know that Transamerica cannot and will not use health information obtained from the plan for any employment-related actions. However, health information collected by Transamerica from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend or other person you identify who is involved in your care or payment for your care. Information about your location, general condition or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the p disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties

Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are armed forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the plan will obtain your authorization before it communicates with you about products or programs if the plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

The plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and the plan's right to refuse

You have the right to ask the plan to restrict the use and disclosure of your health information for treatment, payment or health care operations, except for uses or disclosures required by law. You have the right to ask the plan to restrict the use and disclosure of your health information to family members, close friends or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the plan to restrict use and disclosure of health information to notify those persons of your location, general condition or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the plan must be in writing.

The plan is not required to agree to a requested restriction. If the plan does agree, a restriction may later be terminated by your written request, by agreement between you and the plan (including an oral agreement) or unilaterally by the plan for health information created or received after you're notified that the plan has removed the restrictions. The plan may also disclose health information about you if you need emergency treatment, even if the plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the plan will accommodate reasonable requests to receive communications of health information from the plan by alternative

means or at alternative locations.

If you want to exercise this right, your request to the plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the plan will provide you with one of these responses:

The access or copies you requested.

- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The plan also may charge reasonable fees for copies or postage. If the plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the plan amend your health information in a designated record set. The plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the plan (unless the person or entity that created the information is no longer available), is not part of the designated record set or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment or health care operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.

- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a “limited data set” (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the plan must be in writing. Within 60 days of the request, the plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2018. However, the plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the plan’s privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints

If you believe your privacy rights have been violated or your plan has not followed its legal obligations under HIPAA, you may complain to the plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint, contact Employee Services at **866-558-5560.**

Contact

For more information on the plan’s privacy policies or your rights under HIPAA, contact Employee Services at **866-558-5560**.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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.

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 9.56% 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.[1]

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?

For more information about your coverage offered by your employer, please check your summary plan description or see **mytabenefits.com**.

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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

10/17

[1]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.