2021 Unity Health Care / Nonstop Wellness Benefits Guide

Everything You Need to Know About Your Benefits

Table of Contents

Welcome Letter

Welcome to your Nonstop Wellness benefits with Unity Health Care, Inc.! We are thrilled to have you on board. Nonstop's mission is to support the growth and sustainability of nonprofit organizations by providing high-quality, affordable, and accessible employee health care. We do this by wrapping a section 105 medical expense reimbursement plan (MERP) around a high deductible health plan (HDHP) from Kaiser and CareFirst. We then provide you with a Nonstop Visa debit card to help cover those out-of-pocket costs associated with having a HDHP.

As you'll see in this guide, the Nonstop Wellness program is relatively easy to use so long as you follow these three "golden rules:"

1. **Stay in-network for all services and prescriptions**
2. **Use your Nonstop Visa card to help pay for in-network, carrier-approved expenses for the CURRENT plan year**
3. **Give us a call if you have any questions or run into any issues**

We are here to help you in any way. Call 877-626-6057 or email clientsupport@nonstopwellness.com anytime you have a question. We look forward to supporting you with your healthcare needs!

Again, welcome to the Unity & Nonstop family of health care. We couldn't be happier to extend the Nonstop Wellness program to you and your family to ensure that you stay happy and healthy all year long.

Best,

Graham Edwards

Graham Edwards
Chief Operating Officer
Nonstop Administration and Insurance Services Inc.

Available Benefits for 2021

Below is a snapshot of the medical plan options available to you in 2021. Please refer to the Employee Documents tab in the Nonstop Exchange (NSE) member portal to access and view all complete plan summaries from each carrier. All legal and compliance-related notices will also be located under the Employee Docs tab in NSE.

Carrier/Plan Name	Coverage Type	Benefits snapshot (in-network coverage)
Nonstop Wellness	HRA wrapped with medical coverage	Section 105 HRA wrapped around the below medical plan. Nonstop Wellness provides you with a Visa card to help pay for in-network, carrier-approved medical expenses and prescriptions. Nonstop Wellness only works for medical expenses and cannot be used for dental or vision expenses
CareFirst BlueChoice	Medical	**Deductible**: $6,000/$12,000 **Out-of-Pocket Maximum**: $6,550/$13,100 **Office visit copay**: $30 PCP/$40 Specialty after deductible **Lab/X-ray coinsurance**: No charge after deductible **Hospital Outpatient coinsurance**: Facility: No charge; Physician: $30 PCP/$40 Specialist **Hospital Inpatient coinsurance:** Facility: $250 after deductible; Physician: No charge after deductible **Rx coverage at plan pharmacy**: *Please refer to CareFirst*
Kaiser DHMO Plus MV 4	Medical	**Deductible**: $5,000/$10,000 **Out-of-Pocket Maximum**: $8,500/$17,000 **Office visit copay**: $50 per visit, deductible does not apply **Lab/X-ray coinsurance**: Lab: $50, X-ray: $150 per visit, deductible does not apply **Hospital coinsurance**: 40% coinsurance **Rx coverage at plan pharmacy**: **Generic**: $25 **Preferred Brand name**: $60 **Non-Preferred Brand name**: 50% coinsurance
Kaiser HDHP MV 2 SIG	Medical	**Deductible**: $4,500/$9,000 **Out-of-Pocket Maximum**: $6,250/$12,500 **Office visit copay**: 40% coinsurance **Lab/X-ray coinsurance**: 40% coinsurance **Hospital coinsurance**: 40% coinsurance **Rx coverage at plan pharmacy**: **Generic**: $25 **Preferred Brand name**: $50 **Non-Preferred Brand name**: 50% coinsurance

CareFirst + Nonstop Wellness Plan

Below is an overview of services covered; please see full benefits summary in the Employee Documents section of the Nonstop Exchange (NSE). As a reminder, use your Nonstop Visa card to pay for covered, in-network, carrier approved medical services and prescriptions.

Please Note: The Summary of Benefits & Coverage (SBC) for 2021 was not available at the time the "Guide" was published. Once finalized, the 2021 SBC will be added as an amendment. The SBCs for the 2021 plan year overrides and supersedes any other documents related to the CareFirst benefit.

Plan Highlights	In-Network
Calendar Year Annual Deductible	
Individual / Family	$6,000/$12,000
Calendar Year Out-of-Pocket Maximum	
Individual / Family	$6,550/$13,100
Lifetime Maximum	
Individual	None
Professional Services	
Primary Care Physician (PCP)	$30 copay
Specialist	$40 copay
Preventive Care Exam	No charge
Well-baby Care	No charge
Maternity Services (scheduled pre-natal)	No charge
Most diagnostic X-ray and Lab	No charge
Therapy, including Physical, Occupational & Speech	No charge
Hospital Services	
Inpatient	$250 copay per admission
Outpatient Surgery	Facility fee, then no charge
Emergency Room	$10 copay per visit
Urgent Care	$40 copay per visit
Mental Health & Substance Abuse	
Inpatient	$250 copay per admission
Outpatient – Individual	No charge
Prescription Drugs	
Generic	$15
Preferred	$35
Non-preferred	$60
Preferred Specialty	50% of allowed benefit up to $100
Non-preferred Specialty	50% of allowed benefit up to $100

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

Kaiser DHMO Plus + Nonstop Wellness Plan

Below is an overview of services covered; please see full benefits summary in the Employee Documents section of the Nonstop Exchange (NSE). As a reminder, use your Nonstop Visa card to pay for covered, in-network, carrier approved medical services and prescriptions.

Plan Highlights	In-Network
Calendar Year Annual Deductible	
Individual / Family	$5,000/$10,000
Calendar Year Out-of-Pocket Maximum	
Individual / Family	$8,500/$17,000
Lifetime Maximum	
Individual	None
Professional Services	
Primary Care Physician (PCP)	$50 per visit, deductible does not apply
Specialist	$80 per visit, deductible does not apply
Preventive Care Exam	No charge (plan deductible doesn't apply)
Well-baby Care	No charge (plan deductible doesn't apply)
Maternity Services (scheduled pre-natal)	No charge (plan deductible doesn't apply)
Most diagnostic X-ray and Lab	Lab: $50 per visit, X-ray: $150 per visit (deductible does not apply)
Therapy, including Physical, Occupational & Speech	$80 per visit, deductible does not apply
Hospital Services	
Inpatient	40% coinsurance after deductible
Outpatient Surgery	40% coinsurance after deductible
Emergency Room	40% coinsurance after deductible
Urgent Care	$80 per visit, deductible does not apply
Mental Health & Substance Abuse	
Inpatient	40% coinsurance after deductible
Outpatient – Individual	$50 per individual visit, $25 per group visit
Prescription Drugs	
Generic Drugs	$25
Preferred-brand Drugs	$60
Non Preferred-brand Drugs	50% coinsurance
Specialty Drugs	50% coinsurance with a $150 maximum

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

Kaiser HMO HDHP + Nonstop Wellness Plan

Below is an overview of services covered; please see full benefits summary in the Employee Documents section of the Nonstop Exchange (NSE). As a reminder, use your Nonstop Visa card to pay for covered, in-network, carrier approved medical services and prescriptions.

Plan Highlights	In-Network
Calendar Year Annual Deductible	
Individual / Family	$4,500/$9,000
Calendar Year Out-of-Pocket Maximum	
Individual / Family	$6,250/$12,500
Lifetime Maximum	
Individual	None
Professional Services	
Primary Care Physician (PCP)	40% coinsurance after deductible
Specialist	40% coinsurance after deductible
Preventive Care Exam	No charge (plan deductible doesn't apply)
Well-baby Care	No charge (plan deductible doesn't apply)
Maternity Services (scheduled pre-natal)	No charge (plan deductible doesn't apply)
Most diagnostic X-ray and Lab	40% coinsurance after deductible
Therapy, including Physical, Occupational & Speech	40% coinsurance after deductible
Hospital Services	
Inpatient	40% coinsurance after deductible
Outpatient Surgery	40% coinsurance after deductible
Emergency Room	40% coinsurance after deductible
Urgent Care	40% coinsurance after deductible
Mental Health & Substance Abuse	
Inpatient	40% coinsurance after deductible
Outpatient – Individual	40% coinsurance after deductible
Prescription Drugs	
Generic	$25
Preferred	$50
Non-preferred	50% coinsurance

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

2021 Medical Health Plan Rates

The medical rates below reflect the employee and employer costs for 2021. The rate chart displays both bi-monthly and monthly rates for the employee's cost, employer monthly costs and total monthly premium for each medical plan. **The rates are effective January 1, 2021 through December 31, 2021.**

PAYROLL DEDUCTIONS

The employee rate/premium is deducted twice per month over 24 pay periods. The deductions occur on the first two pay periods in a month.

EMPLOYEE PREMIUMS WHEN ON APPROVED LEAVE

Employees are responsible for their portion of the medical insurance premium during approved leaves of absence (e.g. FMLA, DCFMLA, PLOA, etc.). Employees may choose to use their accrued vacation, sick and/or personal leave to cover the cost of their premium during this time away from work. If an employee does not have leave available in his/her leave bank, the employee must provide payment either through a check or money order, payable to Unity Health Care, Inc. The payment is due on the pay date in which the premium would have been deducted. If payments are not received during an employee's time away from work, while on an approved leave status, the employee's premiums will go into arrears. The premium will be collected from the employee's pay along with the current premium, when he/she returns to work. If an employee separates from Unity and has an outstanding balance in arrears, the balance will be deducted from the employee's last paychecks including any vacation leave payouts.

CareFirst BlueChoice HDHP				
Tier	**EE Monthly Rate ($)**	**EE Bi-Monthly Rate ($)**	**ER Monthly Cost ($)**	**Total Monthly Premium**
Employee Only	$110.00	$55.00	$602.00	$712.00
Employee + Spouse	$280.00	$140.00	$1,267.00	$1,547.00
Employee + Child(ren)	$248.00	$124.00	$1,259.00	$1,507.00
Employee + Family	$560.00	$280.00	$1,381.00	$1,941.00
Kaiser DHMO Plus HDHP				
Tier	**EE Monthly Rate ($)**	**EE Bi-Monthly Rate ($)**	**ER Monthly Cost ($)**	**Total Monthly Premium**
Employee Only	$ 75.00	$37.50	$561.00	$636.00
Employee + Spouse	$ 228.00	$114.00	$1,156.00	$1,384.00
Employee + Child(ren)	$ 218.00	$109.00	$1,130.00	$1,348.00
Employee + Family	$ 468.00	$234.00	$1,268.00	$1,736.00
Kaiser HMO HDHP				
Tier	**EE Monthly Rate ($)**	**EE Bi-Monthly Rate ($)**	**ER Monthly Cost ($)**	**Total Monthly Premium**
Employee Only	$ 66.00	$33.00	$473.00	$539.00
Employee + Spouse	$ 212.00	$106.00	$841.00	$1,053.00
Employee + Child(ren)	$ 208.00	$104.00	$921.00	$1,129.00
Employee + Family	$ 435.00	$217.50	$991.00	$1,426.00

***EE = Employee / ER= Employer**

Eligibility

EMPLOYEES
All full-time and part-time employees who regularly work at least 30 hours per week are eligible for health benefits. Employees must work 30 hours or more per week to be eligible for dependent coverage.

ELIGIBLE DEPENDENTS
Your eligible dependents include:

- Your spouse (unless you are divorced or legally separated) or domestic partner
- Your dependent children, up to age 26 regardless of their student or marital status.

Coverage may be available for a mentally or physically disabled child who is age 26 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact your Human Resources Department if you believe this applies to your family.

When Can I Enroll?

NEW HIRES/NEWLY ELIGIBLE FOR BENEFITS
Your benefits will begin on the first day of the month following your date of hire. After your initial 15-day enrollment window, you will have the opportunity to re-enroll in the benefits program each year during the Annual Open Enrollment period, unless you have a Qualifying Life Event (QLE).

QUALIFYING FAMILY STATUS CHANGE
During the annual open enrollment period, you can change coverage(s) for the next plan year. **Plan year begins January 1, 2021 and is in effect through December 30, 2021.**

After the annual enrollment period, you generally will *only* be able to change your coverage if you have a qualifying life event. Qualifying life events include, but are not limited to:

- Change in employment status for you or your spouse (commencement, termination, leave of absence, reducing hours from full-time to part-time, temporary, or per diem)
- Change in marital status (marriage, death of spouse, divorce, legal separation)
- Change in dependents (birth, death, adoption, eligibility status, and child support order)
- Special enrollment rights under Health Insurance Portability Accountability Act (“HIPAA”)
- Medicare or Medicaid entitlement for you, your spouse, or dependent

Contact your Total Rewards Team for a complete explanation of qualifying family status change.

What If I Leave My Organization?

If your employment with Unity Health Care (or Unity Business Solutions) ends, your benefits will end on the last day of the month following your separation. Other circumstances which may result in termination of coverage for you and/or your dependents include: reduction in regular hours, divorce/legal separation, and dependent children who reach age 26.

COBRA ELIGIBILITY
Employees and covered dependents may be eligible to continue their medical, dental, vision and FSA Medical coverage after separation from Unity through COBRA. COBRA requires continuation coverage to be offered to covered employees, their spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. Eligible employees will receive a COBRA application from Unity & NSW’s COBRA Administrator, Navia Benefits, following separation. Employees may also call 877-920-9625 for more information.

What is Nonstop Wellness?

Nonstop Wellness is a type of healthcare program that allows nonprofits to fund a portion of their employees' healthcare premiums and out-of-pocket expenses (e.g. deductibles, copays, and coinsurance) while also saving on premium expenses annually. The Nonstop Wellness program combines an ACA-compliant health plan with a section 105 medical expense reimbursement plan (MERP) – and provides you, the member, with a Visa card to help pay for in-network, carrier-approved medical expenses.

With Nonstop Wellness, you will receive two cards in the mail after you enroll: your carrier identification card from Kaiser or CareFirst and your Nonstop Visa card from Nonstop Administration and Insurance Services, Inc. (Nonstop). Cards should be received within 14-21 business days after enrollment. During heavy enrollment periods, cards may take up to 4 weeks to be processed and delivered.

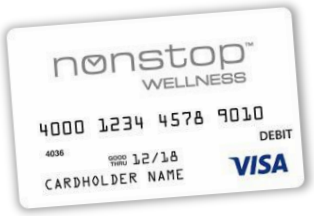
What Should I Do With Each Card?

CARRIER CARD

The carrier card comes from Kaiser or CareFirst, and includes information relevant to the HDHP.

You must present the carrier ID card from Kaiser or CareFirst during every doctor visit and for prescription purchases. This is important to ensure that Kaiser or CareFirst is apprised of the charge and properly credits your services towards your in-network deductible/out-of-pocket maximum

NONSTOP VISA CARD



The Nonstop Visa card comes from Nonstop and can be used to pay for in-network, carrier approved medical services and prescriptions. You cannot use the Nonstop Visa card to purchase over the counter drugs.

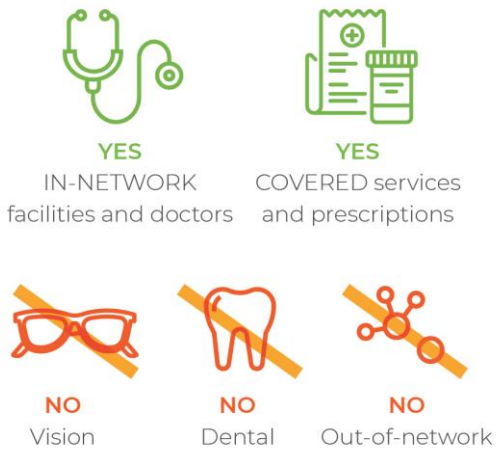
You will receive two Nonstop Visa cards and they will both only be in your name. If you need additional cards, please call us at 1-877-626-6057. We recommend that you DO NOT set up a PIN as this will only allow you to use the card as a debit card and not a credit card.

How Do I Use Nonstop Wellness at My Provider or Pharmacy?

If/when you receive a bill for in-network services, please pay that bill with your Nonstop Visa card.
You cannot use the Nonstop Visa card for dental or vision payments.
You will be responsible for any out-of-network or un-approved charges on the card.

Please note!

- Nonstop Wellness is only designed for medical services and prescriptions. As such, you cannot use the Nonstop Visa card for dental or vision payments.
- You will be responsible for any out-of-network or un-approved charges on the card.
- If you receive a reimbursement check from your carrier or a provider, please know that money needs to be re-deposited back into your employer's account with Nonstop. We request that you endorse the check and mail it to Nonstop at 1800 Sutter St. Suite 730, Concord, CA 94520
- There is a $100 Nonstop Wellness copay for all Emergency Room visits (which is waived if admitted) and this copay is NOT covered under the Nonstop Wellness program. It will be your responsibility to pay out of pocket.



What Are Some Good Tips and Tricks I Should Know About?

Make sure any provider, facility, prescription, and/or service you use is considered in-network for your medical plan; it is better to call ahead and check on this before receiving services or filling a prescription.

Don't go out-of-network for services or prescriptions unless you have written permission from your carrier and confirmation that those expenses will be counted towards your in-network deductible.

Medical discount or coupon programs may not allow prescription/service costs to be applied towards your plan's in-network deductible, which means that these expenses would not qualify for Nonstop Wellness. If this happens, you will be responsible for covering those costs. We recommend checking in with your carrier before accessing a discount/coupon program.

If you have to pre-pay for a service, **please do not pay more than $1,000**; if the provider requires a larger pre-payment, call Nonstop and we will pay the provider directly.

Cosmetic surgery is not covered unless your medical insurance carrier deems it medically necessary.

If you are having surgery or a procedure that involves multiple providers, **please confirm with your doctor and/or insurance carrier that everyone on the team is an in-network provider**. If anyone is out-of-network, please require your provider to find an in-network alternative before proceeding with the surgery/procedure.

If you require **medically-necessary ophthalmology procedures** and your carrier has approved it as part of your medical plan, please know that you will not be able to use your Nonstop Visa card to pay for services as they will be coded for vision. Please call Nonstop before your procedure and we will help pay the provider directly.

Healthcare Terms

Deductible: The amount that must be paid out-of-pocket towards covered healthcare expenses before health insurance kicks in. Once a deductible is met, the employee covers copays and/or coinsurance costs for qualifying services and insurance pays the remainder until the out-of-pocket maximum is reached.

Out-of-Pocket Maximum (OOPM): The maximum amount an enrollee will pay for covered medical services in a year, including deductible, copay, and coinsurance expenses.

Coinsurance: Coinsurance is a percentage of the cost of covered services that is paid (20% for example) at each provider visit after the deductible is met.

Copayment (copay): A copay is a fixed amount that is paid at each provider visit for covered services; copay amounts under an insurance plan can vary for different services.

Nonstop Visa Card Substantiation Policy

You may use the Nonstop Visa card for carrier-approved, in-network services and prescriptions. The card may not be used for out-of-network or elective procedures or anything that your medical carrier would not apply towards your in-network deductible and out-of-pocket tracking. In addition, the Nonstop Wellness program does not cover dental or vision costs so you cannot use your Nonstop Visa card to pay for these services.

Charges on your card may need to be substantiated to ensure they are in-network and carrier-approved. Substantiation simply means that we are confirming acceptable use of your Nonstop Visa card. **Nonstop reserves the right to ask you for documentation to confirm that the charges on the card were allowed and approved by your carrier, and counted towards your deductible and out of-pocket tracking.** Documentation typically includes an Explanation of Benefits (EOB). Please see next page for how to read your Kaiser EOB.

If charges on your Nonstop Visa card cannot be substantiated and/or have not been approved by your carrier, we may request that you repay the amount that does not qualify for the Nonstop Wellness program back into your employer's healthcare plan. If we do not receive documentation or repayment, your card may be suspended and you may be referred to a collections agency. However, before this happens we want to work directly with you to investigate the charge and determine what, if any, errors may have occurred.

THE PROCESS IS AS FOLLOWS:

Please note: if/when we leave you a message or send an email, we cannot include personal health information due to HIPAA compliance regulations. We will simply ask you to call us back or respond to our email.

How to Read Your EOB

CareFirst BlueChoice

CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of Blue Cross and Blue Shield Association. ™ Registered trademark of CareFirst of Maryland, Inc.

Statement Date:
Document Number:

THIS IS NOT A BILL

Subscriber: **ID:** **Group:** **Group Number:**

Patient Name: **Provider:** **Claim Number:**
Date Received: **Payee:** **Date Paid:**

Claim Detail				What Your Provider Can Charge You		Your Responsibility			Total Claim Cost		
				1	2	3	4	5			
Line No.	Date of Service	Service Description	Status	Provider Charges	Allowed Charges	Co-Pay	Deductible	Co-Insurance	Paid by CareFirst	What You Owe	Remark Code
1	01/01/18-01/01/18	Medical Care	Paid	$119.00	$90.22	$30.00	$0.00	$0.00	$60.22	$30.00	
			Total	**$119.00**	**$90.22**	**$30.00**	**$0.00**	**$0.00**	**$60.22**	**$30.00**	

1 Provider charges—the amount billed by your health care providers for your visit(s).

2 Allowed charges—the maximum dollar amount CareFirst will pay for a covered health service, regardless of the provider's actual charge. A provider who participates in the CareFirst BlueCross BlueShield or BlueChoice network cannot charge members more than the allowed benefit amount for any covered service.

3 Copay—a fixed dollar amount you pay when you visit a doctor or other provider. For example, you might pay $40 each time you visit a specialist or $300 when you visit the emergency room.

4 Deductible—the amount of money you must pay each year before CareFirst begins to pay its portion of your claims. For example, if your deductible is $1,000, you'll pay the first $1,000 for health care services covered by your plan and subject to the deductible. CareFirst will start paying for part or all of the services after that. For plans subject to the Affordable Care Act (ACA), certain preventive services are covered prior to meeting your deductible.

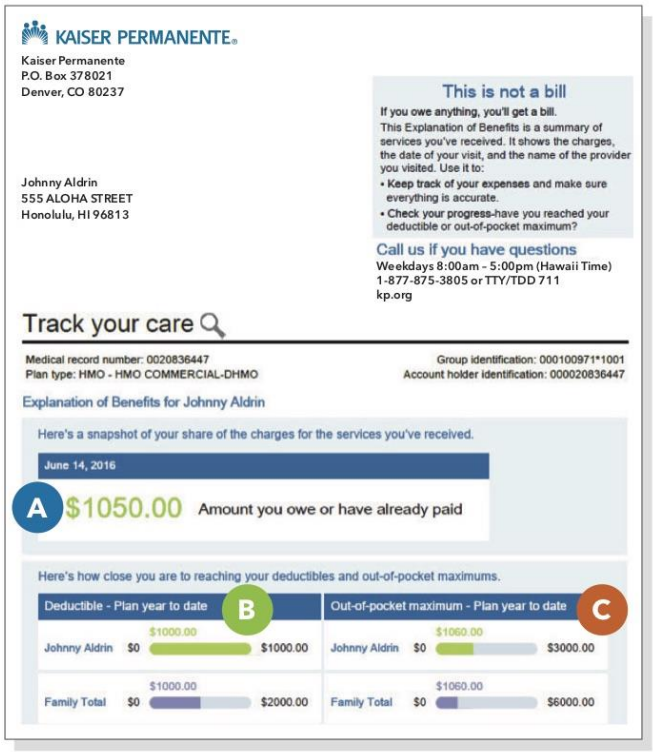
5 Coinsurance—the percentage you pay after you've met your deductible. For example, if your health care plan has a 30 percent coinsurance and the allowed benefit (the amount a provider can charge a CareFirst member for that service) is $100, then your cost would be $30. CareFirst would pay the remaining $70.

You may lower your costs when you choose:

- Generic drugs
- In-network providers
- Care in a non-hospital setting
- Retail health clinics for after-hours care
- A primary care provider to manage your care

How to read your Explanation of Benefits (EOB)

Reading your *Explanation of Benefits* (EOB): In addition to your bill, you may also get an EOB. This document lists all your medical costs that have been applied toward your deductible and out-of-pocket maximum during the calendar year. You'll be mailed an EOB when you receive services that count toward your deductible or out-of-pocket maximum. The EOB is not a bill.



KAISER PERMANENTE®

Kaiser Permanente
P.O. Box 378021
Denver, CO 80237

Johnny Aldrin
555 ALOHA STREET
Honolulu, HI 96813

This is not a bill

If you owe anything, you'll get a bill.
This Explanation of Benefits is a summary of services you've received. It shows the charges, the date of your visit, and the name of the provider you visited. Use it to:
- Keep track of your expenses and make sure everything is accurate.
- Check your progress-have you reached your deductible or out-of-pocket maximum?

Call us if you have questions
Weekdays 8:00am – 5:00pm (Hawaii Time)
1-877-875-3805 or TTY/TDD 711
kp.org

Track your care

Medical record number: 0020836447
Plan type: HMO - HMO COMMERCIAL-DHMO
Group identification: 000100971*1001
Account holder identification: 000020836447

Explanation of Benefits for Johnny Aldrin

Here's a snapshot of your share of the charges for the services you've received.

June 14, 2016

A $1050.00 Amount you owe or have already paid

Here's how close you are to reaching your deductibles and out-of-pocket maximums.

Deductible - Plan year to date (B)				Out-of-pocket maximum - Plan year to date (C)			
Johnny Aldrin	$0	$1000.00	$1000.00	Johnny Aldrin	$0	$1060.00	$3000.00
Family Total	$0	$1000.00	$2000.00	Family Total	$0	$1060.00	$6000.00

A This is your share of the charges, which is the combination of what isn't covered, your deductible, and your copay/coinsurance. If you owe anything, you will receive a bill.

B This area will show how close you are to reaching your individual and family deductibles. In this example, Johnny has a $1,000 individual deductible and he has met it to date. Johnny's family deductible is $2,000, so he has $1,000 left to spend before reaching his family deductible.

C This area will show how close you are to reaching your individual and family out-of-pocket maximums. In this example, Johnny has a $3,000 individual out-of-pocket maximum and he has spent $1,060 towards it to date. Johnny's family out-of-pocket maximum is $6,000 and he spent $1,060 towards it to date.

Once you reach your deductible, you'll start paying less than the full charges for covered services – just a copay or a percentage of the charges (a coinsurance) covered service for the rest of the year.*

Your out-of-pocket maximum helps limit how much you pay for care. This can protect you financially if a serious illness or injury comes up. With some plans, if you reach your out-of-pocket maximum, you won't have to pay for covered services for the rest of the year.*

Visit **kp.org/outofpocket** anytime to see how close you are to reaching your deductible or out-of-pocket maximum.

* Your deductible and out-of-pocket maximum will start over on the new accumulation period. See your *Evidence of Coverage* for your plan details.

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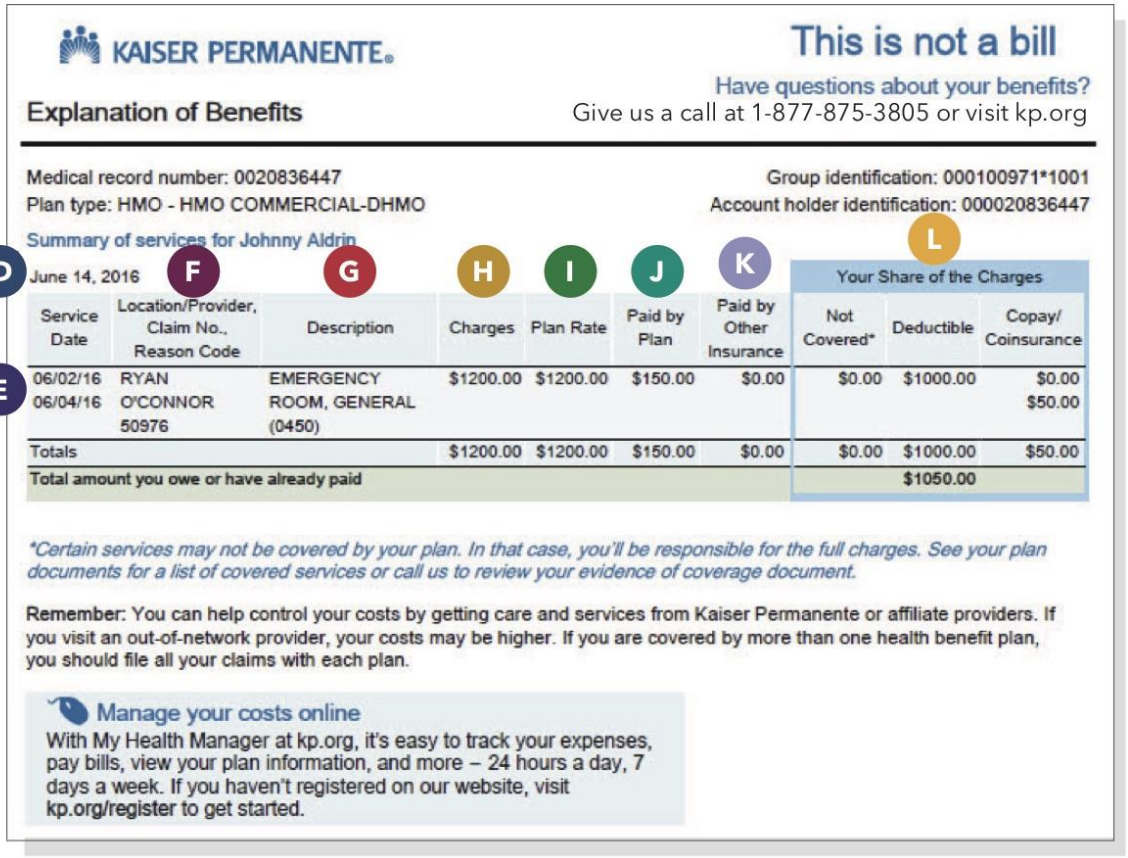
KAISER PERMANENTE®

How to read your Explanation of Benefits (EOB)



KAISER PERMANENTE®

This is not a bill

Have questions about your benefits?
Give us a call at 1-877-875-3805 or visit kp.org

Explanation of Benefits

Medical record number: 0020836447
Plan type: HMO - HMO COMMERCIAL-DHMO

Group identification: 000100971*1001
Account holder identification: 000020836447

Summary of services for Johnny Aldrin

D June 14, 2016

Service Date (E)	Location/Provider, Claim No., Reason Code (F)	Description (G)	Charges (H)	Plan Rate (I)	Paid by Plan (J)	Paid by Other Insurance (K)	Your Share of the Charges (L): Not Covered*	Deductible	Copay/ Coinsurance
06/02/16	RYAN	EMERGENCY	$1200.00	$1200.00	$150.00	$0.00	$0.00	$1000.00	$0.00
06/04/16	O'CONNOR	ROOM, GENERAL							$50.00
	50976	(0450)							
Totals			$1200.00	$1200.00	$150.00	$0.00	$0.00	$1000.00	$50.00
Total amount you owe or have already paid								$1050.00	

Certain services may not be covered by your plan. In that case, you'll be responsible for the full charges. See your plan documents for a list of covered services or call us to review your evidence of coverage document.

Remember: You can help control your costs by getting care and services from Kaiser Permanente or affiliate providers. If you visit an out-of-network provider, your costs may be higher. If you are covered by more than one health benefit plan, you should file all your claims with each plan.

Manage your costs online
With My Health Manager at kp.org, it's easy to track your expenses, pay bills, view your plan information, and more – 24 hours a day, 7 days a week. If you haven't registered on our website, visit kp.org/register to get started.

D This shows the date your EOB was printed and represents your Explanation of Benefits from the start of your annual contract through that date.

E This column shows the date or dates you received specific services.

F This column shows the name of the provider you received services from as well as your claim number, which is a number used to identify the service you received.

G This is a description of the services you received.

H This shows the charges for the services you received. You won't always pay these amounts. They are the full charges before your health plan pays. Your costs are usually lower than the amount shown here.

I This is the rate we negotiated with your care provider for the services you received. The amount you pay will usually be lower once any amounts paid by your health plan are included.

J This is the amount we paid your care provider for the services you received based on your plan details.

K This is the amount paid by your other health insurance plan (if you have one) for services you received. This doesn't include any amount Kaiser Permanente may have paid.

L This shows your share of the charges, including costs that are not covered, the amount you've paid toward your deductible to date, and the amount of your copay or coinsurance (which is the set amount you pay for covered services based on your plan). In this example, Jonny has paid $1,000 toward his deductible to date and his service on 06/04/16 cost him $50 as a copay/coinsurance. So, to date, Johnny owes or has already paid $1,050.

Key Dates and Deadlines

When using the Nonstop Wellness program there are some key dates and deadlines that apply to the Nonstop Visa card as well as the Nonstop claims process. Please read this information carefully so you don't miss any critical deadlines for reimbursement! If you need to submit a claim manually, please visit www.nonstopwellness.com/claims.

The Nonstop Visa card begins upon enrollment:
The Nonstop Visa card cannot be used for claims prior to your enrollment in the Nonstop Wellness program. In other words, if you first enrolled in the Nonstop Wellness plan on January 1, 2021 you cannot use the card to pay for claims with dates-of-service prior to this date (e.g. December 14, 2020).

The Nonstop Visa card can only be used within the current calendar year:
The Nonstop Visa card should not be used to pay for outstanding claims from the prior calendar year, as the Nonstop Visa card can only be used in the same year as the services were rendered. For example, 2020 medical services must be paid for using the Nonstop Visa card in 2020; once the date turns to January 1, 2021, you cannot pay for 2020 expenses with the Nonstop Visa card. Instead, any outstanding claims/costs from the prior calendar year should be submitted manually to Nonstop.

Claims submission deadlines while enrolled in Nonstop Wellness:
All Nonstop Wellness claims must be submitted no later than 90 days after the end of the calendar year. As such, all 2020 claims are due by or **before March 31, 2021**.

January 1 resets for deductibles and OOP maximums:
All carrier plan deductible and OOP maximum calculations are based on a calendar year and reset to $0 every January 1, no matter when your renewal date is. The Nonstop Visa card also resets on January 1.

Claims deadlines when benefits and/or employment is terminated:
If you leave your employer or are no longer benefits eligible, you are required to submit all past claims to the Nonstop Wellness office within **90 days** of your last day of coverage. Your Nonstop Visa card will be cancelled on your last day of coverage and all services performed before the last day of coverage should be submitted manually.

Using the Nonstop Exchange Member Portal

Once you are enrolled with Nonstop Wellness, you will be able to access your plan information via the Nonstop Exchange member portal (**members.nonstopwellness.com**). When you log into the system all your information will be available, allowing you to:

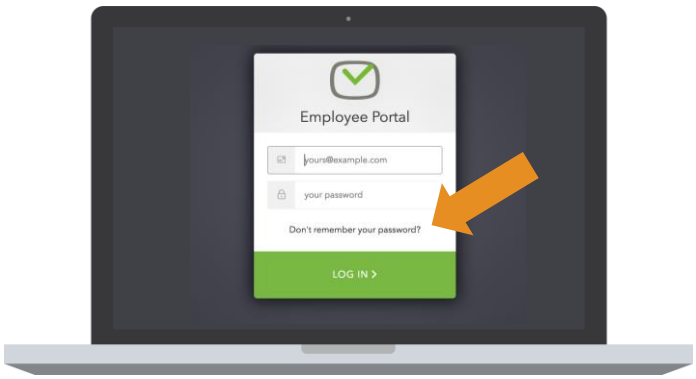
- Enroll in benefits
- Make life event changes
- View available card balances
- View documents about your plan (e.g. summary plan description, benefits summary)
- Navigate to our member help site through the HELP button
- File and view claims submissions

As a reminder, please refer to the Employee Documents tab in the Nonstop Exchange (NSE) member portal to access and view all complete plan summaries from each of your benefits carriers. All legal and compliance-related notices will also be located under the Employee Docs tab in NSE.

Logging into the NSE for the First Time

Once you navigate to the Nonstop Exchange site at members.nonstopwellness.com, you will need to login by entering your user name and password.

Your user name is your email address. When you login for the first time, you will need to put in your email address and then click on "don't remember your password?" This will allow you to set a private password for your account. Please see below for the steps to reset your password.



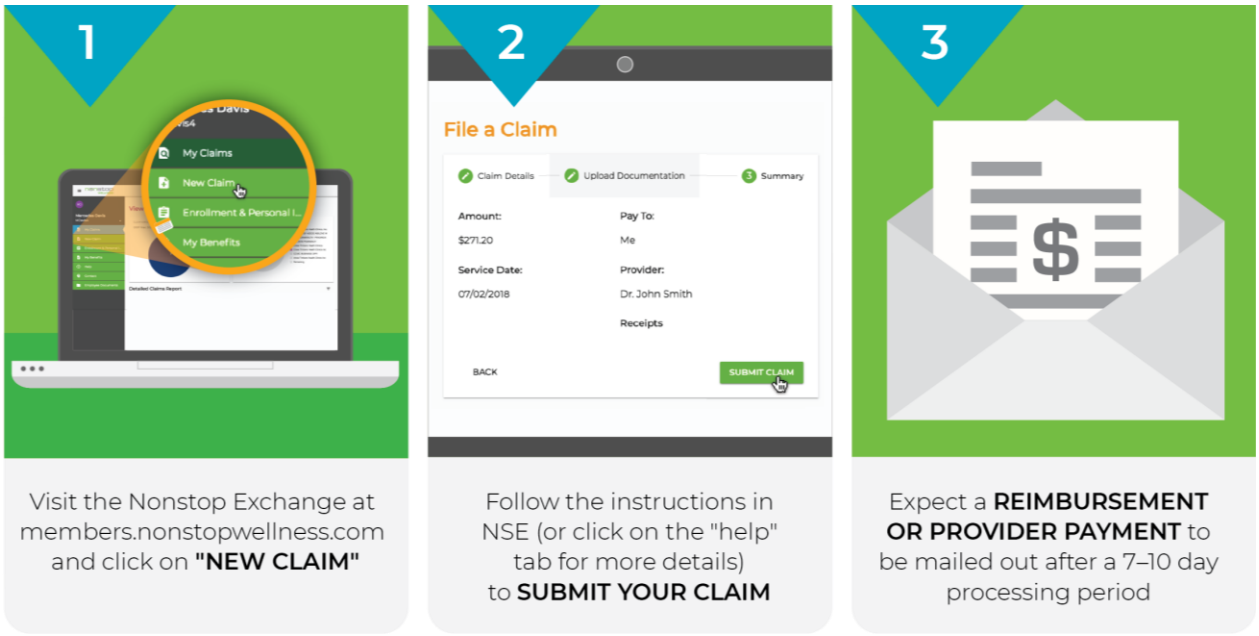
To reset your password:

- *Click on "don't remember your password?"*
- *You'll receive an email with instructions on how to reset your password.*
- *Click the link provided in the email and enter a password with a minimum of 8 characters, at least one number, one special character (i.e., ! # $ etc), and one capital letter.*
- *Once you have reset your password, you can login to the Nonstop Exchange with your username and password.*

Submitting a Claim to Nonstop

While the Nonstop Wellness program is set up to help you pay for a portion of your medical expenses, there may be times when you'll need to pay up front and be reimbursed later. Nonstop makes every effort to help you avoid these situations, but if needed, the claims submission process is quick and easy with reimbursement checks typically processed within 7 to 10 days of submission (assuming no processing delays) and mailed out each Friday.

SUBMITTING A CLAIM AT-A-GLANCE



Visit the Nonstop Exchange at members.nonstopwellness.com and click on **"NEW CLAIM"**

Follow the instructions in NSE (or click on the "help" tab for more details) to **SUBMIT YOUR CLAIM**

Expect a **REIMBURSEMENT OR PROVIDER PAYMENT** to be mailed out after a 7–10 day processing period

Alternatively, you can submit a claim manually by filling out a claims form and emailing it or faxing it to Nonstop. Please visit help.nonstopwellness.com/claims-process for a claims form or ask your HR manager.

What If My Reimbursement Check Doesn't Arrive?

In the rare instance that a payment or reimbursement check is lost, Nonstop will re-issue a check to the provider or employee. Nonstop Wellness will issue a new check after 30 days from date of issue (60 days for Kaiser) and confirmation from service provider that they have not received payment.

How Can I Track A Claim or Reimbursement?

If the claim is submitted via Nonstop Exchange, it will appear as a pending claim on your dashboard. When you submit a claim via email, a ticket number will be assigned to that claim and you'll receive a confirmation response. Please visit help.nonstopwellness.com for more details on filing and viewing claims. If claims were submitted via fax or through the US Postal System, you will need to contact Nonstop Wellness at 877-626-6057 or via email at claims@nonstopwellness.com for details on if the claim was received or has been paid.

What Happens If Nonstop Pays My Provider Directly?

When a bill has been paid by Nonstop, you will not receive a notification from Nonstop that payment has been made. If you continue to receive bills from providers after a claims submission to Nonstop Wellness, it is recommended that you follow up with the Nonstop Wellness team directly. The bill has likely been paid, but has not been credited to your account with your provider yet.

Healthcare/Benefits Notices

Table of Contents

Women's Health & Cancer Rights Act

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

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

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

Newborns' and Mothers' Health Protection Act

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. The law allows the mother or newborn to be released earlier than 48 hours (or 96 hours as applicable) only if the attending provider decides, after consulting with the mother, that the mother or newborn is ready for discharge. 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).

Health Insurance Portability & Accountability Act Non-discrimination Requirements

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

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

HIPAA Privacy Notice

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES
This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

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

OUR PLEDGE REGARDING HEALTH INFORMATION

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

WE ARE REQUIRED BY LAW TO

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

THE PLAN WILL USE YOUR HEALTH INFORMATION FOR

- **Treatment:** The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.
- **Regular Operations:** We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.
- **Business Associates:** There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.
- **As Required by Law:** We will disclose health information about you when required to do so by federal, state or local law.
- **Workers' Compensation:** We may release health information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Law Enforcement:** We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.
- **Public Health:** We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

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

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;

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

THE PLAN'S RESPONSIBILITIES

The plan is required to:

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

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

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

FOR MORE INFORMATION OR TO REPORT A PROBLEM

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

OTHER USES OF HEALTH INFORMATION

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

Special Enrollment Rights

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

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

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

"HIPAA Special Enrollment Opportunities" include:

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

"CHANGE IN STATUS" PERMITTED MIDYEAR ELECTION CHANGES

Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.

Examples of permitted "change in status" events include:

- Change in legal marital status (e.g., marriage (2), divorce or legal separation)
- Change in number of dependents (e.g., birth (2), adoption (2) or death)
- Change in eligibility of a child
- Change in your / your spouse's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage (3)
- Loss of other coverage (2)
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage • You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

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

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

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

Employee Rights & Responsibilities under the Family Medical Leave Act

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

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

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

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

BENEFITS & PROTECTIONS
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

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

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

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

(1) The FMLA definitions of “serious injury or illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition”
(2) Special hours of service eligibility requirements apply to airline flight crew employee

USE OF LEAVE
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for

planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

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

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

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

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

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

UNLAWFUL ACTS BY EMPLOYERS
FMLA makes it unlawful for any employer to:

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

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

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

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

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

Health Insurance Marketplace Notice

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

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

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

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.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility–

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
MedicaidWebsite: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 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

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

Paperwork Reduction Act Statement

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

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

Benefits Contact Information

Unity Health Care, in partnership with the following carriers, strives to meet your benefit needs. If you have any questions regarding your benefits, please contact the corresponding carrier listed below or the Human Resources Department.

Carrier	Phone / Fax / Email	Website
Nonstop Administration & Insurance Services, Inc. (Member Support)	General Phone: 1-877-626-6057 Member Support Email: clientsupport@nonstopwellness.com Substantiation Fax: 719-270-9845 Substantiation Email: eob@nonstopwellness.com Claims Fax: 877-463-1175 Claims Email: claims@nonstopwellness.com	www.nonstopwellness.com Information: help.nonstopwellness.com Nonstop Exchange: members.nonstopwellness.com
Unity Health Care (Open Enrollment) *Starts November 1st runs through November 14th.*	Benefits Phone: 202.741.5615 Support Emails: Open Enrollment: OE@unityhealthcare.org General Benefits Questions: Benefits2@unityhealthcare.org	Open Enrollment/Benefits: https://www.unityhealthcare.org/employeewellness/open-enrollment-2020
Kaiser (Medical) Group #: 24506	D.C. Metro Area: 301-468-600 Outside of D.C.: 800-777-7902	www.kp.org
CareFirst (Medical) Group #: 5802211	855-444-3122	www.member.carefirst.com