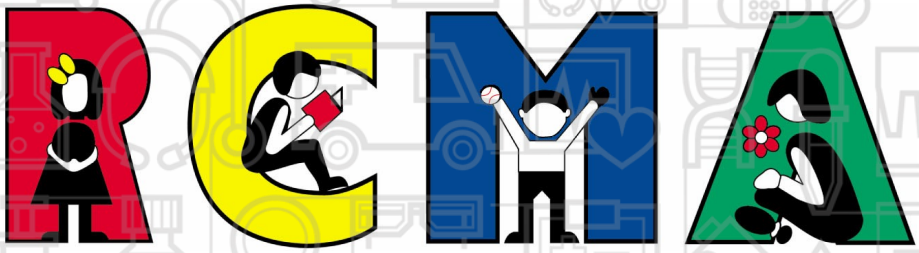

2020/2021 Employee Benefit Enrollment Guide

Effective June 1, 2020—May 31, 2021

Notes

Overview

OUR COMMITMENT

Our benefit program is designed to offer you appropriate health coverage for you and your family. Please review this guide for options available.

This guide is designed to provide an overview of the coverages available. Our Company reserves the right to amend or change benefit offerings at any time.

This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations.
If any discrepancy exists between this guide and the official documents, the official documents will prevail.

Electronic notices will include (but not be limited to) newsletters, enrollment announcements, Summary Plan Descriptions (SPDs), Summaries of Material Modifications (SMMs), Summary Annual Reports (SARs), COBRA notices, Summaries of Benefits and Coverage, Health Insurance Marketplace Notices, Federal and State Guidelines as well as HIPAA certificates of creditable coverage.

BENEFITS ENROLLMENT

April is the time period during which you are able to select your benefits program for the 2020-2021 plan year. The benefit plan year runs from June 1, 2020 through May 31, 2021. Deductible and maximum out of pockets are calendar year. Details of the plan designs offered are included in this guide.

If you do not complete your enrollment through ADP, you will not be able to join the benefit plans until the next annual open enrollment period unless you experience a qualifying event. Be sure to keep a record of your elections until you have confirmed your first paycheck that you are enrolled properly.

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As a plan participant, you are entitled to a comprehensive description of your rights and obligations under our various benefit plans. In order to ensure that you fully understand the benefits available to you and your obligations as a plan participant, it is imperative that you familiarize yourself with the information within the summary plan descriptions (SPD) and summary of benefits and coverage (SBC) these can be obtained on the ADP Employee Self Service platform. ***If you would like to receive a paper copy of the SPD or SBC, please contact Human Resources and one will be provided to you free of charge.***

Important Contacts

Redlands Christian Migrant Association
Lorena Hernandez—HRIS & Benefits Manager
800-282-6540 ext. 261
lorena@rcma.org

Cindy Moreno —Benefits Analyst
800-282-6540 ext. 243
cindy.moreno@rcma.org

UMR
Medical
Group # 76412881
800-826-9781
www.umr.com

Guardian
Dental
Group # 539154
800-541-7846
www.guardiananytime.com

Humana—Vision
Vision Member Services
Group # 861088
800-865-3676
www.humana.com

Principal– Other Coverages
Short Term Disability (STD), Long Term Disability (LTD), Basic Life and AD&D, Voluntary Life
800-986-3343
www.principal.com

Employee Assistance Program (EAP)
Principal—Magellan
800-356-7089
www.magellanhealth.com/member

Real Appeal
1-844-344-7325
help@realappeal.com

If you or your dependents have any questions regarding your benefits, please feel free to contact the

EMPLOYEE CARE CENTER
AT BALDWIN KRYSTYN SHERMAN PARTNERS:
866-784-2242
mybenefits@bks-partners.com
8:30am - 5:00pm, EST

BKS PARTNERS
INSIGHT BEYOND INSURANCE

Eligibility

EMPLOYEES

You are eligible for benefits on the first of the month following , or coinciding with, a two month waiting period of continuous employment, if you are a full-time employee working at least 30 hours or more per week.

DEPENDENTS

You may also elect coverage for your dependents in some circumstances. Eligible dependents may include the following:

1. **Your Legal Spouse**
2. **Dependent Children:**

The term "child(ren)" includes:

- Any natural or legally adopted children
- Any foster children, if placed in your home with state statues prior to their 18th birthday.
- A spouse's child(ren) residing with you and dependent upon you for support; or a child whom you or your spouse have a legal obligation to support, even though not living with you.
- A dependent child who is supported primarily by you, who is incapable of self-sustaining employment because of mental or physical handicap (proof of condition and dependence must be submitted).

Type of coverage	Maximum age	End date	Coverage exceptions
Medical	Age 26 (or age 30, see exception rule)	End of the birthday month	Coverage from age 26 — 30 if they: 1. are unmarried 2. have no dependents of their own 3. live in the same state as employee or is a full-time, out-of-state student 4. don't have coverage as a named subscriber/covered person under any group health insurance plan including group, blanket or franchise health policy. 5. Not have individual health insurance or entitled benefits under Medicare. Coverage continues after age 30 if child is incapable of sustaining his/her own living. Written proof of incapacity required.
Dental	Age 26	End of the birthday month	Coverage continues to age 26 if dependent upon you for support AND resides in employee's home OR is a student
Vision	Age 26	End of the calendar year	Birth to Age 26: dependent upon you for support Age 26+ : primarily dependent upon you for support because of mental or physical handicap
Voluntary Life	Age 26	End of the birthday month	

Note: Employees are responsible for verifying eligibility of dependents (spouse/children) upon enrollment and notifying Human Resources immediately when dependents no longer meet eligibility criteria. Failure to properly report loss of eligibility can result in denied claims, loss of coverage, and additional fees will become member's responsibility.

Section 125 Pre-Tax Benefits

The Medical, Dental and Vision benefits offered by RCMA are covered under the IRS Section 125 plan. This plan allows your premium contributions to be taken out of your paycheck before taxes are applied. This results in a greater take home pay for you.

Because your share of the cost of the plan is taken from your paycheck on a pre-tax basis, the IRS requires that you only change your elections when a family status change takes place or during open enrollment. **Examples of family status change include: Marriage, Adoption, Birth, Divorce and your Spouse obtaining/losing other group coverage (through his/her employer).**

If you would like to make a plan change due to one of the listed reasons, you must notify HR within 30 days of the event. Otherwise, no changes will be allowed until the next annual open enrollment. Remember, if you change your benefit elections, your benefits premium contributions will change.

Medical

RCMA's Voluntary Medical coverage is offered through UMR. **Deductible and Plan Maximum accumulation are on a Calendar Year basis.** The networks will remain the same for 2020-2021.

Please note: the Buy Up plan does not offer any out of network coverages.

Carrier	**UMR**	
Plan	**Base Plan In Network**	**Buy-Up Plan In Network**
Year Maximum	**Calendar Year**	**Calendar Year**
Deductible *Individual* *Family (Individual / Family Maximum)*	 $2,500 $2,500 / $5,000	 $2,000 $2,000 / $4,000
Coinsurance	30%	20%
Out of Pocket *Individual* *Family*	Includes Deductible, Coinsurance, Copays & Rx $5,000 $10,000	Includes Deductible, Coinsurance, Copays & Rx $4,000 $8,000
Hospital Services		
In-Patient Hospital Services	30% after Deductible	20% after Deductible
Outpatient - Hospital	$250	$250
Outpatient - Ambulatory	$250	$100
Emergency Room	$500	$350
Urgent Care	$50	$50
Physician Services at Hospital & ER	30% after Deductible	20% after Deductible
Physician Services		
Preventive *Primary Care Physician (PCP)* *Specialist*	$0 $20 $40	$0 $20 $40
PCP Selection Required?	No	No
X-Ray and Lab *(Freestanding Facility)* *Advanced Imaging (CT Scan, PET Scan, etc.)*	**Lab** - $0 **X-Ray** - 30% after Deductible $200	**Lab** - $25 **X-Ray** - $25 $200
Prescriptions		
Tier 1 *Tier 2* *Tier 3* *Tier 4*	$25 $45 $65 20% up to $200	$20 $40 $60 20% up to $200
Mail Order Rx (90 days)	$0 Tier 1 2 x Tier 2 or 3 Copay	$0 Tier 1 2 x Tier 2 or 3 Copay
Policy Lifetime Maximums	Unlimited	Unlimited
Out of Network Benefits	**Out of Network**	**Out of Network**
Deductible *(Individual / Family)* **Coinsurance** **Out of Pocket** *(Individual / Family)*	$7,500 / $15,000 50% $10,000/$20,000	**Not Covered**

Selecting your Medical Plan & Cost Comparison Tool

Every individual and family has different medical needs. RCMA provides multiple plan options so you can determine which plan is most appropriate for your financial and medical situation.

Questions you may want to consider while choosing the right plan for you and your family are:

- How frequently do I use the plan?
- What type of claims do I incur? (Office visits, hospitalizations, prescriptions)

CONSIDER THIS EXAMPLE…

- You have Employee Only medical coverage
- You have a hospital stay for 3 days
- The hospital **BILLED AMOUNT** for your stay is **$60,000**
- THE **ALLOWABLE AMOUNT** for your stay is **$35,000**

PLAN	Base Plan Salary < $28,000	Base Plan Salary > $28,000	Buy-Up Plan
Coinsurance	**30%**	**30%**	**20%**
Allowable Amount	$35,000	$35,000	$35,000
Deductible (you pay)	($2,500)	($2,500)	($2,000)
Remaining after Deductible	$32,500	$32,500	$33,000
Coinsurance (you pay)	($2,500)	($2,500)	($2,000)
Total INSURANCE paid to Providers	$30,000	$30,000	$31,000
Total YOU paid to Providers	**($5,000)**	**($5,000)**	**($4,000)**
Annual Ins. Premium (you pay)	**($1,291)**	**($2,016)**	**($3,840)**
Total YOU paid	**$6,291**	**$7,016**	**$7,840**

Laboratory Blood Work Updates

Lab and blood work are now provided through LabCorp AND Quest Diagnostics as an in-network provider.

Quest Diagnostics™

labcorp.com

LabCorp

https://appointment.questdiagnostics.com

Please note: When using LabCorp facilities, you do **NOT** need to put a credit card on file or pay up-front to receive services ***unless*** you have previously unpaid balances. If you have an outstanding balance and refuse to pay or make payment arrangements on a prior balance then LabCorp can refuse to offer a service (even if that service is covered 100%).

OptumRx Mail Order Diabetes Drugs & Supplies

RCMA is offering **FREE** diabetic supplies and medications **through mail order only**.

Please see list of supplies and medications below.

The drugs listed below are grouped into broad categories. Each category includes an alphabetical list of drugs. Standard utilization management programs may still apply to certain drugs.

ACARBOSE
ACTOPLUS MET
ACTOPLUS MET XR
ACTOS
AFREZZA
ALOGLIPTIN
ALOGLIPTIN/METFORMIN HCL
ALOGLIPTIN/PIOGLITAZONE
AMARYL
AVANDIA
BYDUREON
BYETTA
CHLORPROPAMIDE
CYCLOSET
DUETACT
FORTAMET
GLIMEPIRIDE
GLIPIZIDE
GLIPIZIDE ER
GLIPIZIDE XL
GLIPIZIDE/METFORMIN HCL
GLUCOPHAGE
GLUCOPHAGE XR
GLUCOTROL
GLUCOTROL XL
GLUCOVANCE
GLUMETZA
GLYBURIDE
GLYBURIDE MICRONIZED
GLYBURIDE/METFORMIN HCL
GLYNASE
GLYSET
GLYXAMBI
HUMALOG
HUMALOG KWIKPEN
HUMALOG MIX 50/50
HUMALOG MIX 50/50 KWIKPEN
HUMALOG MIX 75/25
HUMALOG MIX 75/25 KWIKPEN
HUMULIN 70/30
HUMULIN 70/30 KWIKPEN
HUMULIN N
HUMULIN N KWIKPEN
HUMULIN R
HUMULIN R U-500 (CONCENTRATED)
HUMULIN R U-500 KWIKPEN
INVOKAMET
INVOKANA
JANUMET
JANUMET XR
JANUVIA
JARDIANCE
KOMBIGLYZE XR
KORLYM
LANTUS
LANTUS SOLOSTAR
METFORMIN HCL
METFORMIN HCL ER
MIGLITOL
NATEGLINIDE
ONGLYZA
PIOGLITAZONE HCL
PIOGLITAZONE HCL/METFORMIN HCL
PIOGLITAZONE HCL-GLIMEPIRIDE
PRANDIN
PRECOSE
RELION R
REPAGLINIDE
REPAGLINIDE/METFORMIN HYDROCHLORIDE
RIOMET
STARLIX
SYMLINPEN 120
SYMLINPEN 60
SYNJARDY
TOLAZAMIDE
TOLBUTAMIDE
TOUJEO SOLOSTAR
TRESIBA FLEXTOUCH
TRULICITY
VICTOZA

This list may not be all inclusive and is subject to change due to market availability of the drug.

Diabetic medications, supplies and insulin covered at zero cost share through OptumRx Order. List is subject to change.

OptumRx Mail Order forms can be found by logging on to ADP.

OPTUMRx®

Order your prescriptions easily by mail with **Optum Rx**!

NO CREDIT CARD REQUIRED FOR $0 MAIL ORDER RX

- **FREE Standard Shipping**
- **COST SAVINGS: pay less for medications with a 3-month supply**
- **24/7 ACCESS and REMINDERS: talk to a pharmacist, receive text and email reminders**

By online registration:
Visit **optumrx.com,** register and follow the simple step-by-step instructions. You can manage your medication online, including filling new prescriptions and transferring other prescriptions to home delivery. You can also set up text message reminders to help manage your medication schedule. Be sure to have your health plan ID card and medication bottles on hand.

By phone:
Just call the member phone number on the back of your plan ID card to talk with a customer service representative right now. It's helpful to have your plan ID card and medication bottle available. The representative can also contact your doctor directly if you need a new prescription.

By mail:
Ask your doctor for a new prescription for up to a three-month supply, plus refills for up to one year. Then go to **optumrx.com** and download the new prescription order form. Mail it to the address provided on the bottom of the form.

By fax / ePrescribe:
Ask your doctor to call **1-877-559-2955** for instructions on how to fax your prescription directly to OptumRx. Or your doctor can send an electronic prescription to OptumRx.

Once OptumRx receives your complete order for a new prescription, your medication should arrive within 10 business days. Completed refill orders should arrive in about seven business days.

Need your medication right away? Ask your doctor for a one-month supply that can be immediately filled at a participating retail pharmacy.

Real Appeal by UHC

Real Appeal

Weight loss that's free.* A transformation that's real.

Real Appeal® is a digital weight loss program customized to what works for you.

With Real Appeal, you learn simple steps to help you transform.

Transformation Coach

10 lbs+ Lost

4 out of 5 at-risk Real Appeal members lost an average of 10 lbs. after attending 4 online classes.[1]

Up to a year of support.

With Real Appeal, you get professional weight loss coaching from a Transformation Coach who leads your weekly online group sessions. Our coaches are experts in helping you meet your goals.

Made for real life.

A Success Kit containing step-by-step guides, workout DVDs, gear, delicious recipes, healthy kitchen cooking tools and more comes after your first group session.

100,000+ members and 1 million+ pounds lost make it real.

Enroll today at

enroll.realappeal.com

For the best experience, access Real Appeal from your own device.

*Real Appeal is offered at no additional cost to you as part of your medical benefits plan, subject to eligibility requirements.

[1]Consult with your physician or health care provider before engaging in any weight-loss program. Results may vary.

Real Appeal | 1 million pounds lost

Dental

RCMA's Voluntary Dental coverage is offered through Guardian. **Deductible and Plan Maximum accumulations are on a Calendar Year basis.**

Carrier	Guardian	
Plan	DHMO Plan In Network	PPO Plan In Network
Primary Dentist Required?	Yes	No
Individual / Family Calendar Year Deductible	N/A	$50/$150
Preventive Care		
Benefit Percentage	See Copay Schedule	0%
Deductible Waived?	N/A	Yes
Other Services		
Basic Services	See Copay Schedule	20% after Deductible
Major Services	See Copay Schedule	50% after Deductible
Endodontics/Periodontics	See Copay Schedule	Covered in Basic
Calendar Year Maximum	N/A	$1,500
Orthodontia		
Benefit Percentage	See Copay Schedule	Not Covered
Deductible Waived?	N/A	
Adult, Child(ren) Coverage	Child(ren) Only	
Calendar Year Maximum	See Copay Schedule	
Rollover Benefit		
Included?	No	Yes, $500*
Out of Network Benefits	**Out of Network**	**Out of Network**
Individual / Family Calendar Year Deductible	Not Covered	$50/$150
Preventive Care		0%
Basic Services		20% after Deductible
Major Services		50% after Deductible
Orthodontia		N/A

Notes:

- To be eligible for the rollover, a member must use their dental benefits at least one time during the plan year, not exceed $700 in claims and satisfy all applicable late entrant waiting periods. Credit is applied 60 days after plan renewal date. There is a $1250 maximum accumulated rollover. Once maximum is reached, credits must be exhausted before accumulation beings again. Member must be on plan for at least 3 years in order to hit the maximum.
- Waiting periods only apply to those who did not elect the coverage when they are first eligible for the dental insurance, as they are considered "Late Entrants" (12 month waiting period applies).

Vision

RCMA's Voluntary Vision coverage is offered through **Humana**. The plan offers coverage both In Network and Out of Network. If you utilize a provider out of the network the benefit for your services will be subject to a specific dollar reimbursement schedule (as shown in the table below).

Carrier	Humana	
Plan	**Humana Insights**	
	In Network	**Out of Network**
Eye Exam		
Exam Copay	$10	$30 Allowance
Frequency	Once Every 12 Months	
Lenses *(in lieu of contacts)*		
Singular Vision	$25	$25 Reimbursement
Bi-Focal	$25	$40 Reimbursement
Tri-Focal	$25	$60 Reimbursement
Lenticular	$25	$100 Reimbursement
Frequency	Once Every 12 Months	
Frames		
Frame Benefit / Allowance	$100 Allowance + 20% off balance	$50 Allowance
Frequency	Once Every 24 Months	
Contact Lenses *(in lieu of glasses)*		
Elective	$100 Allowance + 15% off balance	$80 Reimbursement
Medically Necessary	$0	$200 Allowance
Laser Vision Correction		
Benefit / Discount	10% Discount	N/A

***In-Network contact lens benefit ($100 allowance):**

Under your plan, the **vision exam copayment is included in the contact lens allowance.** The contact lens allowance is designed to provide you with coverage for the vision exam, contact lens evaluation, fitting and follow up fees. Remaining balances, if any, can be used towards the purchases of contact lenses from the provider.

Did you know about the LASIK discounts offered through Principal?

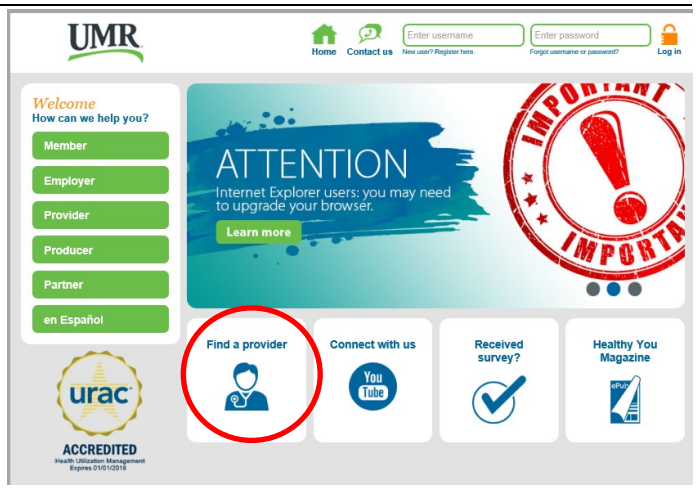
Lasik Vision Network

The LASIK network gives members excellent access to approximately 550 provider locations nationwide. Members and their eligible dependents are entitled to significant and exclusive savings. Visit http://www.principallasik.com/#/home or call 1-888-647-3937.

Locate a Provider

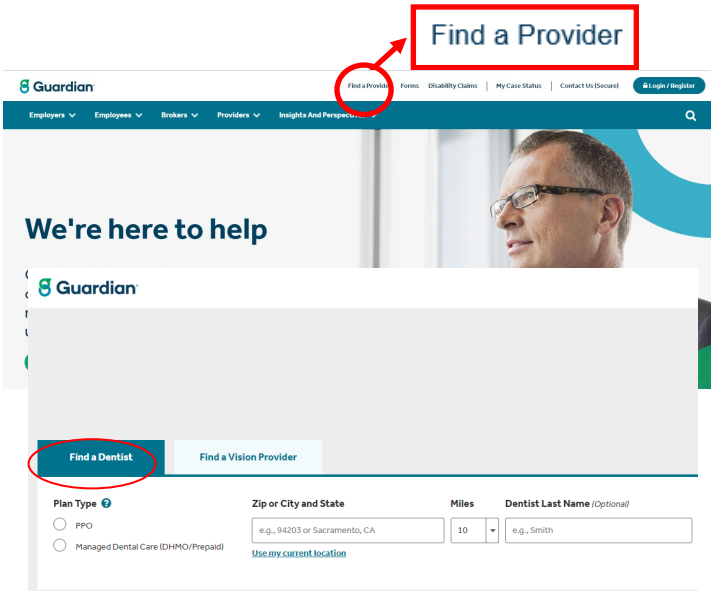
MEDICAL: UMR

1. Visit **www.umr.com**
2. Select "Find a Provider"
3. Select Medical under Provider Network Search
4. Enter network provider name: United Healthcare Choice Plus Network
5. For medical providers, choose "Search for a medical provider." For behavioral health providers (including counseling and substance abuse) select "View directory of behavioral health providers"



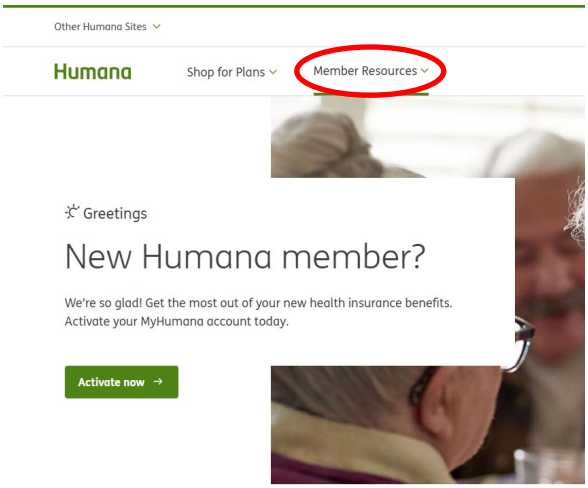
DENTAL: Guardian

1. Visit www.guardiananytime.com
2. Select "Find a Provider" at the top left of screen.
3. Select the link to "Find a Dentist."
4. Select Advanced Search:
5. Select your Dental Plan:
   - If DHMO plan, select: Managed Dental Care
   - If PPO plan, select: PPO
6. Select your Dental Network:
   - If Managed Dental Care, select: The Guardian Life Insurance Company of America
   - If PPO plan, select: DentalGuard Preferred



VISION: Humana

1. Visit: www.humana.com
2. Click on the "Find a Doctor or Pharmacy" section of the screen, under Member Resources.
3. Select "Vision" as your "Search Type". Then click on the "Go" button.
4. Select "Vision Coverage through your employer or purchased on your own" then click the "Go" button.
5. Select "Humana Insight Network" as your plan.
6. Search by the Provider's name or location. If you enter your Zip Code you can locate Providers near you.



Balance Billing:** By staying in-network, you're protected by the insurance contract and can't be charged more than what is agreed to by the plan. This is called "Balance Billing". Out of network providers are not limited in the amount they may charge and can balance-bill the difference of what the insurance paid and the billed charges. Many out of network providers do not bill insurance that they do not participate with and require that you pay for the full cost of services and materials and submit for reimbursement. ***We recommend that you use an in-network provider whenever possible.

Basic Life and AD&D

All full-time eligible employees are provided with Basic Life and AD&D. This benefit is **100% paid for by your employer**. The Basic Life and AD&D provides your beneficiary with a benefit of **$40,000**.

It is your responsibility to notify your employer as to whom should be listed as your beneficiary (ies).

Please Note– after age 70, a reduction schedule is applied to the Basic Life and AD&D benefit.

**Please speak with a lawyer prior to designating minor children as beneficiaries since children under the age of 18 cannot access life insurance benefits without the proper Trust, UTMA designation, or financial Principal arrangement in effect.*

Voluntary Life

You have the opportunity to purchase additional life insurance for you and your family. This coverage is offered through **Principal.**

Covers	Benefit Amount
Employee	You may elect life insurance in increments of **$10,000** to a maximum of **$500,000**. **The most you may elect without having to provide evidence of good health is $180,000.** This is commonly referred to as the Guarantee Issue Amount. If you elect more than the Guarantee Issue, Principal may require you to complete certain requirements to prove good health before coverage will become effective. See your Summary Plan Description for more details. *Please Note– after age 70, a reduction schedule is applied to this benefit.*
If you elect Voluntary Life Insurance for yourself, you also have the opportunity to elect coverage for your spouse and/or children.	
Spouse	You may elect life insurance in increments of **$5,000** not to exceed 50% of the employee's elected amount up to a maximum of **$250,000**. The Guarantee Issue for spousal coverage is **$50,000**. If you elect an amount that exceeds the Guarantee Issue for your spouse, your spouse will need to provide evidence of good health that is satisfactory to Principal before the excess can become effective. *Please Note– after age 70, a reduction schedule is applied to this benefit.*
Child(ren)	You may elect life insurance for your child(ren). The Guarantee Issue for child(ren) coverage is **$10,000**.

An Evidence of Insurability (EOI) Form is required if:

- ***You had previously waived coverage and are now electing the benefit (late entrant)***
- ***You are increasing your current coverage***
- ***You are electing an amount of coverage greater than the Guarantee Issue amount***
- ***You had previously waived coverage for your spouse or child and are now electing OR increasing their current coverage amount.***

Please log in to ADP for the EOI form.

Customized rates are age banded and will be confirmed via the ADP system during your enrollment.

Portability — If your employment ends, you may be eligible to continue your life insurance without submitting Proof of Good Health. You must contact your employer for the portability forms and information on how you can apply.

Conversion—If your employment ends, there are several circumstances where you and your covered dependents can convert to individual policies. You must contact your employer for the conversion forms and information on how you can apply. The purchase amount varies depending on the termination situation.

Keep in mind that you will have 31 days from the date of termination to submit the appropriate forms.

Exception If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, elected benefits will be postponed until the day after discharge from such facility; until home confinement ends; or until the dependent resumes the normal activities of someone of like age and sex.

Voluntary Short Term Disability

Short Term Disability (STD) is insurance for your paycheck. This benefit is set up to help provide you with short term income protection in the event you become ill or injured up to a period of 13 weeks. In the event of an accident you will not be required to satisfy the elimination period. Short Term Disability is offered through Principal and is 100% voluntary which means premiums are paid 100% by the employee. **If you previously waived and are newly electing this benefit, a Evidence of Insurability (EOI) is required. This form can be obtained on the ADP Employee Self Service.**

Carrier	Principal
Benefit Percentage	Increments of $25, up to Maximum Benefit
Maximum Weekly Benefit	$700 or 60%, whichever is less
Elimination Period	
Accident	1st Day
Illness	8th Day
Benefit Duration	13 weeks
***Pre-existing Limitation**	6 Months Prior / 12 Months Insured

Pre-Existing Condition:
If you are treated for a condition 6 months prior to the effective date of this policy and that condition results in a disability within 12 months, benefits will not be payable. Once you have been insured for 12 months, the pre-existing condition clause no longer applies.

Did you know maternity is a covered benefit under Short Term Disability?

However, it is only covered if you elect the benefit prior to becoming pregnant.

Example: If an employee is pregnant in May 2020 and elects the STD benefit effective June 1, 2020, the pregnancy is considered a "pre-existing condition" and not covered since the pregnancy is prior to the start of the coverage.

If an employee elects the benefit April 2020, and then becomes pregnant in January 2021, the STD benefit would be available to the employee since the pregnancy was after the start of the coverage.

Pre-Existing Condition means during the 6 months prior to the Employee's effective date of Insurance (June 1, 2020) the Employee received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines for the disabling condition. The Pre-Existing Condition Exclusion will not apply if the Employee's Total or Partial Disability begins later than 12 months after the Employee's Effective Date of Insurance or later than 12 months after the effective date of any increase in an Employee's amount of insurance.

Please see ADP for the per payroll deductions.

Long Term Disability

This benefit is offered through Principal and is **100% paid for by RCMA**. **Therefore if you become disabled and receive benefits, these benefits will become taxable income.**

Carrier	Principal
Benefit Percentage	60%
Maximum Monthly Benefit	$5,000
Benefit Duration	Social Security Normal Retirement Age
Elimination Period	90 days
Own Occupation Period	2 Years
***Pre-existing Limitation**	3 Months Prior / 12 Months Insured
Definition of Earnings	W-2 Earnings

Pre-existing Limitation: If you are treated for a condition 3 months prior to the effective date of this policy and that condition results in a disability within 12 months, benefits will not be payable. Once you have been insured for 12 months, the pre-existing condition clause no longer applies.

Premiums / Payroll Deductions

Premium Contributions

Your premium deductions each paycheck are based on your coverage elections. To determine the amount of your Medical, Dental and Vision payroll deductions, use the rate tables below.

UMR - Medical (24) Payroll Deductions	Base Plan	Buy-Up Plan
Employee Only (salary < $28,000)* Based on prior year W-2—updated annually on 6/1	$53.78	$160.00
Employee Only (salary > $28,000)* Based on prior year W-2—updated annually on 6/1	$84.00	$160.00
Employee + Spouse	$355.06	$517.69
Employee + Child(ren)	$289.80	$424.44
Employee + Family	$483.65	$703.44

Guardian - Dental	DHMO	PPO
Employee Only	$6.93	$18.86
Employee + 1	$13.24	$34.84
Employee + Family	$21.29	$56.13

Humana - Vision	
Employee Only	$3.35
Employee + Family	$9.58

Summer Deductions for Seasonal (Laid-off)

Automatic advance medical, dental and vision deductions for lay-off period (summer deductions).

To reduce administrative costs and lost premiums, RCMA began automatic advance deductions in January 2020 for seasonal staff. Deductions will be made January 15th through May 31st paycheck. Any adjustments owed to employee or to RCMA will be made upon employee's return to work after lay-off.

Family Term Life Insurance and Short-Term Disability voluntary benefit coverage will be dropped from the RCMA group at time of lay-off.

Family Term Life: During lay-off, employees can convert family term life policies to private, individual life policies. The policy change must be handled by the employee. The employee will contact The Principal Financial Group **within 30 days of lay-off** to complete required paperwork to convert their policy. (The private individual policy will be more expensive than the group rate.) When employees return from lay-off, their previous coverage will be reinstated to a group rate (whether the policy was converted during lay-off or if the policy lapsed during lay-off) with no requirement for Evidence of Insurability.

Short Term Disability: Employee is unable to convert to an individual policy while on layoff. When employees return from lay-off, their previous coverage will be reinstated with no requirement for Evidence of Insurability if 12-month time requirement has been met. The Principal Financial Group will credit any pre-existing condition time that the employee previously satisfied.

Example 1: Employee has had RCMA short term disability for 2 years. The 12 month time requirement has already been met when employee returns to work after lay-off.

Example 2: Employee was just hired and enrolled in short term disability November 1. At the time of June 1 lay-off, employee had satisfied 7 months of pre-existing condition time requirement and will need to work 5 more months at RCMA to finish the 12 month pre-existing condition time requirement for the short term disability insurance.

Principal Discounts & Services

American Hearing Benefits

Through your group benefits with Principal, you are eligible for American Hearing Benefits (AHB). This free hearing benefits program gives you access to free hearing consultations and discounts on hearing aids through our nationwide network of hearing professionals.

How the AHB process works:

Step 1 →

Call (877) 890-4694 and a Hearing Care Advisor will assist you in finding an AHB hearing care location near you.

Step 2 →

You will have your hearing evaluated to determine your hearing needs. Should a hearing aid benefit you, we will provide hearing aid options to fit your lifestyle and your budget.

Step 3

Begin your life of better hearing with AHB's 60-day trial period. Your Hearing Care Advisor and provider will be with you throughout the process to ensure we have found a solution that helps you hear best.

ARAG Services

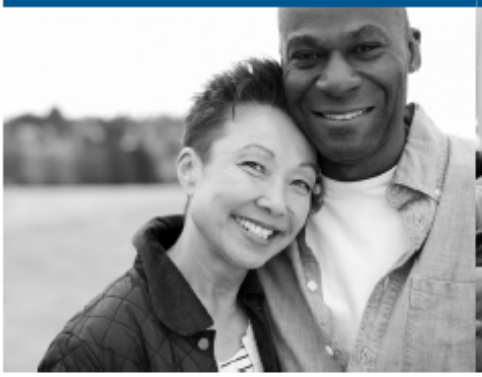
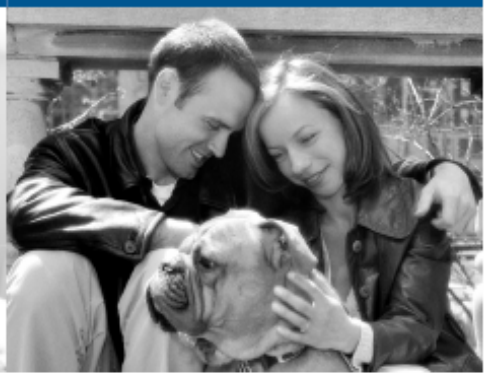
ARAG services can help in providing protection for your family, finances and future. With ARAG, services include:

- Will & Legal Document Center
  - ◊ Standard Will
  - ◊ Durable Power of Attorney
  - ◊ Living Will
- Identity Theft Kit
- Education and Tools
  - ◊ Useful Legal Links
  - ◊ Legal Terms Glossary
- Personal Information Organizer

Visit https://principal.araggroup.com/onlineDocsMVC/index.htm or call 800-546-3718.

Employee Assistance Program

Your Employee Assistance Program (EAP) offers the tools and resources you need to help you deal with life's challenges – any time, day or night. Your EAP, provided by Magellan Healthcare, provides valuable services focused on a range of concerns, including finding elder or child care, educational information about everyday topics, and ways to improve your emotional health and wellness.

I was having a terrible time trying to get to sleep. My Magellan EAP counselor recommended Computerized Cognitive Behavioral Therapy. This six-week online program helped me work through my insomnia and finally get a good night's sleep.	*As a first-time mother, I really appreciated being able to call and speak with a counselor. She helped me find parenting ideas for my toddler. With services available any time, day or night, I found the help I needed.*	*When we moved to a new state, we needed to find a good vet in our area. Magellan's EAP was able to find us a great vet not far from home. They also provided dozens of articles on pet care and health.*
		

Your EAP can also provide tools and resources on some of the following topics, and more:

- Face-to-face visits with a licensed mental health practitioner
- Web-based confidential care programs
- Self-assessment tools for identifying disorders with sleep, stress, depression or alcohol use
- Health and wellness educational guides, pre-recorded webinars, podcasts and calculators
- Finding elder and child care resources
- Medication interaction database
- Teen and adolescent issues including anorexia, dating and college preparation
- Tips on parenting and grandparenting
- Phone-based consultation with a licensed counselor and referrals to supportive resources

Visit *MagellanHealth.com/member*. You'll find valuable information and resources for your everyday, and not-so-everyday, life challenges. Remember, your EAP is available to you and your household members 24/7 by telephone or online.

Help is just a click or phone call away

Online: www.MagellanHealth.com/member
Toll-Free: 1-800-356-7089
International access: 1-800-662-4504
For TTY users: 1-800-456-4006

Employer Contributions

RCMA is committed to providing one of the most competitive benefits packages to employees and their families and contributes an average of $688 per employee for monthly medical benefits.

Medical Coverage	Annual Employee Payroll Deduction	Annual RCMA Cost	Annual Premium
Base Plan			
Employee Only (Salary < $28,000)	$1,291	**$6,703**	$7,994
Employee Only (Salary > $28,000)	$2,016	**$5,966**	$7,982
Employee & Spouse	$8,521	**$8,241**	$16,762
Employee & Children	$6,955	**$8,210**	$15,166
Family	$11,608	**$12,338**	$23,946
Buy-Up Plan			
Employee Only	$3,840	**$4,379**	$8,219
Employee & Spouse	$12,424	**$4,836**	$17,260
Employee & Children	$10,186	**$5,430**	$15,616
Family	$16,883	**$7,775**	$24,657

RCMA also pays for:

- Basic Life and AD&D premium
- Long Term Disability
- Employee Assistance Program
- Hearing Benefits
- Real Appeal Weight Loss Program
- ARAG Services (Will & Document Center, Identity Theft Kit, Education and Tools and Personal Information Organizer)
- Diabetic supplies and medications—via mail order

Affordable Care Act (ACA)

ACA Eligibility Testing

RCMA uses a 12-Month standard measurement period to measure the hours of all ongoing part-time, and variable-hour employees hired on or before the start date of a standard measurement period. If an employee is determined to be eligible for health coverage during an initial or standard measurement period, the employee must be allowed to remain enrolled in health coverage for the entire associated stability period. (see below)

Change in Status

If you are full-time, and your status changes to part time, or variable hours, during the stability period—you will continue to be covered on the insurance for a full 3 months, at which time your employer will be allowed to re-test your eligibility. If you continue to meet the hourly requirements, then you will be extended benefits through the remainder of the stability period. If you do not, then you will be removed from the benefits and will be retested at the next Measurement Period. However, if you remain qualified, but wish to terminate your coverage, this can be a Qualifying Event due to the change in compensation and hours worked. If you remain on the benefits, you will be responsible to pay your portion of the premiums regardless of the amount of pay on your checks. Based on your new status as a variable hour employee, you will be subject to the Standard Measurement Period, and may not be qualified to continue benefits upon testing for the next Stability Period.

If you are a part-time or variable hour employee and have a change in status to full-time then you may be eligible to come on to the plan, as long as you were not previously eligible (and declined) based on ACA standard testing during the previous measurement period.

Annual Testing Standards		New Hire Testing Standards	
Measurement Period	May 1-April 30	**Measurement Period**	1st day of the month, following date of hire—continues for 12 months
Administrative Period	May 1-May 31	**Administrative Period**	1st day of the month following measurement period—continues for 1 month
Stability Period	June 1– May 31	**Stability Period**	1st day of the month following administrative period—continues for 12 months

ACA Definitions

Full-Time	At time of hire or change in job classification, employee is reasonably expected to work, on average, 30 or more hours per week [1500 hours annually]
Part-Time	At time of hire or change in job classification, employee is reasonably expected to work less than 30 hours per week. [1500 hours annually]
Variable-Hour	At time of hire or change in job classification, Employer cannot reasonably determine whether employee will or will not average 30 or more hours per week. [1500 hours annually, or 125 hours in any single month]
Measurement Period	The defined time period chosen by your Employer (12 consecutive calendar months) used to determine eligibility for health benefits
Administrative Period	A period of time (one month) for Employer to measure eligibility, before the stability period begins.
Stability Period	The defined time period chosen by your Employer (12 Months) for which employees may elect and remain on the health benefits.

ACA Minimum Value and Affordability:

All of the benefit plans offered by RCMA meet affordability and minimum value standards under the Affordable Care Act (ACA). You will not be eligible to receive a premium tax credit or cost-sharing reduction subsidy if you choose to waive health benefits in order to enroll in an individual or family plan through the Health Insurance Marketplace.

If you were to enroll and claim a subsidy, you would have to repay that subsidy to the federal government at the end of the year.

Federal Guidelines

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. 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 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

AFFORDABLE CARE ACT (ACA) HEALTHCARE REFORM EXCHANGE NOTICE - Under ACA, large employers are responsible to provide eligible employees with coverage that meets the affordability and actuarial value rules set by our government. The plans offered by your employer meet these standards. You will receive a separate notice with specific information. As a result, you and/or your dependents may not be eligible for a federal or state subsidy when applying for coverage in the Healthcare Marketplace.

HIPAA– PRIVACY ACT LEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract providers.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

SECTION 111 OF JANUARY 1, 2009 Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including social security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine which plan pays first-Employer plan or Medicare/Medicaid/SCHIP for those employees covered under a government plan and an employer sponsored plan.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

MICHELLE'S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC). This law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38.The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA). See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides employees with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans' Preference.

Federal Guidelines

IMPORTANT NOTICE ABOUT HEALTHCARE REFORM EXCHANGES Under the ACA Individual Mandate, most individuals are required to obtain acceptable health insurance coverage for themselves and their family members as of January 1, 2014, or pay a penalty. Individuals may shop for private health insurance coverage through state and federal health insurance marketplaces (also called exchanges). You are not required to purchase individual coverage through the marketplace, nor does reviewing coverage options on the marketplace obligate you to purchase a plan from the marketplace.

The availability of coverage through the marketplace does not affect your eligibility for coverage through Our Groups health plan. If you are eligible for **Our Groups** plan and you choose to purchase a health insurance policy from the marketplace, you will be responsible for direct payment of your policy to the insurance carrier and the full amount of the premium cost. Since our health insurance plan meets the requirements of being both affordable and providing minimum value, you will not be eligible for a premium assistance subsidy.

In 2016, the penalty enforced for not obtaining credible health coverage is $695 per person, or up to 2.5% of household income. This penalty amount is set to increase in subsequent years and will be calculated when your annual federal taxes are filed.

HIPAA SPECIAL ENROLLMENT

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

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

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

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

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

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

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage. **For More Information or Assistance** To request special enrollment or obtain more information, please contact:

Redlands Christian Migrant Association

Lorena Hernandez

402 West Main Street

Immokalee, FL 34142

239-658-3560

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage. **Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.**

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the "Health Information Technology for Economic and Clinical Health (HITECH) Act". The HITECH Act supports the concept of electronic health records - meaningful use [EHR-MU], an effort led by Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

RESCISSIONS The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

PREVENTIVE CARE Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Federal Guidelines

PATIENT PROTECTION MODEL DISCLOSURE Our plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, UMR designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Lorena Hernandez at 239-658-3560.

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

You do not need prior authorization from UMR or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Lorena Hernandez at 239-658-3560.

HIPAA PRIVACY NOTICE The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, the right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Individual Rights You may obtain a copy of your health claims records and other health information from us typically within a 30 day period from your request. We may charge a reasonable, cost-based fee. You may ask us to correct your health/claims records if you think they are incorrect. We reserve the right to say "no" to your request, but will give you an explanation in writing within a 60 day period. Requesting a specific way to contact you for confidential reasons is permitted (home or office phone for example), specifically if you would be in danger from a certain form of communication.

If you would like us not to use or share certain health information for treatment, payment or our operations, you are permitted to do so. However, we are not required to agree to your request if it would affect your care. At your request, we will provide you with a list of the times we have shared your health information up to six years prior to your request date, who we shared it with, and why. This list will include all disclosures excluding treatment, payment, and health care operations, as well as other certain disclosures (such as any you ask us to make). We provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You can ask for a paper copy of this notice at any time, which we will promptly provide, even if you have agreed to receive the notice electronically. If you have given someone medical power of attorney or if you have a legal guardian, that person can exercise your rights and make choices about your health information. We will make sure they have this authority and can act in your interests before we take any action.

If you feel that we have violated your rights, you may contact us using the information on the back page, or file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We can assure no retaliation from us against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. You have the right and choice to tell us to share information with your family, close friends, or others involved in payment for your care, and in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest and when needed to lessen a serious and imminent threat to health or safety. We never share your information for marketing purposes of sale of your information without your expressed written consent.

Our Uses and Disclosures We typically use or share your information in several different ways. We help manage the healthcare treatment you receive by sharing information with professionals who are treating you. We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage (this does not apply to long term care plans). Our organization can use and disclose your health information as we pay for your health services, as well as disclose your health information to your health plan sponsor for plan administration.

Other Uses and Disclosures Typically in the matter of public health and safety issues, we can use and share your information. For instance, preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, as well as preventing or reducing a serious threat to anyone's health or safety, and health research.

We may need to share your information if state or federal law requires it, including the Department of Health and Human Services if it wishes to see that we're complying with federal privacy law. Other organizations and professionals we may share your information with are organ procurement organizations, coroners, medical examiners, and funeral directors. We can share your information in special instances such as for worker's compensation claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Continuation Coverage Rights under COBRA

Dear Employee, Spouse and Dependent Children:
We have been retained by your sponsoring employer to provide you with information concerning your rights under COBRA. You are receiving this notice because you have recently become covered or will become covered under your sponsoring employer's group health plan ("the Plan"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice only gives a summary of your continuation coverage rights under the Plan. For additional 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 or Discovery Benefits**.**

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

· 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 any of the following qualifying events happens:

· 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."

Qualified beneficiaries also include a child born to or placed for adoption with the covered employee who satisfies the plan eligibility requirements and becomes covered under the Plan during the period of COBRA coverage.

Retirees

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your sponsoring employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Discovery Benefits has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the sponsoring employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify Discovery Benefits of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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) causing a loss of coverage, you must notify Discovery Benefits in writing within 60 days after the later of the date the qualifying event occurs or the date that you would lose benefits due to a qualifying event. The employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event. The written notice of the qualifying event should be sent to Discovery Benefits, at the address provided in this notice, and should include all of the following:

- Date (month/day/year)
- Spouse/Dependent's Name
- Social Security Number/ID#
- Spouse/Dependent's Address
- Spouse/Dependent's Telephone #
- Gender
- Date of Birth (month/day/year)
- Relationship to Employee
- Employer's Name
- Employee's Name
- Employee's SSN/ID#
- Reason for Loss of Coverage
- Loss of Coverage (month/day/year)

If you need help acting on behalf of an incompetent beneficiary, please contact Discovery Benefits for assistance.

How is COBRA Coverage Provided?

Once Discovery Benefits 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. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your continuation coverage plus a 2% administration fee, if applicable.

How long does COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). There are two ways in which an 18-month period of COBRA continuation coverage can be extended:

1) Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA vendor in writing in a timely fashion, you and your entire family may be entitled to receive an additional 11 months of COBRA continuation coverage for a total 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 continuation coverage. The qualified beneficiary must provide the written determination of disability from the Social Security Administration to Discovery Benefits within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the qualifying event or the benefit termination date; and prior to the end of the 18-month COBRA continuation period. You will be required to pay up to 150% of the group rate during the 11- month extension.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to Discovery Benefits. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan should be addressed to the Plan Administrator of the sponsoring employer identified at the top of the first page of this document. Questions concerning your COBRA continuation coverage rights should be addressed to Discovery Benefits at the address listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Please Note

Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements. Additionally, under certain circumstances, COBRA coverage may be paid with pre-tax dollars from a cafeteria plan under Section 125.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and Discovery Benefits informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to either the Plan Administrator or Discovery Benefits.

Creditable Coverage Disclosure Notice

Medicare Part D

Important Notice from Redlands Christian Migrant Association (RCMA) About Your Prescription Drug Coverage and Medicare

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current employee coverage will not be affected. You can keep this coverage if you elect part D and the UMR plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current employer provided coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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 Social Security on the web at www.socialsecurity.gov, or call them 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 drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date	06/01/2020
Name of Entity	RCMA
Contact	Lorena Hernandez HRIS & Benefits Manager
Address	402 West St Immokalee, FL 34142
Phone	800.282.6540

SUMMARY PLAN DESCRIPTION

Please note this guide is designed to provide an overview of the coverages available. Your employer reserves the right to amend or change benefit offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations. If any discrepancy exists between this guide and the official documents, the official documents will prevail. If you would like a printed copy of the materials, please contact your employer or the Employee Care Center (ECC) and one will be provided to you.

SUMMARY OF BENEFIT COVERAGE

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is provided by your Medical carrier. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual open enrollment period, upon plan renewal and upon request at no charge to you.

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www.rcma.org

Redlands Christian Migrant Association