Colville

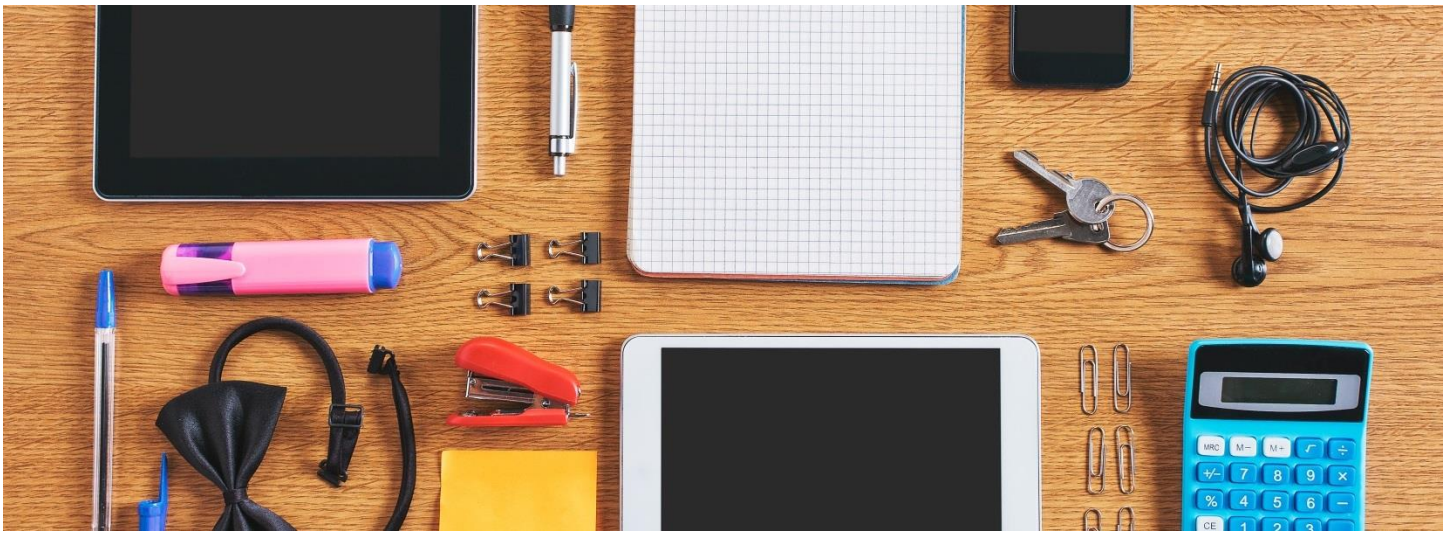
EMPLOYEE BENEFITS
INFORMATION GUIDE

CONTENTS

Colville

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

WE'VE GOT YOU COVERED



Welcome to your Benefits Information Guide!

At Colville, we are dedicated to providing you with unique benefits that meet the needs of you and your family. We understand the importance of a well-rounded benefits program, and because of that, offer a range of plans that help protect you in the case of illness or injury. You can learn about the details of these plan options by reading through this Benefit Information Guide.

Starting with the basics of how to enroll, followed by the details of each plan, this guide is a go-to resource for all things benefits related. Once you better understand the various options we offer, you can make an informed decision on which plans work best for you and your family.

We encourage you to read through this booklet in its entirety. Included you will find details about:

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

We appreciate the hard work and dedication you bring to Colville. For this and many other reasons, we want to offer you competitive and cost effective benefits. It's one way we can say thank you for your contributions.

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

Sincerely,

Eric Helzer, CEO

ELIGIBILITY & ENROLLMENT

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

Who Can Enroll

Full-time employees working a minimum of 30 hours per week are eligible to participate in the benefits program. Eligible employees may also choose to enroll eligible family members, including a legal spouse/state registered and unregistered domestic partner and/or children.

Children are considered eligible if they are:

- You or your spouse's/state registered and unregistered domestic partner's biological children, stepchildren, adopted child or foster child up to age 26
- You or your spouse's/state registered and unregistered domestic partner's children of any age if they are incapable of self-support due to a physical or mental disability

When Coverage Begins

Your enrollment choices remain in effect for the benefits plan year, January 1 through December 31. Benefits for eligible **new hires** will commence as outlined below:

Eligibility Date	Benefit Plan
The first day of the month coinciding with or next following completion of a 60-day waiting period (you must enroll within 60 days of becoming eligible)	• Medical Plan • HRA • HSA • Flexible Spending Account • Dental Plan • Vision Plan
The first day of the month coinciding with or next following completion of a 60-day waiting period (you must enroll within 60 days of becoming eligible)	• Life and AD&D • Voluntary Life and AD&D • Short and Long Term Disability

Please note: If you do not enroll for coverage during your eligibility period, you must wait until our next Open Enrollment, unless you have a qualifying event during the plan year. See next page for details.

ELIGIBILITY & ENROLLMENT

Changes during the Year

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

Generally, you may add or remove dependents from your benefits, as well as add, drop or change coverage if you submit your request for change within 60 days of the event. Examples include:

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

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

For a complete explanation of qualified status changes, please refer to the *Legal Information Regarding Your Plan* section of this guide.

Enrollment Made Easy

Paper Enrollment/Contact HR

- After reviewing your options, complete the paper enrollment forms and return to Human Resources. Forms are located in the Human Resources office.
- If you have questions when completing your enrollment forms, contact Human Resources at 907.786.8085 or kquisenberry@colvilleinc.com.

Paying for Coverage

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

Waive-Out Provision

Employees may elect to "decline" medical, dental and/or vision coverage if you have access to coverage through a spouse or through another plan. To decline coverage, you must select the "Decline Coverage" box on the Election Form.

It is important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be during our next open enrollment period (in the fall season) or when a Qualifying Status Change occurs.

MEDICAL COVERAGE

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

Your Medical Plan Options

Colville offers two plans which are administered by Meritain Health:

- a High Deductible Health Plan (HDHP) with a Health Reimbursement Account (HRA) component, and
- a Consumer Directed Health Plan (CDHP) with a Health Savings Account (HSA) component.

With both plans, you have greater flexibility and choice to use both in-network and out-of-network physicians. However, you are encouraged to receive services from Aetna in-network doctors, specialists, or facilities. By doing so, you obtain a higher level of benefit than if services were rendered from an out-of-network provider. Additional important information regarding the use of a PPO plan includes:

- You and any enrolled dependent(s) are permitted to visit any doctor or facility without a referral from a Primary Care Physician (PCP)
- Certain services, such as doctor's visits, may require a fixed-dollar payment up front, referred to as a copayment
- Before the insurance company will pay certain medical expenses, you may be required to pay a plan specific amount, referred to as the deductible
- Once the deductible has been fulfilled, the insurance company will pay a large percentage of the cost of your care, known as coinsurance. You are then financially responsible for the remaining cost up to the out-of-pocket maximum
- Claim forms are submitted to the insurance company on your behalf when services are received from within the network

To help guide your plan selection, the following sections include details concerning how the plans operate, as well as plan highlights and features. For your reference, an illustration of rates is listed in *The Cost of Health Coverage* section of this guide. Please refer to your Summary Plan Description (SPD) for a complete listing of covered services under each plan.

Your Medical Plan Options (Continued)

Using the HDHP or CDHP

While the High Deductible Health Plan (HDHP) and Consumer Directed Health Plan (CDHP) both enforce a relatively larger deductible than traditional health plans, they generally have lower payroll deductions. These medical plans encourage members to analyze their health care decisions and the type of care utilized. The plans operate as follows:

- You are financially responsible for all eligible expenses, such as doctor's or specialist visits, prescriptions and lab charges, until the deductible has been met
- Regardless of whether you have satisfied the deductible, several types of screenings, immunizations and other forms of in-network preventive care will be covered at 100%
- Once the deductible is met, the plan pays a large percentage of eligible expenses until the out-of-pocket maximum is reached
- You may use the provider of your choice, but the plan will pay more if you see in-network physicians or facilities
- After reaching the out-of-pocket maximum, covered expenses are paid at 100% for the remainder of the plan/calendar year
- The **HDHP** is paired with a Health Reimbursement Account (**HRA**) to help pay for the medical deductible
- The **CDHP** can be paired with a Health Savings Account (**HSA**) to help pay for qualified health care expenses

Meritain Health manages the health plans and Discovery Benefits administers both the HRA and HSA. The following sections contain a summary of covered services under each medical plan, as well as detailed information regarding the use of an HRA or HSA. The Summary Plan Description (SPD) contains a complete list of services covered under the medical plans.

How to Find a Provider

Before you go to the doctor or receive health care services, make sure your doctor, facility, or specialist is participating in your plan's network. This may ensure you receive the highest level of benefit and could reduce your health care costs. Check out the instructions below to find out how to perform a "Provider Search" for your plan or call Aetna at 800.343.3140 to speak with a representative.

Aetna Choice® POS II Network

1. Visit www.aetna.com/docfind/custom/mymeritain
2. Enter your search terms or choose a provider type from the list of common searches
3. In the *Select a Plan* drop down menu, select **Aetna Choice® POS II (Open Access)**

iBenefits – Employee Benefits on Your Mobile Devices

With iBenefits, you can take your Employee Benefits information on the go!

Available for iOS and Android mobile devices, the iBenefits app makes checking your benefits information easier than ever!

With iBenefits, you can:

- View our company's benefit plans, 24/7
- Access group numbers and review detailed plan information when you need it most
- Quickly contact an insurance company
- Keep up with important benefit plan announcements such as Open Enrollment dates, deadlines and more

Get it Now:

Use Company Code **colville2017** to log in to the app to view your 2017 benefits.

iBenefits

Download on the App Store

ANDROID APP ON Google play

Using Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- Tiered prescription drug plans require varying levels of payment depending on the drug's tier, and your copayment or coinsurance will be higher with a higher tier number
- Prescription drugs under the CDHP plan are subject to the medical deductible (you are financially responsible for all eligible prescription drug expenses until the medical deductible has been met)
- The plans include a four-tier prescription benefit
- **Tier 1** prescriptions offer the greatest value compared to other drugs that treat the same conditions and are often the lowest cost
- **Tier 2** drugs are generally brand-name with a medium copayment; some drugs may also be Tier 2 because they are "preferred" among other drugs that treat the same conditions
- **Tier 3** drugs are a higher copayment compared to the lower tiers, as they are higher cost drugs; some drugs on this list may have a generic counterpart in Tier 1 or Tier 2
- Many drugs on **Tier 4** are "specialty" drugs used to treat complex, chronic conditions and may require special storage or close monitoring

Watching Your Wallet?

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

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

For a current version of the prescription drug list, visit www.scripworld.com. The summary chart listed at the end of this section contains plan coverage information.

MEDICAL COVERAGE

Selecting a Plan that's Right for You

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

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

Free Preventive Health Care

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

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

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

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

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

Informing You of Health Care Reform

As of January 1, 2014, most U.S. citizens and legal residents are responsible for paying a penalty if they do not have qualifying health insurance coverage. In 2017, the penalty is the greater of 2.5% of household income or $695 per adult per year (50% of the adult penalty for children under 18 years of age), per household, up to $2,085 per tax household.

To avoid paying the penalty this year and in future years, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State Health Insurance Exchange.

For more information regarding Health Care Reform, please visit www.cciio.cms.gov.

MEDICAL PLANS

Plan Highlights [1]	HDHP w/HRA Plan		CDHP w/HSA Plan	
	In-network	Out-of-network [2]	In-network	Out-of-network [2]
Employer Fund Contributions				
Employee Only	$2,250		$1,500	
Family (applies if 2+ enroll)	$6,750		$3,000	
Annual Calendar Year Deductible				
Individual	$3,000		$3,000	
Family (applies if 2+ enroll)	$9,000		$9,000	
Maximum Calendar Year Out-of-pocket [3]				
Individual	$6,000	Unlimited	$6,000	Unlimited
Family	$12,000	Unlimited	$12,000	Unlimited
Lifetime Maximum				
Individual	Unlimited		Unlimited	
Professional Services				
Physician Visits (combined with Urgent Care visits)	First 6 visits at $30 copay; thereafter deductible & 20% coinsurance		20%	
Preventive Care Exam	Covered in full		Covered in full	
Well-baby Care	Covered in full		Covered in full	
Diagnostic X-ray and Lab	20%	50% (hospital); 20% (outpatient)	20%	50% (hospital); 20% (outpatient)
Complex Diagnostics (MRI/CT Scan)	20%	50% (hospital); 20% (outpatient)	20%	50% (hospital); 20% (outpatient)
Outpatient Therapies, including Physical, Occupational, Speech, Massage; Cardiac & Pulmonary Rehab; and Chronic Pain	$30 copay/visit (up to 45 visits per calendar year)		20%	50% (hospital); 20% (outpatient)
Hospital Services				
Inpatient	20%	50%	20%	50%
Outpatient Surgery	20%	50%	20%	50%
Emergency Room	$200 copay/visit, then deductible, then 20%		20%	
Urgent Care (combined with Physician Visits)	First 6 visits at $30 copay; thereafter deductible & 20% coinsurance		20%	
Maternity Care				
Preventive Prenatal Care	Covered in full		Covered in full	
All Other Prenatal Care or Postnatal Care	20%		20%	
Mental Health & Substance Abuse				
Inpatient	20%	50% (facility); 20% (physician fees)	20%	50% (facility); 20% (physician fees)
Outpatient	$30 copay/visit	50% (facility); $30 copay (all others)	20%	50% (facility); 20% (physician fees)
Retail Prescription Drugs (30-day supply)			*Medical deductible, then:*	
Tier 1	$10 copay		$10 copay	
Tier 2	$30 copay		$30 copay	
Tier 3	$50 copay		$50 copay	
Tier 4	$200 copay		$200 copay	
Mail Order Prescription Drugs (90-day supply)	2 x retail copay		2 x retail copay	

(1) Copays are not subject to the deductible unless otherwise noted. All coinsurance percentages apply after the deductible has been satisfied.

(2) Some out-of-network benefits require prior authorization for benefits to be paid at the highest level.

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

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

HEALTH REIMBURSEMENT ACCOUNT (HRA)

A Health Reimbursement Account (HRA) is an IRS-approved employer provided fund used to pay for eligible out-of-pocket health care expenses. The HDHP medical plan option offers an HRA fund to pay for your eligible health care expenses by reimbursing a portion of your medical deductible.

HRA Overview

Our Health Reimbursement Account (HRA) is administered by Discovery Benefits and works in conjunction with the HDHP medical plan option.

Colville makes contributions to your HRA based on your coverage tier (individual or family) on an annual basis:

- If you have individual (employee-only) coverage, the annual maximum for deductible reimbursement is $2,250
- If you have family coverage, the annual maximum for deductible reimbursement is $6,750
- In order to qualify for the higher family HRA contribution, your dependent(s) must meet the Health Plan's definition of an eligible dependent and be enrolled in the medical plan
- Per IRS regulations, employees may not contribute to an HRA, as an HRA must be solely funded by an employer

Receiving HRA Funds

Discovery Benefits is the administrator of our Health Reimbursement Account.

- The HRA will be set-up automatically upon enrollment
- Requests for reimbursement of your medical deductible must be made no later than 90 days after the end of the plan year using the proper form along with your claim number and appropriate documentation. Claims may be submitted using your online account, through the Discovery Benefits mobile app, by fax at 866.451.3245 or by mail to Discovery Benefits, PO Box 2926, Fargo, ND 58108-2926
- View the status of your claims and check your HRA balance at www.discoverybenefits.com

Please review the HRA Summary Plan Description for full coverage details. Should there be a discrepancy between the information contained herein, the Summary Plan Description and/or Plan contract shall prevail.

Additional HRA Information

The *Directory & Resources* section of this guide provides information for Discovery Benefits in case you are seeking answers or help.

Additionally, the Internal Revenue Service can provide even more information to you regarding HRAs, which includes information on qualifying health care deductible expenses.

Visit http://www.irs.gov/publications/p969/ar02.html#en_US_2012_publink1000204194 or call 800.829.1040 for more information.

Please note: This is informational only and not intended to serve as legal, tax, or financial advice. Participants in an HRA should consult with their tax advisor.

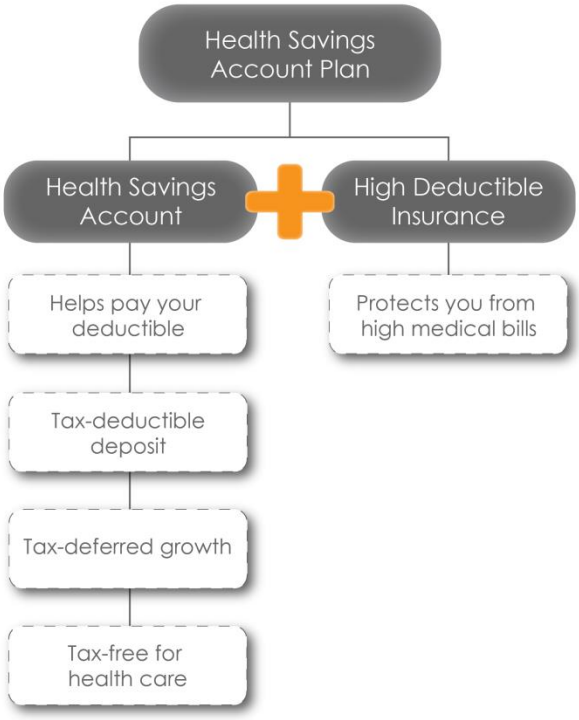
HEALTH SAVINGS ACCOUNT (HSA)

By enrolling in the CDHP, you will have access to a Health Savings Account, which provides tax advantages and can be used to pay for qualified health care expenses.

HSA Overview

Administered by an authorized financial institution, a Health Savings Account (HSA) accumulates funds that can be used to pay current and future health care costs. The HSA works in conjunction with the Consumer Directed Health Plan (CDHP), and your additional HSA contributions can reduce your federal income taxes while enabling you to pay certain health-related expenses on a tax-deductible basis.

When you incur costs while enrolled in the CDHP, you can utilize HSA dollars to help pay the deductible as well as copayments and other qualified medical, dental and vision out-of-pocket expenses, subject to funds availability. After satisfying the deductible, the plan may provide coverage for covered medical expenses.



- The funds you contribute to your HSA are tax-deductible on your tax return if contributed post-tax
- Distributions are tax-free for qualified expenses
- The amount in an HSA rolls over from year-to-year
- Because you own the HSA, the monies in the account will remain with you if you leave the company or the work force
- HSA funds accumulate tax-free interest, subject to change by State law

Advantages of an HSA

HSAs encourage consumers to purchase health care wisely, simply for the reason that you are utilizing personal funds to pay health-related expenses. Although an HSA comes with this responsibility, the CDHP with an HSA may also lend several advantages, including:

- Lower costs than traditional PPO medical plans
- Reduced taxable income and tax-free withdrawals when paying for qualified expenses
- A vehicle to save for future health needs, such as long term care premiums or health care after retirement

Qualifying for an HSA

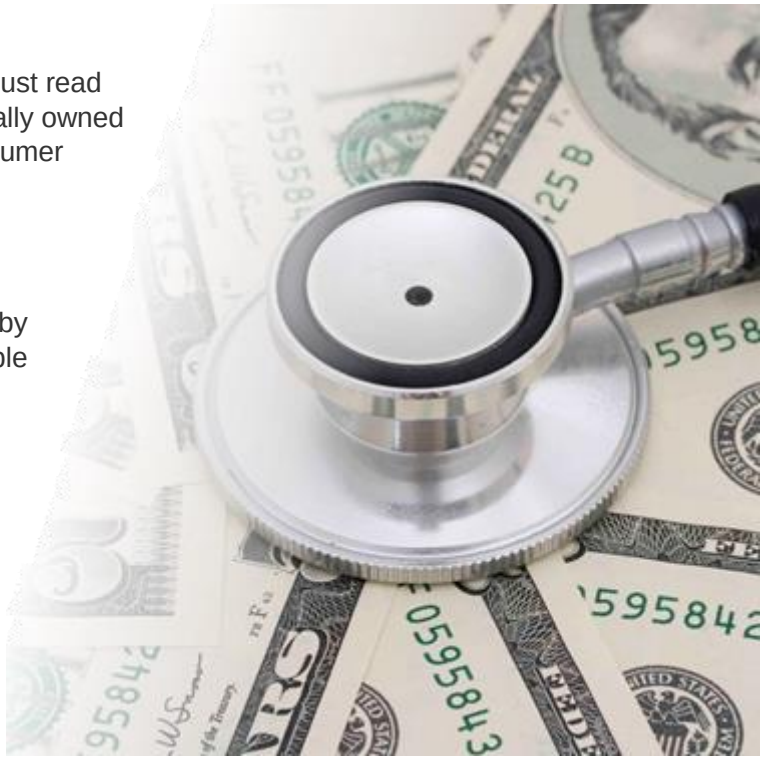
The IRS has set guidelines regarding who qualifies for an HSA. An individual is considered eligible if:

- You are covered under a *qualified* high deductible health plan, such as the CDHP
- You do not have qualified health insurance outside of the CDHP, including access to Indian Health Services (IHS)
- You are not enrolled in Medicare or Tricare
- You are not claimed as a dependent on someone else's tax return
- You are not enrolled in a general Health Care FSA

HEALTH SAVINGS ACCOUNT (HSA)

Activating an HSA

Before participants can access their HSA funds, they must read and agree to the terms and conditions for their individually owned accounts. These agreements can be found on the consumer portal at www.discoverybenefits.com.



Access to your HSA

You can manage and access your account at any time by visiting www.discoverybenefits.com. You may not be able to view the account balance, transactions, make contributions or receive claim reimbursements from the HSA until the account is set up.

Questions regarding account activation? Contact Discovery Benefits by calling 866.451.3399 or visiting their website, www.discoverybenefits.com.

Contributing to the HSA

Eligible employees, individual family members, any other person and Colville can make financial contributions toward an individual's HSA.

Colville makes contributions to your HSA based on your coverage tier (individual or family) on an annual basis, beginning January 1, 2017:

- If you have individual (employee-only) coverage, Colville's annual contribution to your HRA is $1,500
- If you have family coverage, Colville's annual contribution to your HRA is $3,000
- In order to qualify for the higher family HSA contribution, your dependent(s) must meet the Health Plan's definition of an eligible dependent and be enrolled in the CDHP medical plan
- Per IRS regulations, employees may also contribute to an HSA

The chart below outlines the total maximum allowed amounts and other taxation information.

Contribution Amounts	Important Contribution Information
Aggregate contributions in the 2017 calendar year cannot exceed: • $3,400 for employee only • $6,750 for an employee covering dependents • $1,000 catch-up contribution only for individuals 55+ years of age	• Aggregate funds include those made by any contributing source • The maximum aggregate contribution is adjusted each year to align with inflation • A catch-up contribution is an amount in addition to the HSA maximum aggregate contribution
Please note: Consult your tax advisor for additional taxation information or advice.	

HEALTH SAVINGS ACCOUNT (HSA)

Using HSA Funds

The most convenient way to pay for qualified HSA expenses is to utilize the HSA Debit Card. You can also use your own cash or a personal credit card and request a reimbursement. It is your responsibility to keep receipts of HSA purchases in case you should ever be audited by the IRS.

Keep in mind, the IRS only allows HSA funds to pay for qualified medical, dental and vision costs incurred by the plan member or dependent(s) and will not allow for reimbursement for claim dates prior to the HSA account being open. Such examples include:

- Out-of-pocket expenses such as the high deductible and copayments
- Qualified health care expenses for services not covered under the high deductible health plan
- Some dental expenses, including braces, mouth guards and more
- Some vision expenses, including LASIK eye surgery, glasses, contacts and more
- Lab fees, X-rays and more

Explicit guidelines for determining eligible expenses have not been provided by the Internal Revenue Service (IRS); for a list of potential eligible expenses that may be covered by a Health Savings Account (HSA) visit Internal Revenue Code (IRC) section 213 (d). Also, IRS Publication 502 (Medical and Dental Expenses) may be used as a guide for what expenses may be considered by the IRS to be for medical care; however, these guidelines should be used with caution when trying to determine what expenses are reimbursable under an HSA.

Please note: This is informational only and not intended to serve as legal, tax, or financial advice. Participants in an HSA should consult their tax advisor before making any changes to their plan.

Using HSA Funds (continued)

HSA Year-to-Year Illustration

Because HSAs are employee-owned and there are no "use it or lose it" provisions, any unused funds remain in your account for future use. In the example below you'll learn just how your HSA can benefit you year after year.

Year 1: Amanda started with $2,500 in her HSA. As shown in the chart to the right, she used $580 from her HSA to pay her Year 1 medical expenses.

Amanda was not required to take any money out of her own pocket. And, because she only used $580 in Year 1, she will carry over $1,920 to Year 2.

Service Type	Year 1 $2,500 in HSA Fund
Preventive Care Exam	$0
Physicians Services	$400
Prescriptions	$180
Total Medical Expenses	**$580**
Paid by HSA Funds	**$580**
Paid by Amanda	**$0**
Remaining HSA Funds	**$1,920**

Year 2: Amanda had $1,920 remaining in her HSA from Year 1 and an additional $2,500 was contributed in Year 2 for a total of $4,420.

Amanda used $85 from her HSA to pay for her Year 2 expenses. Again, she was not required to pay any money out of pocket. Now, a total of $4,335 will carry over to Year 3, which allows her to continue using funds for future eligible expenses.

Service Type	Year 2 $2,500 in HSA Fund + Remaining from Year 1
Preventive Care Exam	$0
Office Visit for Cold	$77
Generic Prescription	$8
Total Medical Expenses	**$85**
Paid by HSA Funds	**$85**
Paid by Amanda	**$0**
Remaining HSA Funds	**$4,335**

Please Note: This example does not reflect your plan's coverage and does not take into consideration any possible payroll deduction for the HDHP. It simply provides you an illustration of how HSA funds rollover from year-to-year to be used towards future health care expenses.

Additional HSA Information

The *Directory & Resources* section of this guide provides information for contacting Discovery Benefits in case you are seeking answers or help.

Additionally, the U.S. Department of Treasury and IRS can inform individuals on what is new regarding HSAs, qualified medical expenses, qualifying for HSAs, contributions, distributions, balances, death of an account holder, forms required and more. They have also provided a comprehensive listing of Frequently Asked Questions regarding HSAs.

Call 800.829.1040 or visit www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx for more information.

FLEXIBLE SPENDING ACCOUNT (FSA)

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

FSA Overview

You may have the option to enroll in and contribute towards the following types of Flexible Spending Accounts (FSAs), helping to reduce your taxable income and pay for eligible expenses for yourself, your spouse and your eligible dependents, on a tax-free basis. The FSA plan operates on a calendar year basis from January 1 through December 31. You may participate in one or both of the following accounts:

- A **Health Care FSA** can reimburse for health care expenses that are not covered, or are only partially covered, by your medical, dental and vision insurance plans including other eligible expenses. You will have immediate access to the entire annual contribution amount from the first day of the benefit year, before all scheduled contributions have been made. Only those who are eligible to participate in the Colville major medical coverage are eligible to participate in the Health Care FSA.
- A **Limited Purpose FSA** is the option for employees who are also enrolled in a Health Savings Account (HSA). You can elect the Limited Purpose FSA to reimburse for preventive care, dental and vision expenses, in addition to using the HSA.
- The **Day Care FSA** can be used to pay for qualified childcare and/or caregivers for a disabled family member living in the household who is unable to care for themselves. Unlike the Health Care FSA, you can only access the money that is currently in the account.

With regard to the FSA types available,

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

FLEXIBLE SPENDING ACCOUNT (FSA)

Enrolling in an FSA

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

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

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

Carryover funds from your 2017 Health FSA to 2018

Colville will offer employees the ability to carry over up to $500 from your 2017 Health Flexible Spending Account to the 2018 plan year. We have outlined what this means to Health FSA participants below:

- Although the FSA Plan Year runs from January 1, 2017 through December 31, 2017, you will have the opportunity to carryover up to $500 of any unused FSA funds from January 1, 2017 through December 31, 2017 to the January 1, 2018 through December 31, 2018 plan year and get reimbursed for expenses incurred during that time.
- If you have not had the opportunity to incur expenses during the plan year, this provision allows you additional time to incur expenses, up to the amount of your carryover.
- The plan will allow a "run-out period" from January 1, 2018 through March 31, 2018, allowing you to seek reimbursement for expenses 3 months after the plan year ends on December 31, 2017.
- The amount of your carryover from 2017 will not affect your annual maximum allowed contribution to your 2018 FSA.
- Remember, any remaining amounts above $500 that are not submitted for expenses incurred between January 1, 2017 and December 31, 2017 to Discovery Benefits by the end of the "run-out period", March 31, 2018, will be forfeited.

Any questions? Be sure to contact Discovery Benefits at 866.451.3399.

FLEXIBLE SPENDING ACCOUNT (FSA)

Using Your Funds

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

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

[(1)] **Please note:** This is informational only and not intended to serve as legal, tax, or financial advice. Participants in a Health Care FSA or Day Care FSA should consult their tax advisor before making any changes to their plan.

If you are at a participating FSA merchant when you incur eligible expenses, use your FSA debit card to complete your transaction. Each FSA enrolled employee receives one debit card, which is mailed to the address on file with Discovery Benefits.

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

FLEXIBLE SPENDING ACCOUNT (FSA)

Contributing to Your Accounts

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

Account Type	Contribution Limit
Health Care FSA	• You can contribute up to $2,600 pre-tax in 2017
Day Care FSA	• If you are single, you can contribute up to $5,000 pre-tax in 2017 • If you are married and filing a joint tax return or you are head of a household, you can contribute up to a combined $5,000 pre-tax in 2017 • If you are married and file separately, you can contribute up to $2,500 pre-tax in 2017
Please note: Consult your tax advisor for additional taxation information or advice.	

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

Health Care FSA Worksheet

Eligible Expenses Enter the amount not covered or reimbursed by your health care plans:	Annual Estimated Amount
Deductibles (medical, dental and vision)	$_____
Copayments and coinsurance amounts	$_____
Charges above the amount payable by your health care plans	$_____
Medical, dental, orthodontia and vision care expenses not covered by your or your dependents' health care plans	$_____
Prescription drug expenses	$_____
Other potential eligible expenses as identified in IRC section 213 (d) and IRS Publication 502	$_____
Total Estimated Health Care Expenses (maximum annual allowed contribution of $_____)	**$**_____

Day Care FSA Worksheet

Eligible Expenses	Annual Estimated Amount
Tax deductible wages or salary paid to a baby-sitter or companion in or outside of your home residence	$_____
Services of a daycare center and/or nursery school	$_____
Cost of care at facilities away from home, such as family daycare or adult daycare centers	$_____
Wages paid to an individual for providing care for an eligible dependent	$_____
Other potential eligible expenses as identified in IRC sections 129 and 21 and IRS Publication 503	$_____
Total Estimated Dependent Care Expenses (maximum annual allowed contribution of $_____)	**$**_____

FLEXIBLE SPENDING ACCOUNT (FSA)

Receiving Reimbursements

You will have until March 31, 2018 to submit a reimbursement request for claims incurred between January 1 and December 31, 2017. If you do not receive automatic reimbursement by using your debit card, you can submit a manual reimbursement request by:

- **Online:** www.discoverybenefits.com
- **Mobile App:** Discovery Benefits®
- **Email:** customerservice@discoverybenefits.com
- **Fax:** 866.451.3245
- **Mail:** PO Box 2926, Fargo, ND 58108-2926

You may receive your manual reimbursement by check in the mail or by means of direct deposit into your personal Checking or Savings Account.

Use It – Don't Lose It

With this FSA, up to $500 can be carried over to the next plan year.

- So long as you incurred expenses between January 1 and December 31, 2017, and you were benefits-eligible during that time, any qualified expenses incurred within that time period can be submitted for reimbursement as late as March 31, 2018
- Any leftover amount above the $500 carryover after March 31, 2018 will be forfeited.

Saving with an FSA

Whether you are single, a working couple or have a family of four, an FSA provides more take-home pay and reduces your taxable income. The scenarios below highlight potential tax savings available through the FSA program.

	Single Person		Family of Four	
	Without FSA	With FSA	Without FSA	With FSA
Annual Salary	$36,000	$36,000	$80,000	$80,000
Annual Pre-tax Contribution	$0	$2,000	$0	$5,000
Taxable Income	$36,000	$34,000	$80,000	$75,000
Taxes Withheld [(1)]	($11,034)	($10,421)	($24,520)	($22,988)
Annual After Tax Expenses	($2,000)	$0	($5,000)	$0
Annual Take-home Pay	$22,966	$23,579	$50,480	$52,013
Increase in Annual Take-home Pay with FSA		**$613**		**$1,533**

(1) **Please note:** For example purposes, taxes were estimated at 30.65%. The tax advantages you receive will vary depending on your annual salary, tax filing status and annual contribution amount.

The FSA Health Plan and Termination

If you are a participant in your Health FSA plan and you are terminated, your funds may be preserved and you may have other options available to you at the time of termination, if applicable. It is important that you check your Summary Plan Description or contact Human Resources at 907.786.8085 if you have any further questions regarding your FSA health plan funds at the time of termination. Your failure to act in conjunction with your Health FSA plan may cause your funds to be permanently forfeited after your termination.

WELLNESS PROGRAM

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

Healthy Merits™ Wellness Program

The Healthy Merits™ Wellness Program through Meritain Health includes a variety of wellness related education and opportunities for participation during the open enrollment season, such as:

- Health assessment
- Biometric screening
- Online health courses
- Wellness campaigns
- Health coaching

Please note: Alternative standards will be made available to anyone who is medically unable to complete the programs required to earn rewards. Incentives may be taxable to the recipient. Review the Healthy Merits Wellness Program Plan Document for program details, and contact Healthy Merits at 877.348.4533 with any questions.

Program Incentives

During the open enrollment season, we will roll out the biometric screening and health risk assessments. We will provide an incentive for your participation and engagement! Employees who participate in both the biometric screening AND the health risk assessment will qualify for a $300 gift card.

Employees who choose not to participate in both the biometric screening and the health risk assessment will incur a surcharge in an amount equivalent to $300 annually (deducted with your medical premium).

Contact Human Resources with any questions.

Jumpstart Your Health

Take the steps outlined below to begin your journey to improved health and overall wellness:

- Step 1: Visit www.healthymerits.com
- Step 2: To register, click on the "Create a new account" link and follow the instructions.
- Step 3: Enter your newly created Username and Password to access the site. If you have forgotten your Username or Password, click "Forgot Password" and follow the instructions.

DENTAL COVERAGE

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

Your Dental Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan administered by Meritain Health.

Using the Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind: you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. If your dentist is not an in-network dentist you can still use your dental benefits. Additionally, no claim forms are required when using in-network PPO dentists.

Helpful Dental Hints

- Don't forget about your semi-annual Dental Cleanings! Review your plan information to learn more about what is covered under the plan
- To find an in-network dentist, visit www.aetna.com/docfind/custom/mymeritain and search the Provider Network or call 866.808.2609

Plan Highlights	Dental Plan (1)
Pre-determination Limit (2)	$450
Calendar Year Deductible	
Individual	$50
Family	$150
Annual Maximum	
Per Covered Person	$1,500
Dental Services	
Preventive	Covered in full
Basic	20% after deductible
Major	50% after deductible

(1) Claims are subject to Usual and Customary charges.

(2) When the total cost of eligible dental expenses is expected to exceed the Pre-determination Limit, the dentist's treatment plan should be sent to Meritain Health before the first date of treatment. Based on the treatment plan, Meritain Health will estimate the amount of the benefit available if treatment is performed and inform the dentist of the determination.

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

VISION COVERAGE

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

Your Vision Plan

Vision coverage is administered by Meritain Health.

Using the Plan

The vision plan is designed to give you the freedom to receive vision care from any licensed optician, optometrist or ophthalmologist of your choice. Keep in mind: you'll receive the highest level of benefit from the plan if you select an in-network provider versus an out-of-network provider who has not agreed to provide services at the negotiated rate. If your provider is not in-network, you can still use your vision benefits.

Any questions pertaining to your vision coverage can be directed to Meritain Health by calling 866.808.2609 or by visiting their website, www.meritain.com.

Can You See It?

Common daily symptoms that may suggest a problem with your vision:

- Blurriness, blind spots or halos around lights
- Frequent headaches
- Loss of sharpness
- Sitting too close to the television
- Squinting

Plan Highlights	Vision Plan
Eye Exam	10% coinsurance; 1 exam per calendar year
Hardware (Lenses, Frames, Contacts and Contact Lens Fitting)	Covered in full; $350 maximum per calendar year

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

THE COST OF HEALTH COVERAGE

The rates below are effective November 1, 2016 – October 31, 2017.

Coverage Level	Total Monthly Cost	Colville Monthly Contribution	Employee Monthly Payroll Deduction
Medical Plan – HDHP/HRA			
Employee Only	$774.85	$774.85	$0
Employee and Spouse/Domestic Partner	$1,627.18	$774.85	$852.33
Employee and Child(ren)	$1,394.72	$774.85	$619.87
Employee and Family	$2,247.06	$774.85	$1,472.21
Medical Plan – CDHP/HSA			
Employee Only	$697.36	$697.36	$0
Employee and Spouse/Domestic Partner	$1,464.46	$697.36	$767.10
Employee and Child(ren)	$1,255.25	$697.36	$557.89
Employee and Family	$2,022.35	$697.36	$1,324.99
Dental Plan			
Employee Only	$43.40	$43.40	$0
Employee and Spouse/Domestic Partner	$91.13	$43.40	$47.43
Employee and Child(ren)	$78.11	$43.40	$34.71
Employee and Family	$125.84	$43.40	$82.44
Vision Plan			
Employee Only	$20.95	$20.95	$0
Employee and Spouse/Domestic Partner	$43.99	$20.95	$23.04
Employee and Child(ren)	$37.72	$20.95	$16.77
Employee and Family	$60.76	$20.95	$39.81

Please note: Your premium contribution will be deducted from your paycheck automatically on a pre-tax basis. If you don't want your premium deducted pre-tax, you must notify HR immediately.

LIFE AND AD&D COVERAGE

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

Employer Paid Basic Life and AD&D

Paid for in full by Colville, the benefits outlined below are provided by Unum:

- Basic Life Insurance of $20,000
- Basic Life Insurance of $2,000 for employee's spouse
- Basic Life Insurance of $1,000 for employee's child
- AD&D of $20,000

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

Select Your Beneficiary

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

- You can change your beneficiary designation at any time
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the amount you specify
- To select or change your beneficiary, contact Human Resources at 907.786.8085 or kquisenberry@colvilleinc.com

DISABILITY COVERAGE

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

Short Term Disability (STD)

Administered by Unum, STD coverage provides a benefit equal to 60% of your earnings, up to $1,000 per week for a period of up to 13 weeks. The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days if the disability is due to sickness. If the disability is due to an injury, the plan begins paying benefits after 0 days.

Defining Disability Coverage

- **Benefit Period:** Maximum amount of time you may receive proceeds for a continuous disability
- **Commencement Date:** The first day your disability is covered, which immediately follows the completion of the waiting period
- **Elimination or Waiting Period:** The time you must wait before you are eligible to receive benefit payments

Long Term Disability (LTD)

If your disability extends beyond 13 weeks, the LTD coverage through Unum can replace 60% of your earnings, up to maximum of $5,000 per month. Your benefits may continue to be paid until you reach normal retirement age as long as you meet the definition of disability.

Taxation of Disability Coverage

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

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

VOLUNTARY COVERAGE

In addition to employer paid coverage, a variety of optional benefits are available for purchase if you are seeking additional insurance.

Voluntary Employee Paid Life and AD&D

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

- **For employees**: Increments of $10,000 up to 7 times salary, not to exceed $500,000.
- **For your spouse/state registered and unregistered domestic partner:** Increments of $5,000 up to a $250,000 maximum. Benefits will be paid to the employee.
- **For your child(ren):** Live birth to 6 months of age, up to a $1,000 maximum; 6 months old up to age 19 (or to age 26 if they are full-time students), up to a $10,000 maximum. Benefits will be paid to the employee.
- **Optional AD&D:** No requirements for a medical questionnaire, and coverage is available for purchase in the same amounts as optional life insurance amounts above.

If you do not elect optional life insurance when you are first eligible, you will be required to submit a health questionnaire to Unum, also known as Evidence of Insurability (EOI). An EOI will also be required if you wish to become insured for an amount greater than $110,000 or if you wish to insure a dependent for an amount greater than $50,000.

Please consider the following if you are purchasing voluntary Life/AD&D for a dependent:

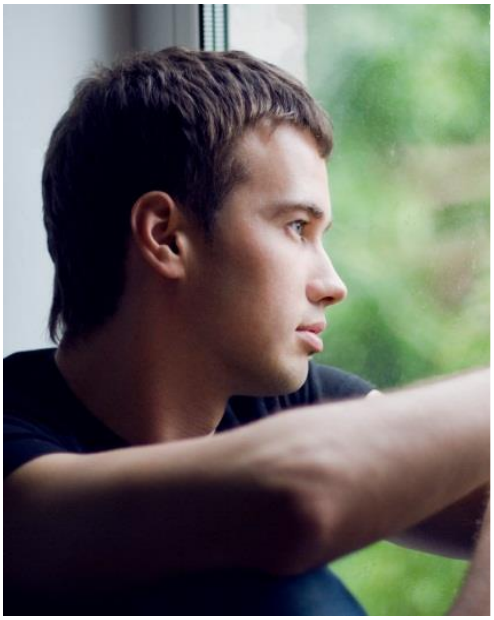
- You must purchase coverage for yourself in order to purchase coverage for your spouse or child(ren)
- Spouse amount cannot exceed 50% of the employee's supplemental Life benefit
- All children will be insured for the same amount
- For child(ren) coverage, one rate is charged for all eligible children in a family, regardless of the number

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Cost of Voluntary Coverage

	Employee	Spouse/Domestic Partner	Child
Age of Insured	**Monthly Rate per $10,000**	**Monthly Rate per $5,000**	**Monthly Rate per $2,000**
Less than 25	$0.80	$0.40	$0.50
25–29	$0.80	$0.40	
30–34	$0.80	$0.40	
35–39	$1.20	$0.60	
40–44	$2.10	$1.05	
45–49	$2.30	$1.65	
50–54	$5.60	$2.80	
55–59	$9.60	$4.80	
60–64	$13.10	$6.55	
65–69	$22.00	$11.00	
70–74	$38.70	$19.35	
75+	$64.50	$32.25	

EMPLOYEE ASSISTANCE PROGRAM (EAP)



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

Your EAP

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

Consultations are available for subjects such as:

- Child and eldercare assistance
- Access to financial experts
- Marital, relationship, parenting and family problems
- Depression, stress and anxiety
- Bereavement or grief counseling
- Substance abuse and recovery

Access Support Today!

- **By Phone:** 800.854.1446
- **Online:** www.lifebalance.net
- **Mobile App:** LifeWorks

User ID and password: lifebalance

Using the Program

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

- Up to three face-to-face sessions per issue for short-term problem resolution
- Financial services to support issues such as budgeting, controlling debt, preparing for retirement and more
- Legal services to guide you through a divorce, civil lawsuits and other topics
- Work/life services to offer referrals for important matters such as childcare and eldercare services, amongst other subjects
- Valuable consumer information on many topics such as health, wellness, career, education, legal matters and personal finances, accessible through the EAP website

ADDITIONAL BENEFITS

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

Emergency Travel Assistance

Whenever you travel 100 miles or more from home — to another country or just another city — you and your legal dependents can get support for medical, legal, and other important services through Unum.

Whether traveling for business or pleasure, one phone call connects you to:

- Multi-lingual, medically certified crisis management professionals
- A state-of-the-art global response operations center
- Qualified medical providers around the world

Benefits of emergency travel assistance include:

- Help replacing lost prescriptions and passports
- Referrals to Western-trained, English-speaking medical providers
- Hospital admission assistance
- Emergency medical evacuation
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Critical care monitoring and emergency trauma counseling
- Legal and interpreter referrals
- 24/7 services anywhere in the world

Access Travel Support Today!

- **By Phone:** 800.872.1414 *(within the U.S.)* (U.S. access code)+609.986.1234 *(abroad)*
- **Online:** www.assistamerica.com
- **Mobile App:** Assist America

Reference number: 01-AA-UN-762490

BridgeHealth Surgery Program

BridgeHealth is a program offered as part of your health plan—at no additional charge to you. The program provides you with access to highly rated providers for certain non-emergency surgeries like knee replacement or back surgery. BridgeHealth also helps your employer save on healthcare costs—and those savings are passed on to you.

By participating in the BridgeHealth program, you will qualify for an incentive of up to $500. Contact Human Resources for more information.

How it works

- Contact a care coordinator at 1.888.387.3909 or email support@bridgehealth.com before you schedule surgery
- Receive care from a top-rated provider in the BridgeHealth network. For you, this means a better outcome and faster recovery
- Reduce your out-of-pocket medical costs for savings in the thousands!

To learn more about the BridgeHealth Surgery Program, simply contact a care coordinator at 1.888.387.3909, email support@bridgehealth.com or visit www.bridgehealth.com.

BridgeHealth™

PLAN GUIDELINES AND EVIDENCE OF COVERAGE

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

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

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

MEDICARE PART D NOTICE

Important Notice about Your Prescription Drug Coverage and Medicare

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

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

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

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

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

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

LEGAL INFORMATION REGARDING YOUR PLANS

Required Notices

Women's Health & Cancer Rights Act

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

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

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

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

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

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

Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

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

"HIPAA Special Enrollment Opportunities" include:

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

"Change in Status" Permitted Midyear Election Changes

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

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

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

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

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

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

Our Pledge regarding Health Information

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

We are required by Law to

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

The Plan will use Your Health Information for

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

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

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

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

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

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

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

Your Rights Regarding Your Health Information

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

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

The Plan's Responsibilities

The plan is required to:

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

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

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

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

LEGAL INFORMATION REGARDING YOUR PLANS

For More Information or to Report a Problem

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

Other Uses of Health Information

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

Important Information on how Health Care Reform Affects Your Plan

Grandfathered Plans

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

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

Prohibition on Excess waiting Periods

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

Preexisting Condition Exclusion

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

Continuation Coverage Rights Under COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about **your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to anyone covered under the Plan who are spouses, dependent children, or anyone else eligible for COBRA continuation coverage under the Plan.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

LEGAL INFORMATION REGARDING YOUR PLANS

How is COBRA continuation coverage provided? (Continued)

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Meritain Health, Inc.
P.O. Box 860093
Minneapolis, MN 55486-0093
(886) 808-2609

For More Information

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

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

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

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 one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

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

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

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

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

Right to Continue Coverage

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

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

How to Continue Coverage

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

What Happens if You do not Elect to Continue Coverage?

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

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

Premium for Continuing Your Coverage

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

Length of Time Coverage Can Be Continued

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

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

Reporting to Work / Applying for Reemployment

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

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

Definitions

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

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

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

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2016. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**	**OREGON – Medicaid**
Website: www.myalhipp.com Phone: (855) 692-5447	Website: www.mass.gov/masshealth Phone: (800) 462-1120	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: (800) 699-9075
ALASKA – Medicaid	**MINNESOTA – Medicaid**	**PENNSYLVANIA – Medicaid**
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: http://mn.gov/dhs/ma/ Click on Healthcare, then Medical Assistance Phone: (800) 657-3739	Website: http://www.dhs.pa.gov/hipp Phone: (800) 692-7462
ARKANSAS – Medicaid	**MISSOURI – Medicaid**	**RHODE ISLAND – Medicaid**
Website: http://myarhipp.com/ Phone: (855) 692-7447	Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005	Website: www.eohhs.ri.gov Phone: (401) 462-5300
COLORADO – Medicaid	**MONTANA– Medicaid**	**SOUTH CAROLINA – Medicaid**
Website: www.colorado.gov/hcpf Medicaid Customer Contact Center: (800) 221-3943	Website: http://dphhs.mt.gov/montanahealthcareprograms/hipp Phone: (800) 694-3084	Website: www.scdhhs.gov Phone: (888) 549-0820
FLORIDA – Medicaid	**NEBRASKA – Medicaid**	**SOUTH DAKOTA – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/hipp/ Phone: (877) 357-3268	Website: http://dhhs.ne.gov/children_family_services/accessnebraska/pages/accessnebraska_index.aspx Phone: (855) 632-7633	Website: http://dss.sd.gov Phone: (888) 828-0059
GEORGIA – Medicaid	**NEVADA – Medicaid**	**TEXAS – Medicaid**
Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: (404) 656-4507	Medicaid Website: dwss.nv.gov/ Medicaid Phone: (800) 992-0900	Website: https://www.gethipptexas.com/ Phone: (800) 440-0493
INDIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**	**UTAH – Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: (877) 438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: (800) 403-0864	Website: www.dhhs.nh.gov/oii/documens/hippapp.pdf Phone: (603) 271-5218	Medicaid Website: health.utah.gov/medicaid CHIP Website: health.utah.gov/chip Phone: (877) 543-7669
IOWA – Medicaid	**NEW JERSEY – Medicaid and CHIP**	**VERMONT– Medicaid**
Website: www.dhs.state.ia.us/hipp/ Phone: (888) 346-9562	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: (609) 631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: (800) 701-0710	Website: www.greenmountaincare.org/ Phone: (800) 250-8427
KANSAS – Medicaid	**NEW YORK – Medicaid**	**VIRGINIA – Medicaid and CHIP**
Website: www.kdheks.gov/hcf/ Phone: (785) 296-3512	Website: www.nyhealth.gov/health_care/medicaid/ Phone: (800) 541-2831	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: (800) 432-5924 CHIP Website: http://www.covera.org/programs_premium_assistance.cfm CHIP Phone: (855) 242-8282
KENTUCKY – Medicaid	**NORTH CAROLINA – Medicaid**	**WASHINGTON – Medicaid**
Website: chfs.ky.gov/dms/default.htm Phone: (800) 635-2570	Website: http://www.ncdhhs.gov/dma Phone: (919) 855-4100	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-programw Phone: (800) 562-3022 ext. 15473
LOUISIANA – Medicaid	**NORTH DAKOTA – Medicaid**	**WEST VIRGINIA – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: (888) 695-2447	Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: (844) 854-4825	Website: www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: (877) 598-5820, HMS Third Party Liability
MAINE – Medicaid	**OKLAHOMA – Medicaid and CHIP**	**WISCONSIN – Medicaid & CHIP**
Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: (800) 442-6003 TTY: Maine relay 711	Website: www.insureoklahoma.org Phone: (888) 365-3742	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: (800) 362-3002
		WYOMING – Medicaid
		Website: https://wyequalitycare.acs-inc.com Phone: (307) 777-7531

To see if any other States have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

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

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

DIRECTORY & RESOURCES

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

Information Regarding	Group/Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources: Kristen Quisenberry HR and Benefits Administrator		907.786.8085	kquisenberry@colvilleinc.com
Medical/Dental/Vision Benefits			
Meritain Health Customer Service	15315	866.808.2609	www.meritain.com
Aetna Choice® POS II Provider Network			
Aetna Provider Line	15315	866.808.2609	www.aetna.com/docfind/custom/mymeritain
Precertification			
Meritain Health Medical Management	15315	800.242.1199	
Prescription Drug Benefits			
Scrip World Customer Service	15315	866.475.7589	www.scripworld.com
Fund Accounts (HRA, HSA and FSA)			
Discovery Benefits		866.451.3399	www.discoverybenefits.com
Healthy Merits™ Wellness Program			
Meritain Health	15315	877.348.4533	www.healthymerits.com
Life, AD&D and Disability			
Unum • Group Life, AD&D, Disability • Voluntary Life and AD&D	 851189 851190	866.679.3054	www.unum.com
Employee Assistance Plan			
Unum	851189	800.854.1446 800.999.3004 TTY/TDD	www.lifebalance.net *user ID and password:* lifebalance
Surgery Program			
BridgeHealth		888.387.3909	www.bridgehealth.com
Travel Assistance			
Unum	851189	*Within the U.S.:* 800.872.1414 *Outside the U.S.:* (U.S. access code) +609.986.1234	www.unum.com medservices@assistamerica.com *Reference number:* 01-AA-UN-762490
Benefits Broker			
Maria Suavillo Marsh & McLennan Agency LLC 1031 West 4th Avenue, Suite 400 Anchorage, AK 99501		907.257.6305	maria.suavillo@marshmc.com

NOTES

Prepared by: **Marsh & McLennan Agency LLC**
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