2018 - 2019 EMPLOYEE BENEFITS GUIDE

Camino Health Center

Affiliated with Mission Hospital, St. Joseph Health

Supporting employees with a commitment to excellence and care

INTRODUCTION & EMPLOYEE RESOURCES

Flexible Solutions For Your Benefits Needs

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our organization, we are committed to providing you with a complete benefits program as part of your total compensation.

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference. If you are well-informed, you will be able to make better benefit choices that best meet your needs.

Gallagher Employee Support Center (ESC)

Gallagher Employee Support Center provides a dedicated team of specialized representatives ready to assist employees and dependents. Your Employee Support Center (ESC) is available to you via a toll free hotline Monday through Friday, 8a.m. to 4p.m. (PST) or via email inquiry.

The ESC team can support you as you utilize your employee benefits by providing education and issue advocacy when necessary. The licensed representatives will work with both providers and the insurance companies on your behalf while protecting the privacy of your healthcare information.

If you or your dependents have any questions or need assistance with selecting the right plan for you or your family, or need assistance with services listed on this page, please contact the Employee Support Center directly.

ELIGIBILITY & ENROLLMENT

New Hires/Newly Eligible for Benefits

All full-time employees who work on average at least 30 hours per week throughout the year are eligible for benefits. Your benefits are effective the 1st of the month following 30 days of employment. Once you have completed your new hire waiting period, you have 30 days to enroll for benefits. If you do not enroll within that time period, you will not be eligible for benefits until the next Open Enrollment, unless you have a Qualifying Family Status Change.

Eligible Dependents

Your eligible dependents include your legally married spouse, registered domestic partner, and children. Due to Health Care Reform, your medical, dental, and vision plans cover dependents to age 26. However, for other plans, age limits may apply.

Coverage may be available for a mentally or physically disabled child who is age 19 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact your Benefits Administrator if you believe this applies to your family.

Open Enrollment

During Open Enrollment, you will have the opportunity to make changes to your benefit elections. You must enroll by the Open Enrollment deadline for your benefits to be effective December 1st (Medical, Dental, Vision, and Life) and January 1st (FSA). Except for a Qualifying Status Change, you will not be able to change your elections until the next year's Open Enrollment.

Qualifying Status Change

If you have a qualifying family status change, you may be able to change your benefits before the next Open Enrollment. You must notify Human Resources within 30 days of the change.

Qualifying Status Includes:

- Newly hired as full-time benefits-eligible
- Change in work schedule for you or your spouse (part-time to full-time)
- Change in employment for you, your spouse or dependent (i.e. your spouse loses their job and benefits)
- Change in marital status
- Change in dependents
- Gaining other coverage through your spouse
- Loss of other coverage for your dependent
- Change in residence causing loss of coverage
- Medicare or Medicaid entitlement for you, your spouse or dependent
- Qualified Medical Child Support Order (QMCSO)

BENEFITS AT A GLANCE

BENEFITS	COVERAGE OPTIONS
Costs Shared By You & Camino Health Center	
Medical	• Blue Shield Access+ HMO Per Admit 20-500 • Blue Shield Full PPO No Network Deductible 10 100/50
Dental	• MetLife Dental PPO
Vision	• VSP Choice Network
Benefits Provided By Camino Health Center	
Basic Life and AD&D	• Mutual of Omaha – Benefit amount of 1 times annual salary up to a maximum of $50,000
Short Term Disability	• Mutual of Omaha – 30% of your basic weekly income up to $1,000 per week
Long Term Disability	• Mutual of Omaha – 60% of your basic monthly income up to $8,000 per month
Employee Assistance Plan (EAP)	• Mutual of Omaha – 24 hour toll-free telephone consultations and referral service available 7 days a week
Voluntary Employee-Paid Benefits	
Supplemental Life and AD&D for Employees	• Mutual of Omaha – Coverage in increments of $10,000 up to $300,000, not to exceed 5 times annual salary
Supplemental Life and AD&D for Dependents	• Mutual of Omaha – Spouse coverage in increments of $5,000 up to $100,000, not to exceed 100% of employee coverage amount • Mutual of Omaha – Child(ren) coverage in increments of $5,000 up to $25,000, not to exceed 100% of employee coverage amount
Flexible Spending Accounts (FSA)	• Payroll Systems Health Care FSA – $2,650 maximum plan year contribution Dependent Care FSA – $5,000 maximum plan year contribution

MONTHLY CONTRIBUTIONS

MEDICAL COVERAGE	BLUE SHIELD ACCESS+ HMO	BLUE SHIELD FULL PPO
	Employee Cost	Employee Cost
Employee Only	$0.00	$171.60
Employee + Spouse	$133.03	$510.55
Employee + Child(ren)	$88.68	$397.57
Family	$232.80	$764.76

DENTAL COVERAGE	METLIFE DENTAL PPO
	Employee Cost
Employee Only	$0.00
Employee + Spouse	$9.13
Employee +Child(ren)	$12.01
Family	$23.36

VISION COVERAGE	VSP CHOICE NETWORK
	Employee Cost
Employee Only	$0.00
Employee + One dependent	$0.89
Employee + Two or More dependents	$2.36

FIVE WAYS TO SAVE MONEY

ONE

Go to an In-Network provider

The medical plan works with a wide range of health care providers who have agreed to accept the insurance company's set rate as payment for services. If you use an Out-of-Network provider, you may be surprised when you have to pay a much higher bill out of your own pocket. Pricing for Out-of-Network claims aligns with Medicare's pricing or allowance (not "usual and customary" charges).

To find out whether or not your provider is in the network, use the Provider Finder online at www.blueshieldca.com or call Blue Shield at 800-393-6130.

TWO

Get your annual physical

If you go to an In-Network doctor then certain wellness care — like your annual physical and related lab work— is covered at 100% before the deductible.

Make sure to schedule your free annual preventive exams with your primary care doctor annually.

THREE

Do your homework before your appointment

Make sure that any high tech or high cost procedures are covered under your plan before you go to the appointment. Also, call your doctor's office ahead of any scheduled procedure to confirm that your health plan approved your service. If you don't double check, there's a chance you could be hit with a higher bill than you expected.

Visit www.blueshieldca.com or call Blue Shield at 800-393-6130 to find out whether or not your service is covered.

FOUR

Save the Emergency Room (ER) for true emergencies

The ER is the best place to go when you or a family member are experiencing a life threatening medical situation. Trips to the ER are expensive for both you and the Plan. So when the medical situation isn't urgent, know the other options for getting care.

Find an In-Network urgent care center and retail health clinic near you, so you know where to go for care when you need it.

FIVE

Purchase generic drugs

Generic drugs contain the same active ingredients as their brand-name counterparts. However, they often cost much less.

Whenever you're getting a prescription from your doctor, be sure to ask about the generic options you have.

MEDICAL PLAN OPTIONS

You have two medical plans to choose from. The medical plans provide comprehensive coverage but are different in how they are designed.

You decide which Blue Shield plan best meets your needs:

Blue Shield Access+ HMO Per Admit 20-500
Blue Shield Full PPO No Network Deductible 10 100/50

Blue Shield HMO Plan

If you choose the Blue Shield HMO plan, you must select a primary care physician who will manage your care and refer you to a specialist when it is needed. Most services are covered at 100% after you pay a copayment.

Blue Shield PPO Plan

The Blue Shield PPO plan offers a network of providers who have agreed to discount their fees for their services. You may choose to have your treatment provided by a PPO provider and receive a higher level of benefit with a lower out-of-pocket cost to you. You may also choose to go outside the network; however, generally, benefits are reimbursed at a lower level and you may have higher out-of-pocket costs.

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BLUE SHIELD MEDICAL

	ACCESS+ HMO PLAN BENEFITS	FULL PPO PLAN BENEFITS	
WHAT YOU PAY	**HMO Network**	**In Network**	**Out of Network***
Calendar Year Deductible (Single/Family)	**No Deductible**	**No Deductible**	**$500/$1,000**
Calendar Year Out-of-Pocket Maximum (Single/Family)	**$2,000/$4,000**	**$500/$1,000**	**$2,000/$4,000**
Preventive Services	**No Charge**	**No Charge**	**Not Covered**
Office Visits (Primary/Specialist)	**$20/$20**	**$10/$10**	**50%**
Lab & X-ray	**No Charge**	**$10**	**50%**
Complex Radiology (Includes CT, PET and MRI)	**No Charge**	**Radiology Center: No Charge Hospital: $100**	**Radiology Center: 50% Hospital: 50%**
Inpatient Hospital Services (Includes maternity)	**$500/Admission**	**$100/Admission**	**50%/Admission**
Outpatient Surgery	**Ambulatory Surgical Center: $125 Hospital: $250**	**Ambulatory Surgical Center: No Charge Hospital: No Charge**	**Ambulatory Surgical Center: 50% Hospital: 50%**
Urgent Care (Co-pay waived if admitted)	**$20**	**$10**	**50%**
Emergency Room (Co-pay waived if admitted)	**$100**	**$100**	**$100**
Ambulance	**$100**	**No Charge**	**No Charge**
PRESCRIPTION DRUGS			
Calendar Year Drug Deductible	**No Deductible**	**No Deductible**	
Retail Prescription (Up to a 30-day supply) (Tier 1/Tier 2/Tier 3)	**$10/$25/$40**	**$10/$25/$40**	**25% + Retail Prescription Co-pay**
Mail-Order Prescription (Up to a 90-day supply) (Tier 1/Tier 2/Tier 3)	**$20/$50/$80**	**$20/$50/$80**	**Not Covered**

** Out-of-network (OON) are subject to maximum allowed amounts. Any amount above maximum allowed amount does not apply to out-of-pocket maximum.*

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

www.blueshieldca.com

MEDICAL PREVENTIVE SERVICES

The following are examples of Preventive Services covered by your policy. For a complete list of these services, please refer to your combined Evidence of Coverage and Disclosure Form. Preventive Services are covered 100%.

CHILD PREVENTIVE CARE	MEN & WOMEN'S PREVENTIVE CARE	ADULT PREVENTIVE CARE
Screening Tests o Behavioral counseling to promote a healthy diet o Blood pressure o Cervical dysplasia screening o Cholesterol and lipid level o Depression screening o Type 2 diabetes screening o Hearing screening o Height, weight and body mass index (BMI) o Hemoglobin (blood count) o HPV screening o Lead testing o Newborn screening o Screening and counseling for obesity o Oral (dental health) assessment o Screening and counseling for STIs o Vision screening **Immunizations** o Diphtheria, tetanus and pertussis (whooping cough) o Haemophilus influenza type b o Hepatitis A and Hepatitis B o Human papillomavirus (HPV) o Influenza o Measles, mumps and rubella o Meningococcal (meningitis) o Pneumococcal (pneumonia) o Polio o Rotavirus o Varicella (Chicken Pox)	**Men** o Aortic aneurysm screening (men who have smoked) o Prostate cancer **Women** o Well-woman visits o Breast cancer testing for BRCA 1 and BRCA 2 when certain criteria are met o Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling o Contraceptive (birth control) counseling o FDA-approved contraceptive services provided by a doctor o Counseling related to chemoprevention for women with a high risk of breast cancer o Counseling related to genetic testing for women with a family history of ovarian or breast cancer o HPV screening o Screening and counseling for interpersonal and domestic violence o Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, iron deficiency, anemia, and STDs o Pelvic exam and Pap test, including screening for cervical cancer	**Screening Tests** o Behavioral counseling to promote a healthy diet o Blood pressure o Bone density test to screen for osteoporosis o Cholesterol and lipid (fat) level o Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate) o Depression screening o Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965 o Type 2 diabetes screening o Eye chart test o Obesity o STIs o Tobacco use: related screening and behavioral counseling o Violence, interpersonal and domestic: related screening and counseling **Immunizations** o Diphtheria, tetanus and pertussis o Hepatitis A and Hepatitis B o HPV o Influenza o Meningitis o Measles, mumps and rubella o Pneumococcal o Varicella (Chicken pox) o Zoster (shingles)

BLUE SHIELD TELADOC

What is Teladoc?

This service offers members convenient access to physicians who can treat many non-emergency medical issues. Available to members through phone or video consultations 24 hours a day, 365 days a year, Teladoc saves members from having to travel to a hospital emergency room, an urgent care center or their doctor's office. All of Teladoc's doctors are U.S. board-certified and state-licensed specializing in internal medicine, family practice, pediatrics and emergency medicine, and prescribe medication as needed.

Teladoc is for primary care services only, and does not include access to a specialist. Although Teladoc offers a convenient way to access care, it does not replace your personal physician.

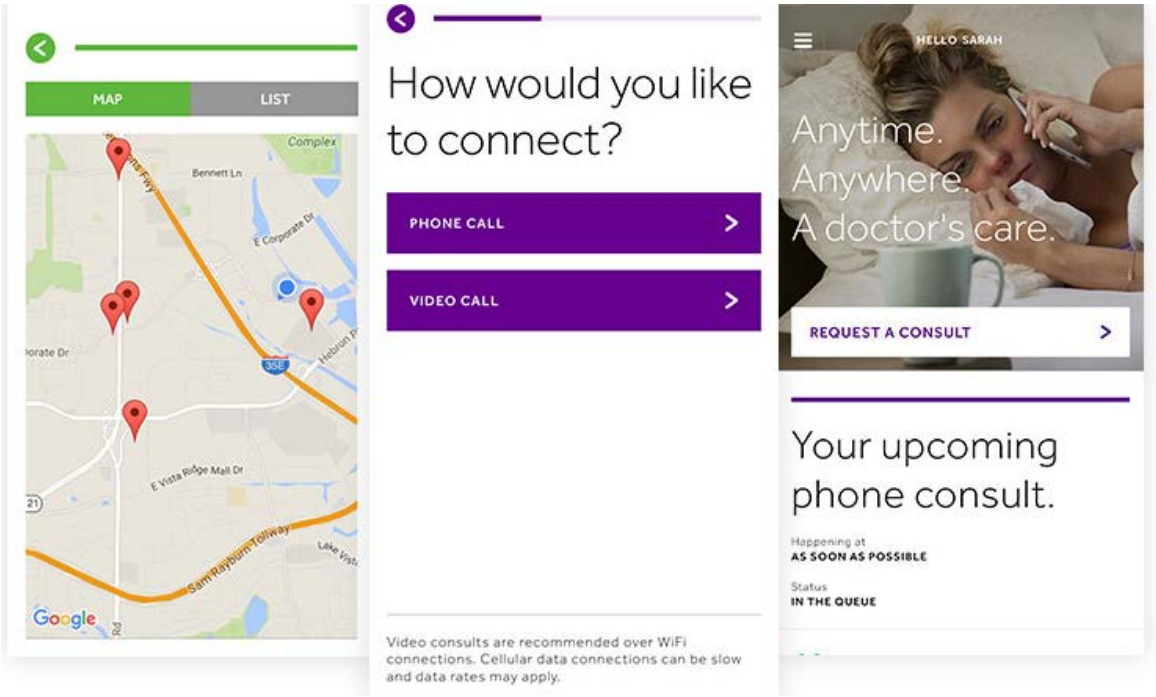
Common Uses

The most common reasons members use Teladoc include:

Sinus problems	Nasal congestion	Cough	Flu	Allergies
Ear infection	Upper respiratory infection	Urinary tract infection	Bronchitis	Pink eye

Download on the App Store

GET IT ON Google Play



BLUE SHIELD MOBILE TOOLS

Manage your health care from anywhere with the Blue Shield app. View your ID card, search for doctors, track your claim information, understand your benefits, and more. The Blue Shield app provides members enhanced 24/7 service and ease-of-access to the information that matters most.

Download on the App Store

GET IT ON Google Play

Features

- Find a doctor or urgent care
- View Blue Shield member ID card
- View deductible and copayment year-to-date totals
- View claims
- Benefits information
- NurseHelp 24/7
- Contact us

Member registration is easy!

One username and password gives you 24/7 access to your health plan information from your desktop, laptop and mobile device.

Download the mobile app today or visit www.blueshieldca.com/mobile for more details and FAQs.

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The Blue Shield mobile website and mobile apps have been designed for easier access on the go. Visit the mobile website by entering www.blueshieldca.com in your mobile phone's browser.

BLUE SHIELD PROVIDER SEARCH

Use the below steps to find In-Network physicians, urgent cares, and hospitals.

	ACCESS+ HMO Network	PPO NETWORK
STEP 1	Go to www.blueshieldca.com/findaprovider Click on **"Doctors"**	Go to www.blueshieldca.com/findaprovider Click on **"Doctors"**
STEP 2	If you are not a registered member click **"No".**	If you are not a registered member click **"No".**
STEP 3	Enter City, state or Zip and click **"Continue"**	Enter City, state or Zip and click **"Continue"**
STEP 4	Then next screen will ask **"Do you have a plan in mind?"** Click "**Yes**"	Then next screen will ask **"Do you have a plan in mind?"** Click "**Yes**"
STEP 5	Under **"Plan Year"** select **"2018"**. Under **"Plan type"** from the drop down select **"2018 Employer Groups Plans (101+ Employees)"** and under **"Subplan"** select **"Access+ HMO"**. Then click on **"Continue with this plan"**.	Under **"Plan Year"** select **"2018".** Under **"Plan type"** from the drop down select **"2018 Employer Groups Plan (101+ Employee)"** and under **"Subplan"** select **"PPO".** Then click on **"Continue with this plan"**.
STEP 6	Select Doctor Type. Scroll down to select Doctor Type. Click **"Search"** and your list will be generated.	Select Doctor Type. Scroll down to Select Doctor Type. Click **"Search"** and your list will be generated.
REMINDER	If you select: **HMO plan**: you will need to elect a Primary Care Physician and medical group. **PPO plan**: you do not need to elect a Primary Care Physician, however we recommend you confirm the provider is contract under your plan to ensure you get the most out of your coverage.	

blue california

If you would like provider search assistance, please contact the Employee Support Center at (855) 670-2222 or by email at LosAngeles.ESC@ajg.com

DENTAL & VISION PLANS

MetLife Dental PPO

You may see any dentist, but you will have a higher benefit level and lower out-of-pocket costs if you visit a MetLife PPO network dentist. Savings are greater when you visit an In Network provider because MetLife contracted dentists have agreed to provide care at a negotiated rate.

Out of Network benefit amounts are subject to the MetLife contracted fee schedule. You will be responsible for the difference between the plan payment and the dentist's usual charge.

VSP Vision Care

A vision plan is one of the most requested benefit options. We are pleased to provide an affordable vision plan. The plan utilizes the Vision Service Plan (VSP) Choice network.

VSP has one of the largest networks of private practicing optometrists, ophthalmologists, and opticians. In addition to the vision plan benefits provided through your benefits program, VSP offers a number of non-covered services at a discount.

METLIFE DENTAL PPO

DENTAL PPO PLAN BENEFITS	WHAT YOU PAY	
	In Network*	Out of Network*
Plan Maximums		
Calendar Year Deductible (Single/Family)	**No Deductible**	**$25/$75**
Calendar Year Maximum Benefit	**$1,500 per person per calendar year**	
Preventive Procedures		
Oral Examinations, Bitewing or Full Mouth X-rays, Cleanings	**0% (Deductible waived)**	**0% (Deductible waived)**
Basic Procedures		
Fillings, Endodontics (root canal therapy), Periodontics, Sealants, Simple Oral Surgery, Simple Extractions	**20%**	**20%**
Major Procedures		
Crowns, Inlays, Onlays, Cast Restorations, Bridges, Dentures	**50%**	**50%**
Implants	**50%****	**50%****
Orthodontic Procedures		
Orthodontia Lifetime Maximum	**$1,000 per person per lifetime**	
Orthodontia (Child & Adult)	**50%**	**50%**

**Reimbursement is based on PPO contracted fees for PPO dentists, and maximum allowable charges for non-MetLife dentists.*

*** Implants benefit allows service or repair of 1 per tooth position in 84 months.*

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

www.metlife.com

METLIFE PROVIDER SEARCH

Use the below steps to find contracted dentists, specialists and orthodontists.

PPO NETWORK	
STEP 1	Go to **www.metlife.com**. Under *I want to find a MetLife*: Select the **"Dentist"** tab and enter *Zip, City or State*.
STEP 2	Once the *Zip, City or State* is entered the option **"Select Type of Insurance"** will appear then select **"PDP"**. Then click submit.
STEP 3	Finally, your list will be generated
REMINDER:	**You do not need to elect a primary dental provider, but we recommend requesting pre-determination for all proposed services prior to receiving treatment to determine what the plan will cover and what your out of pocket cost will be.** ***Provider contracts are always changing with the carriers. Please call your provider to ensure that they are still in network before going to see them.***

MetLife

If you would like provider search assistance, please contact the Employee Support Center at (855) 670-2222 or by email at LosAngeles.ESC@ajg.com

VSP VISION

VISION PLAN BENEFITS	WHAT YOU PAY	
	In Network	**Out of Network***
Exams		
Vision Exam (every 12 months)	**$20 Exam Co-pay**	**Reimbursement up to $45**
Lenses		
Single Bifocal Trifocal (every 12 months)	**$20 Materials Co-pay**	**Reimbursement up to:** **$30** **$50** **$65**
Frames		
Frames (every 12 months)	**$130 Frame Allowance**, 20% off remaining balance**	**Reimbursement up to $70**
Contacts (In Lieu of Lenses & Frames)		
Medically Necessary (every 12 months)	**Covered in Full**	**Reimbursement up to $210**
Elective (every 12 months)	**$130 Contacts Lenses Allowance**	**Reimbursement up to $105**
Contact Lens Exam (fitting and evaluation)	**Up to $60 Exam Co-pay**	**Not Covered**

**Exams and Materials are subject to $20 Co-pay except for elective contact lenses if provided Out of Network.*
***Costco provides $70 Frame Allowance if frames are purchased In Network.*

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

www.vsp.com

VSP PROVIDER SEARCH

Use the below steps to find In Network optometrists and retailers.

VSP Choice Network	
STEP 1	Go to **www.vsp.com**
STEP 2	Click on **"Find a Doctor"**
STEP 3	Enter your Zip code or City & State.
STEP 4	Under Choose Network Scroll down to **"Choice"** Network
STEP 5	Click on **"Search"** and your list will be generated.

Provider contracts are always changing with the carriers. Please call your provider to ensure that they are still in network before going to see them.

If you would like provider search assistance, please contact the Employee Support Center at (855) 670-2222 or by email at LosAngeles.ESC@ajg.com

BASIC LIFE INSURANCE

This benefit is paid for 100% by Camino Health Center. There is no cost to you, the employee.

All benefit eligible employees with Camino Health Center are provided with employer-paid Life and Accidental Death & Dismemberment (AD&D) coverage. All eligible employees are automatically enrolled in Life and AD&D plans.

Employee Basic Life Insurance

- Benefit amount of 1 times annual salary up to maximum of $50,000

Accidental Death and Dismemberment (AD&D)

- 100% of the Basic Life benefit
- Provides specified benefits for a covered accidental bodily injury that directly causes dismemberment.
- In the event of death that occurs from a covered accident, both Life and AD&D benefit would be payable each in the amount of the basic life insurance.

Refer to the Mutual of Omaha plan documents for a complete description of this plan.

Benefits After Age 65

Your life benefits will reduce after age 65, and the reduction schedule is as follows:

- Reduce by 35% at age 65
- Reduce by 50% at age 70

Consider updating your Life Insurance beneficiary by completing a Beneficiary Designation form

Mutual of Omaha

SUPPLEMENTAL LIFE INSURANCE

This benefit is paid for 100% by the employee.

As an added benefit, Camino Health Center offers Supplemental Life and Accidental Death & Dismemberment (AD&D) insurance for employees, their spouse, and child(ren). This benefit is voluntary and paid for 100% by eligible employees through payroll deductions.

Supplemental Employee Life/AD&D

Employees may purchase additional coverage in $10,000 increments up to $300,000, not to exceed 5 times annual salary

- Guaranteed Issue amount*of $60,000

Supplemental Spouse Life/AD&D

You may purchase additional coverage for your spouse in $5,000 increments up to $100,000, not to exceed 100% of employee coverage amount

- Guaranteed Issue amount*of $20,000

Supplemental Child(ren) Life/AD&D

You may purchase additional coverage for your child(ren) in $5,000 increments up to $25,000, not to exceed 100% of employee coverage amount

- Guaranteed Issue amount*of $25,000

Refer to the Mutual of Omaha plan documents for a complete description of this plan.

***If you choose to elect an amount over the guaranteed issue amount, you or your spouse will need to complete the Evidence of Insurability Form for medical underwriting purposes.**

Mutual of Omaha

SHORT & LONG TERM DISABILITY

This benefit is paid for 100% by Camino Health Center. There is no cost to you, the employee.

We provide employees with group Short Term and Long Term coverage for those unexpected situations that may keep you from performing the daily responsibilities of your job. Your disability plan is available to help supplement your income when you are not able to continue employment for a certain period of time.

Short Term Disability
You will need to satisfy a 7-day (sickness) and a 7-day (injury) elimination period before short term disability benefits would begin. The plan pays 30% of your weekly salary to a maximum amount of $1,000 per week. The maximum benefit period for this coverage is 25 weeks.

Long Term Disability
You will need to satisfy a 180-day elimination period before long term disability benefits would begin. This elimination period can be satisfied with days of partial disability, total disability or a combination of both. If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a monthly benefit equal to 60% of your basic monthly income, up to $8,000 per month.

Pre-Existing Condition
Your plan is subject to a pre-existing condition limitation. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention, treatment or medication for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.

Refer to the Mutual of Omaha plan documents for a complete description of this plan.

Mutual of Omaha

EMPLOYEE ASSISTANCE PLAN (EAP)

All members of your household can utilize the benefits of this program.

All benefit eligible employees with Camino Health Center are provided with employer paid Employee Assistance Plan (EAP) through Mutual of Omaha. All eligible employees are automatically enrolled in the EAP.

Life is full of challenges and sometimes balancing it is difficult. The EAP is there when you need it. Mutual of Omaha offers the appropriate assistance for a wide range of issues and provides referrals to professional counselors or services that can help you resolve emotional health, family and work issues.

Along with unlimited telephonic access, the EAP also offers 3 face-to-face visits with a counselor per person per issue.

Work or Life Needs, Clinical Counseling, Financial Information, Legal Information, etc.

TOTALLY CONFIDENTIAL

Member Services
Available 24/7

Mutual of Omaha

Visit Online:
www.mutualohomaha.com/eap
Call Toll free:
800-316-2796

FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts (FSA) provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. As an eligible employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to social security (FICA), federal, state or local income taxes—effectively adjusting your annual taxable salary.

Health Care Reimbursement FSA

The Health Care Reimbursement FSA allows you to pay for certain IRS-approved health care expenses not covered by your insurance or reimbursed by any other benefit plan. Eligible expenses include those incurred by you, as well as your spouse and dependents. Typical expenses include copayments, coinsurance, deductibles, and prescription drug expenses. For more information about eligible expenses, please refer to IRS Publication 502 available at **www.irs.gov/publications/p502/index.html**.
The annual maximum contribution to the Health Care Reimbursement FSA is $2,650.

Dependent Care Reimbursement FSA

The Dependent Care Reimbursement FSA allows you to use pre-tax dollars toward qualified dependent care. Care must be for a tax-dependent child under age 13 who lives with you, or a tax-dependent, spouse or child who lives with you and is incapable of caring for themselves. Also, the care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours and cannot be provided by another of your dependents. Typical expenses include baby-sitters, nursery schools, pre-schools, and day care centers.
The annual maximum contribution to the Dependent Care Reimbursement FSA is $5,000.

"Use-It-or-Lose-It" Rule

The Health Care and Dependent Care Reimbursement FSAs run on a calendar basis. The current plan year is from January 1,2019 through December 31, 2019; claims can only be submitted for services/expenses incurred in 2019. All claims MUST be submitted no later than March 30, 2020 (90-days from end of plan year) for reimbursement. Any funds left unclaimed will be forfeited. Camino Health Center has elected to offer a $500 rollover option for Health Care Reimbursement, which will allow you to roll over up to $500 of unused contributions into the next plan year. Be conservative when making elections. Please refer to your plan documents for additional information.

PS ADMINISTRATORS

POWERED BY PAYROLL SYSTEMS

Have leftover funds at the end of the year?
Visit **www.fsastore.com** to purchase FSA-eligible items before the end of the plan year, and also review the updated FSA Eligibility list.

	Without FSA	With FSA
Gross Income	$30,000	$30,000
FSA Contributions	$0	-$5,300
Gross Income	$30,000	$24,700
Estimated Taxes		
Federal	- $2,550	- $1,755
State	- $900	- $741
FICA	- $2,295	- $1,890
After-tax Earnings	$24,255	$20,314
Eligible pre-tax out-of-pocket medical and dependent care expenses	-$5,300	$0
Remaining spendable income	$18,955	$20,314
Spendable income increase	-	$1,359

PAYROLL SYSTEMS MOBILE TOOLS

The healthcare app that's made for mobile but designed for you.

Want to check your healthcare balances and submit receipts anywhere, anytime? Whether on your couch or at the store, the PS Administrator App for iPhone or Android smartphones makes it easy to manage your benefit accounts on the go.

PS Administrators Mobile App enable you to easily and securely access your accounts. You can view accounts balances and detail, submit account claims, ands capture and upload pictures of your receipts anytime, anywhere on any iPhone, Android or tablet device.

But wait, there's more to it…

The newest mobile app from PS Administrators provides time-saving options for you to:

- Check current account balances
- View transaction details
- File new claims with receipt images
- Submit claim and upload receipts using the mobile device's camera
- Manage expense receipts

The app provides you with seamless account access since it is an extension of the consumer portal – and doesn't require you to setup any additional credentials.

Get started with PS Administrators Mobile App in minutes

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ADDITIONAL BENEFITS

Camino Health Center offers the following Additional Benefits to its employees:

- ❖ Paid Time Off (PTO)
- ❖ 403 (B) Retirement Plan
- ❖ Tuition Reimbursement
- ❖ Continuing Education for Practitioners
- ❖ Malpractice Coverage for Practitioners

HEALTH INSURANCE MARKETPLACE

Notice of Medical Coverage Options:

THE NEW HEALTH INSURANCE MARKETPLACE

Under federal law, beginning January 1, 2014, individuals are required to have minimum essential health coverage, or else be subject to a penalty. This is referred to as the "individual mandate." Covered California is intended to help individuals meet the individual mandate requirement by providing another marketplace to purchase coverage, and possibly qualify for federal assistance. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) may opt out of the employer plan during their renewal period and go to Covered California to purchase health insurance (note employers are not required to pass on their employer contribution towards an employee's coverage election in Covered California). Based upon your specific income level and household size, you may receive more affordable coverage for yourself and/or dependents through Covered California. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) are not eligible for federal assistance through the individual mandate.

The Covered California website will help people find out whether they qualify for federal financial assistance that will reduce their costs for medical coverage. Depending on your income and family size, you could be eligible for no-cost Medi-Cal or for tax credits to help reduce your monthly premium costs. You do not need to purchase coverage through Covered California if you already have medical coverage. However, you have the option to do so if you wish.

If you are interested in looking at the plans and potential costs with Covered California medical plans, please visit the link below. By using the "Health Plan Calculator," you can see what your options are and how much coverage would likely cost you.
http://www.coveredca.com/fieldcalc/#calculator

If you have questions, please visit the Covered California website at **www.coveredCA.com**

If you can afford health insurance but choose not to buy it, you must pay a fee called the individual shared responsibility payment. To calculate your estimated penalty if you choose not to elect health coverage, visit:
https://www.healthcare.gov/fees/estimate-your-fee

COVERED CALIFORNIA

IMPORTANT EMPLOYEE NOTIFICATIONS

Model General Notice Of COBRA Continuation Coverage Rights

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

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

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

What is COBRA continuation coverage?: COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

IMPORTANT EMPLOYEE NOTIFICATIONS

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

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

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

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

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

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

IMPORTANT EMPLOYEE NOTIFICATIONS

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

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

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

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

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

Contact your Benefits Administrator for more information.

Newborns' and Mother's Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Blue Shield, MetLife, and VSP plans. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to December 1, 2018.

For more information, contact Blue Shield, MetLife, and VSP.

IMPORTANT EMPLOYEE NOTIFICATIONS

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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).

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

To request special enrollment or obtain more information, contact your Benefits Administrator.

Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under Blue Shield no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment.

For more information, contact Blue Shield.

Primary Protection

Blue Shield generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Shield designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Shield.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

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

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

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

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

IMPORTANT EMPLOYEE NOTIFICATIONS

Out of Network Balance Billing

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out of network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out of network provider. Your out of network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

Prescription Drug Coverage and Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Camino Health Center 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. Camino Health Center has determined that the prescription drug coverage offered by Blue Shield is, 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 Camino Health Center coverage may be affected.

If you decide to join a Medicare drug plan and drop your current Camino Health Center 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 Camino Health Center 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 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 the Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage: Contact the person listed below for further information. Note: you will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Camino Health Center changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. Additional resources: **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 **1-800-663-4227 (TTY 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)**.

Am I eligible for Medicare if I am under 65? There are three ways you can get Medicare coverage if you are under 65 years of age.

1. You are eligible for Medicare if you are a U.S. citizen or have your resident visa, have lived in the U.S. for five years in a row, and you have a disability and have been receiving Social Security Disability Insurance (SSDI) for more than 24 months. Your eligibility begins during the month you receive your 25th SSDI check. You do not need to contact anyone. Social Security should automatically mail you your Medicare card three months before you become eligible.

   Note: If you are receiving railroad disability annuity checks, whether you are eligible for Medicare and when you get it, depends on how your disability has been classified by the Railroad Retirement Board.

OR

2. You have been diagnosed with End-Stage Renal Disease (ESRD) and you are getting dialysis treatments or have had a kidney transplant; apply for Medicare benefits (up to 12 months retroactively); and you

   - are eligible to receive SSDI;
   - are eligible to receive railroad retirement benefits; or
   - are otherwise considered to be fully insured by Social Security, as defined by the length of time you have worked and the amount of money you have made (you need a certain amount of Social Security work credits depending on how long you have worked).

   Note: If you are a railroad worker with ESRD, you must contact Social Security, not the Railroad Retirement Board, to find out if you are eligible for Medicare because you have been diagnosed with ESRD.

   When your Medicare benefits begin depends on the circumstance.

OR

3. You have been diagnosed with Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig's Disease. You will automatically be enrolled in Medicare the first month you receive SSDI or, if you are a railroad worker, the first month you receive a railroad disability annuity check.

   Note: Because Social Security and Medicare eligibility rules are complex, you should call Social Security at **800-772-1213** to get the most accurate information regarding your particular situation.

Date:	December 1, 2018
Name of Entity/Sender:	Camino Health Center
Address:	30300 Camino Capistrano, San Juan Capistrano, CA 92675
Phone Number:	949-240-2030

NOTES

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BENEFIT PLAN CONTACT INFORMATION

Provider	Coverage Type	Phone and Web
blue california	Medical	Blue Shield 800-393-6130 **www.blueshieldca.com**
MetLife	Dental	MetLife 800-275-4638 **www.metlife.com**
vsp	Vision	Vision Service Plan (VSP) 800-877-7195 **www.vsp.com**
Mutual of Omaha	Life and AD&D (Basic & Supplemental)	Mutual of Omaha 800-775-8805 **www.mutualofomaha.com**
Mutual of Omaha	Short Term Disability Long Term Disability	Mutual of Omaha 800-877-5176 **www.mutualofomaha.com**
PS Administrators POWERED BY PAYROLL SYSTEMS	Flexible Spending Account (FSA)	Payroll Systems 800-696-8004 **www.payoll-us.com**
Mutual of Omaha	Employee Assistance Plan (EAP)	Mutual of Omaha 800-316-2796 **www.mutualofomaha.com/eap**

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