2021

2021 / 2022 Employee Benefit Enrollment Guide

June 1, 2021—May 31, 2022

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 2021-2022 plan year. The benefit plan year runs from June 1, 2021 through May 31, 2022. 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. 1043—**lorena@rcma.org**

Samantha Alvarado —Benefits Specialist
800-282-6540 ext. 1064
samantha.alvarado@rcma.org

Rafaela Manzano —Sr HR / Benefits Analyst
800-282-6540 ext. 1061— **rafaela@rcma.org**

UMR
Medical
Group # 76412881
800-826-9781
www.umr.com
Southern Scripts
800-710-9341
SHARx
314-451-3555

Sun Life – Dental | Vision | Life | Disability
Dental, Vision, Short and Long Term Disability, Basic Life and AD&D, Voluntary Life and AD&D - Group # 945350
800-247-6875
Dental: www.sunlife.com/findadentist
Vision: www.vsp.com | 800.877.7195

Employee Assistance Program (EAP)
CompPsych
800-460-4374
www.guidanceresources.com

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

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 27 for more details.

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

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 (End of year of age 30 if exception rule applies)	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 | Vision | 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 2021-2022.

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—30 or 60 Day Supply*		
Tier 1 Generic *Tier 2 Brand Preferred* *Tier 3 Brand Non-Preferred / Compound* *Tier 4 Specialty*	$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**

*May be subject to SHARx program, see pg. 7

Southern Scripts

Southern Scripts is our pharmacy benefit for 2021. FirstChoice is the preferred pharmacy network of Southern Scripts. There are many tools listed below to save you as much as possible.

firstchoice
southernscripts

Processing Information

Group Number: **Reference Member ID Card**
Cardholder ID Format: **Reference Member ID Card**
Bin Number: **015433**
PCN: **SSN (Southern Scripts Network, not SSN#)**
PBM: **Southern Scripts**

What is Variable Copay™?

Variable Copay™ is a free program that utilizes manufacturer-provided coupons to significantly reduce the cost on eligible medications. If your medication has a Variable Copay™ opportunity and you attempt to fill your prescription at an independent or retail pharmacy, the pharmacy will receive a rejection notice stating *"Variable Copay Opportunity Available: Please call (800) 710-9341."* **The rejection notice does not indicate that your medication is not covered but instead determines that your medication is eligible for a manufacturer coupon that will reduce the cost to you.**

CRx Specialty Solutions™ is the preferred Variable Copay™ Pharmacy, who will fill your prescription, administer the Variable Copay™ program, and provide free services such as automated shipping and refills. CRx Specialty Solutions™ will also contact your prescribing physician when additional refills are needed on your prescription.

Contacting the Variable Copay™ Pharmacy

24/7/365 support available

Should you have any issues regarding your Variable Copay™ prescription fulfillment, please call (800) 710-9341 to speak with a CRx Specialty Solutions™ Customer Care Specialist.

Name: **CRx Specialty Solutions Pharmacy**
NPI: **1336141381**

Hours of Operation
Monday-Friday
8:00am - 5:00pm CST

Contact

Toll Free:	(877) 646-1716
Fax:	(318) 214-4190
Website:	crxspecialty.com

Accessing the Southern Scripts Member Portal

To manage your prescriptions online, visit the website below and click on the link entitled **Member Portal**. Each registered member will have instant access to their benefits, prescriptions, cards, and more.

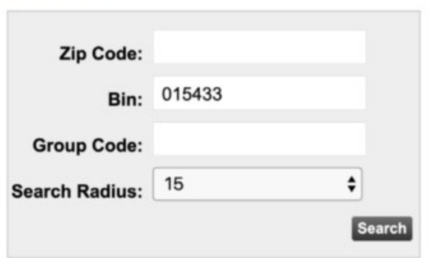
southernscripts.net/members.php

Southern Scripts

Network Pharmacy Locator

southernscripts.net/members.php

A pharmacy network is a group of pharmacies that are contracted with Southern Scripts to provide covered products and services to members at discounted rates. The Southern Scripts pharmacy network consists of independent and retail pharmacies. The Network Pharmacy Locator Tool allows members to search for a list of pharmacies near a specific location that are inclusive to the Southern Scripts pharmacy network. To access the Network Pharmacy Locator, please visit the website to the left.



1. Enter your ZIP code
2. The Southern Scripts Bin Number is **015433**
3. Enter your Group Code found on your insurance/prescription card
4. Select your search radius based on your ZIP code

Mail Order Information

Postal Prescription Services

Name: **Postal Prescription Services**
Pharmacy NPI: **1528003910**
FAQs: **ppsrx.com/topic/postal-prescription-service-faqs**

Hours of Operation

Monday-Friday
6:00am - 6:00pm PST
Saturday
9:00 AM - 2:00 PM PST

Contact

Toll Free: (800) 552-6694
Website: ppsrx.com

Covered Medications under the Pharmacy Benefit

Have questions regarding your covered medications? Please call our dedicated Customer Service Team at (800) 710-9341 for assistance.

Download the app today!

Track and manage your prescriptions fast and simple through the Southern Scripts mobile App. The Southern Scripts App stores a digital Member ID Card, current and previous Southern Scripts prescription lists, and a integrated pharmacy locator!

(800) 710-9341 | support@southernscripts.net | southernscripts.net

SHARx—High Cost Medications

SHARx is a pharmacy advocacy and concierge service, provided to you at no additional cost if enrolled in a RCMA medical plan.

The SHARx program is being offered to provide financial relief for our members who end up paying the most for their medications each year.

With SHARx, most members pay nothing for their high cost medications each month plus the convenience of the medications delivered to your home. Offering SHARx means that these high cost medications are no longer available using the insurance card at your local pharmacy or specialty pharmacy.

If you are taking a specialty medication or a medication that has a cost of $350 or more, then you should expect to hear from SHARx to enroll in the program. Participation is required.

If you are prescribed a high cost medicine, please email sharx@sharxplan.com or call 314-451-3555.

To learn more, please take 3 minutes to view this video about the SHARx program or go to: sharxplan.com.

WELCOME TO THE EMPLOYEE CARE CENTER!

As an Employee of **Redlands Christian Migrant Association,** you have access to the Employee Care Center of Baldwin Krystyn Sherman Partners.

The Employee Care Center (ECC) is a dedicated team of individuals that are here to assist you with your benefits related questions. The ECC is focused on bringing clarity to the open enrollment and claims processes, along with providing education on how and when to use your benefits to maximize efficiency and cost savings.

The ECC will help with explaining benefit plan offerings during Open Enrollment, provide instructions on how to access the carrier sites to order ID cards and find in-network providers, help with escalated claims, and advocate on behalf of the member.

866.784.2242

Available Monday – Friday

8:30 AM – 5:00 PM EST.

mybenefits@bks-partners.com

BKS-PARTNERS | INSIGHT BEYOND INSURANCE

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 provided through LabCorp AND Quest Diagnostics as an in-network provider.

labcorp.com 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%).

Southern Scripts Diabetes Drugs & Supplies

RCMA is offering **FREE** diabetic supplies and medications.*

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
Alogliptin Benzoate
Alogliptin-metFORMIN HCl
Alogliptin-Pioglitazone
Baqsimi One Pack
Baqsimi Two Pack
Diazoxide
Farxiga
Fiasp
Fiasp FlexTouch
Fiasp PenFill
Glimepiride
glipiZIDE
glipiZIDE ER
glipiZIDE XL
glipiZIDE-metFORMIN HCl
Glucagon Emergency
glyBURIDE
glyBURIDE Micronized
glyBURIDE-metFORMIN
Glyxambi
Gvoke HypoPen 1-Pack
Gvoke HypoPen 2-Pack
Gvoke PFS
HumuLIN R U-500 (CONCENTRATED)
HumuLIN R U-500 KwikPen
Insulin Asp Prot & Asp FlexPen
Insulin Aspart
Insulin Aspart FlexPen
Insulin Aspart PenFill
Insulin Aspart Prot & Aspart
Insulin Lispro
Insulin Lispro (1 Unit Dial)
Insulin Lispro Junior KwikPen
Insulin Lispro Prot & Lispro
Invokamet
Invokamet XR
Invokana
Janumet
Janumet XR
Januvia
Jardiance
Lantus
Lantus SoloStar
Levemir
Levemir FlexTouch
metFORMIN HCl
metFORMIN HCl ER
Miglitol
Nateglinide
NovoLIN 70/30
NovoLIN 70/30 FlexPen
NovoLIN 70/30 FlexPen Relion
NovoLIN 70/30 ReliOn
NovoLIN N
NovoLIN N FlexPen
NovoLIN N FlexPen ReliOn
NovoLIN N ReliOn
NovoLIN R
NovoLIN R FlexPen
NovoLIN R FlexPen ReliOn
NovoLIN R ReliOn
NovoLOG
NovoLOG FlexPen
NovoLOG Mix 70/30
NovoLOG Mix 70/30 FlexPen
NovoLOG PenFill
Ozempic (0.25 or 0.5 MG/DOSE)
Ozempic (1 MG/DOSE)
Pioglitazone HCl
Pioglitazone HCl-Glimepiride
Pioglitazone HCl-metFORMIN HCl
ReliOn Glucose
Repaglinide
Rybelsus
Soliqua
Sweet Cheeks
Synjardy
Synjardy XR
TOLBUTamide
Toujeo Max SoloStar
Toujeo SoloStar
Tresiba
Tresiba FlexTouch
Trijardy XR
Trulicity
Value Plus Glucose
Victoza
Xigduo XR
Xultophy

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 Southern Scripts. List is subject to change.

Postal Prescription Servcies Mail Order forms can be found by logging on to ADP.

*May be subject to SHARx program

Postal Prescription Services—Mail Order

Should you prefer to use Mail Order or to transfer your Mail Order prescriptions, please call Postal Prescription Services at (800) 552-6694. Customer Service hours are Monday—Friday, 9am-9pm and Saturday, noon—5pm.

Real Appeal

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.

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 2017 #1323

Dental

RCMA's Dental coverage is offered through Sun Life. The DHMO Plan is using the Florida, Prepaid Plan 225 Network.
Deductible and Plan Maximum accumulations are on a Calendar Year basis.

Carrier	Sun Life	
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?		
Adult, Child(ren) Coverage		
Calendar Year Maximum		
Rollover Benefit		
Included?	No	*Preventive Max Waiver
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:

- ***Preventive Max Waiver:** Paid preventive care does not count toward the annual maximum.
- Waiting periods 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).

Benefit Waiting Periods

• No waiting periods for exams, cleanings, and fillings.
• A Late Entrant Benefit Waiting Period of 6 months for Type II Basic Restorations, 12 months for all other Type II Basic Services, and 12 months for Class III Major Services will apply to employees who enroll in this dental plan more than 31 days after becoming eligible.
• A Late Entrant Benefit Waiting Period of 12 months for Type IV Orthodontic Services will apply to employees who enroll in this dental plan more than 31 days after becoming eligible.

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.

Vision

RCMA's Vision coverage is offered through **Sun Life on the VSP Network**. 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	**Sun Life**	
Network	**VSP**	
	In Network	**Out of Network**
Eye Exam		
Exam Copay	$10	$45 Allowance
Frequency	Once Every 12 Months	
Lenses *(in lieu of contacts)*		
Singular Vision	$25	$30 Allowance
Bi-Focal	$25	$50 Allowance
Tri-Focal	$25	$60 Allowance
Lenticular	$25	$100 Allowance
Frequency	Once Every 12 Months	
Frames		
Frame Benefit / Allowance	$130 Allowance + 20% off balance	$70 Allowance
Frequency	Once Every 24 Months	
Contact Lenses *(in lieu of glasses)*		
Elective	$130 Allowance	$105 Allowance
Medically Necessary	$0	$210 Allowance
Laser Vision Correction		
Benefit / Discount	15% Discount off regular price or 5% off promotional price	N/A

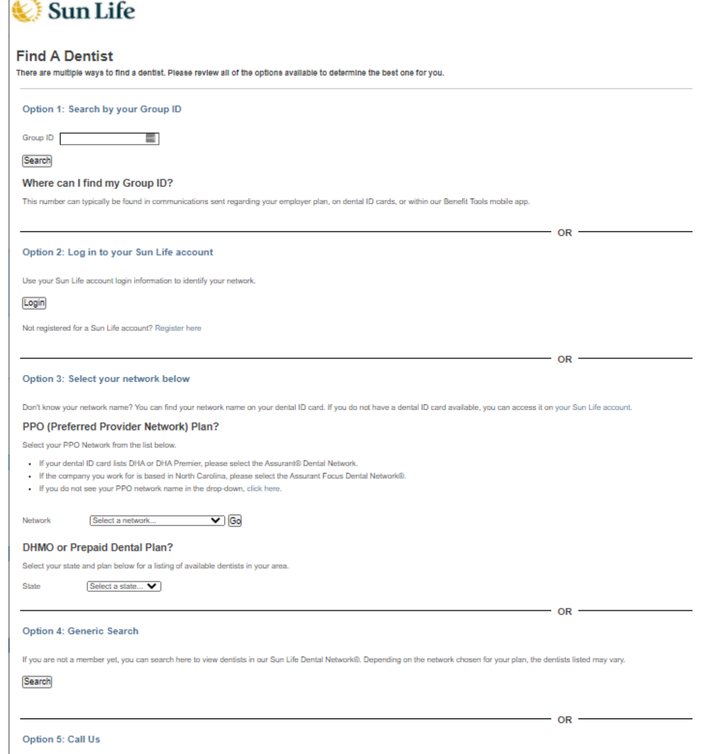
Balance Billing:** By staying in-network, you're protected by the insurance contract and can't be charged more than what is agreed to by the plan. This is called "Balance Billing". Out of network providers are not limited in the amount they may charge and can balance-bill the difference of what the insurance 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.

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: Sun Life



Online

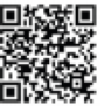
1. Visit www.sunlife.com/findadentist
2. You now have three ways to search for a dentist near you.

3. All three of these methods will bring you to the dentist search screen. Simply complete that form and a list of your local dentists will be generated.

Mobile App

Android

1. Download our mobile app, Benefit Tools (available for Android or iPhone).
2. Select Find a Dentist.
3. You now have three ways to search for a dentist near you.



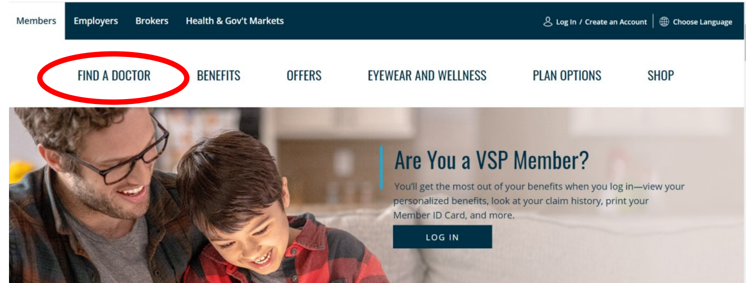
iPhone

4. All three of these methods will bring you to the dentist search screen. Simply complete that form and a list of your local dentists will be generated.

Phone 800-442-7742

VISION: Sun Life - VSP Network

1. Visit: www.vsp.com or call 800-877-7195
2. Click on “Find a Doctor” section of the screen, under Member Resources.
3. Follow the prompts to find a provider in your area.



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 through Sun Life. This benefit is **100% paid for by RCMA**. 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 and AD&D

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

Covers	Benefit Amount
Employee	You may elect life insurance in increments of **$10,000** up to **$500,000. You can elect up to $180,000 for employees under the age of 70 and $10,000 for employees over the age of 70 without having to provide evidence of insurability (EOI).** This is commonly referred to as the Guarantee Issue (GI) Amount. If you elect more than the Guarantee Issue, Sun Life will 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 100% of the employee's elected amount up to a maximum of **$250,000**. The Guarantee Issue for spousal coverage is **$50,000, if under the age of 70, and $10,000 for spouses over age 70**. 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 Sun Life before the excess can become effective. Spouse rates are based on employee age. *Please Note– after age 70, a reduction schedule is applied to this benefit.*
Child(ren)	You may elect coverage in increments of **$2,500,** up to a maximum of $ 10,000 for all of your children 14 days through the age of 26. Children between birth and 14 days have a maximum benefit of $1,000.

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

- ***You had previously waived coverage and are now electing the benefit over $10,000***
- ***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. Even if rates stay the same, as your age increases, your rates will also increase.

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.

Sun Life—(EOI)

It's the quick and easy way to submit EOI, and it's confidential.

Why use our online EOI application?

- Quick – our site leads you step by step through the process, which usually takes less than 15 minutes.
- Easy – we send you an official acknowledgment by email that your EOI application was approved or we ask you for more information in order to make a decision.

If your employer has asked you to complete an EOI application, follow the steps below to submit it online.[1]

1. Get ready to complete EOI. You may need to gather some information from your employer.

- Your group policy number
- Your location
- Coverages for yourself and for any dependents you are including in your EOI application
- Height
- Weight
- Recent medical history for you and any dependents you are including in your EOI application.

2. Access the online application:

- Sign into your account at **www.sunlife.com/account** by entering your Username and password. If you don't yet have an account, you can create one by clicking on *Create an account*.
- Once you've signed in, select *Submit Evidence of Insurability*.

3. Follow the instructions on the Evidence of Insurability screen

- Enter the information you have gathered.
- You'll be able to review your answers and then sign your application electronically before you submit it to us.
- Once you've entered all required information, please make sure to click the *Submit for review* button on the last screen.

If you don't want to create an account, you can submit EOI by visiting https://www.sunlife-usa.net/eoi/.

Sun Life—(EOI)

Frequently asked questions

What is Evidence of Insurability (EOI)?

EOI is a statement or proof of an employee's or dependent's medical history. We use it to determine whether or not to provide the benefit you are requesting.

Why am I required to submit EOI?

The reason you may need to submit EOI depends on your group policy. Usually, EOI is required if:

- you apply for additional coverage that is more than the Guaranteed Issue amount,
- you previously enrolled for the benefit and now want to increase the amount,
- you declined the benefit during your initial eligibility period and now want to enroll, or
- you elect to increase your coverage, and doing so is allowed by your group policy.

What is a Guaranteed Issue amount?

A Guaranteed Issue amount is the quantity of coverage you can receive under your group policy without having to provide EOI.

What are my Guaranteed Issue amounts and deadlines to apply for more coverage?

The Guaranteed Issue amounts and deadlines vary according to your group policy and the type of coverage. Please ask your employer for more information.

What if I apply for coverage after the deadline?

If you apply for coverage after the deadline, you will be considered a "late entrant," and the entire amount you are applying for will be subject to EOI.

Typically, the deadline to apply for coverage is 31 days from your date of eligibility. However, to confirm your actual deadlines, please ask your employer.

What if I don't want to submit EOI online or if the coverage I'm applying for does not yet have an online EOI application?

To download an EOI paper application, visit **www.sunlife.com/us** and under Client support, click on *Find a form*. You can also call us at 800-247-6875, Monday through Friday, 8:00 a.m. to 8:00 p.m. ET.

Fill it out and send it back to us by following the instructions on the application.

What happens after I submit an application online?

Your employer will confirm that you are eligible to apply for your selected coverage. Your employer will not have access to your EOI answers. As soon as your employer verifies your eligibility to apply, we will review your application and contact you by email with a decision.

We'll tell you that your application was either:

Approved

Your coverage will go into effect on the later of the approved date or benefit effective date, or

Pended

We need more information from you before we make a decision. We will be in touch with you via mail for more information.

About privacy and security

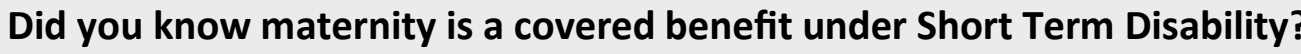
In accordance with Sun Life Financial's strict privacy practices, your answers to the health history portion of the EOI application are completely confidential and are never shown to your employer. Also, we do not share your email address or other personal information with any third parties except as permitted or required by law. Our website includes state-of-the-art security. Any information you enter is encrypted and transmitted using Secure Sockets Layer (SSL) technology.

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 Sun Life 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 2021 and elects the STD benefit effective June 1, 2021, 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 2021, and then becomes pregnant in January 2022, 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, 2021) 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**. **<u>Therefore if you become disabled and receive benefits, these benefits will become taxable income.</u>**

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	$703.45

Sun Life - Dental (24) Payroll Deductions	DHMO	PPO
Employee Only	$3.81	$17.92
Employee + 1	$5.75	$33.10
Employee + Family	$10.31	$53.33

Sun Life - Vision (24) Payroll Deductions	
Employee Only	$2.02
Employee + Family	$5.76

Summer Deductions for Seasonal (Laid-off)

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

To reduce administrative costs and lost premiums, RCMA began automatic advance deductions in January 2021 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 NOT be dropped from the RCMA group at time of lay-off.

If you choose to drop your life or short term disability coverage, then you must complete an EOI to get your coverage reinstated upon your return.

Employee Assistance Program

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues.

- Retirement, taxes, mortgages, budgeting and more

For additional guidance, we can refer you to a local financial professional and arrange to reimburse you for the cost of an initial one-hour in-person consult.

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Help for New Parents

ParentGuidance℠ supports you through the process of becoming a biological or adoptive parent, including:

- Preparing for the baby emotionally and financially
- Finding child care
- Planning for back-to-work and other issues

Free Online Will Preparation

EstateGuidance® lets you quickly and easily create a will online.

- Specify your wishes for your property
- Provide funeral and burial instructions
- Choose a guardian for your children

What happens when I call for counseling support?

When you call, you will speak with a GuidanceConsultant℠, a master's- or PhD-level counselor who will collect some general information about you and will talk with you about your needs. The GuidanceConsultant will provide the name of a counselor who can assist you. You will receive counseling through the EAP up to 3 sessions per issue, per person, per calendar year. You can then set up an appointment to speak with the counselor over the phone or schedule a face-to-face visit.

What counseling services does the EAP provide?

The EAP provides free short-term counseling with counselors in your area who can help you with your emotional concerns.

If the counselor determines that your issues can be resolved with short-term counseling, you will receive counseling through the EAP. However, if it is determined that the problem cannot be resolved in short-term counseling in the EAP and you will need longer-term treatment, you will be referred to a specialist early on and your insurance coverage will be activated.

Contact EAPBusiness Class℠ Anytime

No-cost, confidential solutions to life's challenges.

Your ComPsych® GuidanceResources® program EAPBusiness Class offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 877.595.5281
TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAPBusiness

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

GGFL-1597

Contact EAPBusiness Class Anytime

Call: 877.595.5281
TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAPBusiness

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Sun Life—Travel Emergency Assistance

TRAVEL ASSISTANCE SERVICES

Medical Consultation, Evaluation & Referral
Calls to Assist America's Operations Center are evaluated by medical personnel and referred to qualified doctors and/or hospitals.

Foreign Hospital Admission Assistance
Assist America fosters prompt hospital admission outside the United States by validating the member's health coverage or by advancing funds to the hospital as needed.

Emergency Medical Evacuation
If adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment and personnel necessary to evacuate a member to the nearest facility capable of providing a high standard of care.

Medical Monitoring
Assist America's medical personnel will maintain regular communication with the member's attending physician and/or hospital and relay information to the family, as appropriate.

Medical Repatriation
If a member still requires medical assistance upon being discharged from a hospital, Assist America will repatriate them home or to a rehabilitation facility with a medical or non-medical escort, as necessary.

Prescription Assistance
If a member needs a replacement prescription while traveling, Assist America will help in filling that prescription.

Care of Minor Children
Assist America will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.

Compassionate Visit
If a member is traveling alone and will be hospitalized for more than seven days, Assist America will provide economy, round-trip, common carrier transportation to the place of hospitalization for a designated family member or friend.

Return of Mortal Remains
Assist America will assist with the logistics of returning a member's remains home in the event of his or her death during travel.

Other non-medical emergency assistance services include:

- Return of Vehicle
- Lost Luggage & Document Assistance
- Legal & Interpreter Referrals
- Emergency Message Transmission
- Bail Bond & Emergency Cash Coordination
- Emergency Trauma Counseling
- Pre-trip Information

For more information, visit www.assistamerica.com.

ID THEFT PROTECTION SERVICES

Assist America offers prevention and resolution tools to safeguard your data and restore its integrity if it is used fraudulently. These services include:

24/7 Access to Identity Protection Experts
You have 24/7 direct emergency access to ID Theft Protection experts who can provide guidance in dealing with identity fraud issues.

Credit Card and Document Registration
Register your details using our secure website to store information from credit cards, banks and other important document in a single, centralized and secured location.

Internet Fraud Monitoring
Upon registration, we use a real-time web-crawling technology to monitor any sign of your registered personal data on suspicious sites. You will receive automatic warning notifications if it is discovered that your data is being used fraudulently.

24/7 Identity Fraud Support
If you are a victim of identity fraud, a dedicated ID Theft Protection expert will guide you in mitigating the consequences of the fraud. Your caseworker will also notify credit and debit card issuers if your credit or debit card(s) is lost or stolen.

To activate these identity protection services, visit: **www.assistamerica.com/sunlife**

DOWNLOAD THE MOBILE APP

Access a wide range of global emergency assistance services from your phone by downloading the FREE Assist America Mobile App for iPhone and Android.

The Mobile App's features include:

- **Tap for Help:** One-touch call to our 24/7 Operations Center
- **Pre-Trip Information:** Access detailed country-specific information to prepare your trip
- **Digital ID Card:** Your Assist America membership card is stored inside the App
- **Travel Alerts:** Receive alerts on urgent global situations that may impact travel
- **Travel Status Indicator:** This feature indicated when you are eligible for services
- **Embassy & U.S. Pharmacy Locator:** Locate the nearest embassy/consulate of 23 countries around the world and the nearest pharmacies in the U.S.
- **Available in 7 Languages:** English, Spanish, Arabic, Mandarin, Thai, Bahasa, and French

Complete the set-up process by entering your Assist America reference number **01-AA-SUL-100101**.

GLOBAL EMERGENCY SERVICES

Reference # 01-AA-SUL-100101

If you require assistance when traveling 100 miles from your permanent residence, or in another country, call Assist America's Operations Center at:

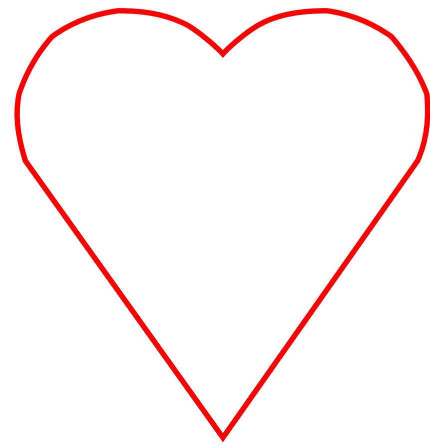
+1 609 986 1234 (outside USA - Collect Call)
+1 800 872 1414 (inside USA - Toll Free)
Or email at: medservices@assistamerica.com

***See flyer with full details, including disclaimer and conditions on ADP.**

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



also pays for:

- Basic Life and AD&D premium
- Long Term Disability
- Employee Assistance Program
- Hearing Benefits
- Real Appeal Weight Loss Program
- Emergency Travel and ID Theft Protection Services
- Diabetic supplies and medications

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

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
Human Resources
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.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

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/

WELLNESS PROGRAM Our company's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which may include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Federal Guidelines

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	06/01/2021
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.

www.rcma.org

Redlands Christian Migrant Association

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