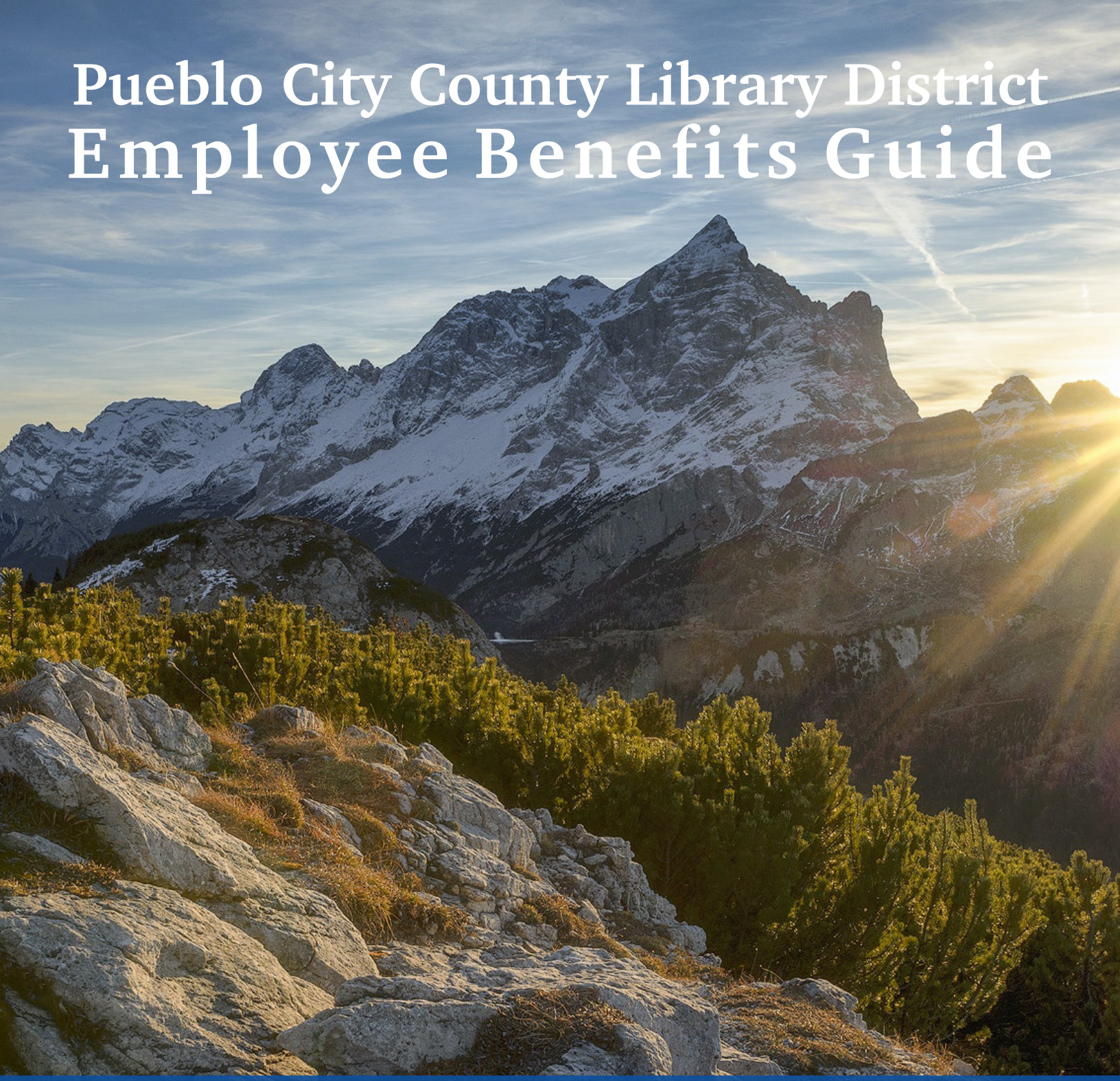
Pueblo City County Library District
Employee Benefits Guide



2022

Public Sector Healthcare Group Open Enrollment

PUBLIC SECTOR

Welcome

Thank you for taking the time to learn more about the employee benefits available to you in 2022. Your employer is a member of the Public Sector Health Care Group (PSHCG), an association of like-minded political entities who know the value of employee benefits and more importantly, maintaining your health and income should you become ill or injured. This benefit booklet offers an overview of the key features of the plans. If you have questions, please contact Human Resources. We thank you for contributing to our success!

Open Enrollment Key Points

It's Open Enrollment time, and that means this is your one opportunity to make your benefit choices for the calendar year, 2022. Outside of a qualifying life event, like marriage or the birth of a child, your benefit selections will remain in place through December 31, 2022. Also, it is important to know that life events only allow you to add or terminate coverage for you or your dependents. They never allow you to change medical insurance plans, if your employer offers a choice. If you do have a life change, please talk with your employer to clear up any questions you have and execute the change within 30 days of the date of your qualifying event.

Dates

Open Enrollment will be held in November. Your employer might have specific dates in mind, so look for further communication.

Who is Eligible?

Full-time employees (as defined by your employer) are eligible to join the PSHCG plans. Check with your HR representative to further clarify their full-time status rules.
Eligible dependents include:

- Your legally married spouse, domestic partner or common law partner
- Dependent children up to age 26 (adopted children and/or stepchildren)

Questions?

Please contact your HR representative for any questions related to open enrollment and benefits.

Medical

United Healthcare

Choice Plus PPO Plan A

Benefits	In-Network
Dr. Office Visit - Primary Care Physician	$25 copay
Specialist Visit	$50 copay
Preventive Care	Plan pays 100%
Individual Deductible	$1,000 in-network
Family Deductible	Max 3 per family
Co-Insurance Percentage *(applied after deductible)*	Plan pays 80% in-network Plan pays 50% out-of-network
Individual Out-of-Pocket Max	$4,500 per individual
Family Out-of-Pocket Max *(after which plan pays 100%)*	$12,700 per family
Inpatient Hospital	Plan pays 80% after deductible
Outpatient Hospital	Plan pays 80% after deductible
Emergency Room	$400 copay
Urgent Care	$25 copay
Associated Lab Work	Plan pays 100% after copay
MRI, CT, PET Scans	Plan pays 80% after deductible
Prescription Drug Copays	$10 / $30 / $60 / 25% max $500

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

Medical

United Healthcare

Choice Plus PPO Plan B

Benefits	In-Network
Dr. Office Visit - Primary Care Physician	$30 copay
Specialist Visit	$50 copay
Preventive Care	Plan pays 100%
Individual Deductible	$3,000 in-network
Family Deductible	Max 3 per family
Co-Insurance Percentage *(applied after deductible)*	Plan pays 100% in-network Plan pays 50% out-of-network
Individual Out-of-Pocket Max	$6,000 per individual
Family Out-of-Pocket Max *(after which plan pays 100%)*	$12,700 per family
Inpatient Hospital	$500 copay; 100% after deductible
Outpatient Hospital	Plan pays 100% after deductible
Emergency Room	$400 copay
Urgent Care	$30 copay
Associated Lab Work	Plan pays 100% after copay
MRI, CT, PET Scans	Plan pays 100% after deductible
Prescription Drug Copays	$15 / $40 / $70 / 25% max $500

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

Medical

United Healthcare

Choice Plus PPO Plan C

Benefits	In-Network
Dr. Office Visit - Primary Care Physician	$0 copay
Specialist Visit	$50 copay
Preventive Care	Plan pays 100%
Individual Deductible	$3,000 in-network
Family Deductible	Max 2 per family
Co-Insurance Percentage *(applied after deductible)*	Plan pays 80% in-network Plan pays 50% out-of-network
Individual Out-of-Pocket Max	$6,500 per individual
Family Out-of-Pocket Max *(after which plan pays 100%)*	$13,000 per family
Inpatient Hospital	Plan pays 80% after deductible
Outpatient Hospital	Plan pays 80% after deductible
Emergency Room	Plan pays 80% after deductible
Urgent Care	$0 copay
Associated Lab Work	$0 copay
MRI, CT, PET Scans	$750 copay
Prescription Drug Copays	$5 / $40 / $60 / 25% max $500

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

Medical

United Healthcare

Choice Plus PPO Plan D HSA

Benefits	In-Network
Dr. Office Visit - Primary Care Physician	Plan pays 100% after deductible
Specialist Visit	Plan pays 100% after deductible
Preventive Care	Plan pays 100%
Individual Deductible	$2,500 per employee only in-network
Family Deductible	$5,000 per family *COMBINED
Co-Insurance Percentage *(applied after deductible)*	Plan pays 100% in-network Plan pays 70% out-of-network
Individual Out-of-Pocket Max	$3,500 per employee only
Family Out-of-Pocket Max *(after which plan pays 100%)*	$7,000 per family *COMBINED
Inpatient Hospital	Plan pays 100% after deductible
Outpatient Hospital	Plan pays 100% after deductible
Emergency Room	Plan pays 100% after deductible
Urgent Care	Plan pays 100% after deductible
Associated Lab Work	Plan pays 100% after deductible
MRI, CT, PET Scans	Plan pays 100% after deductible
Prescription Drug Copays	Deductible then $15 / $40 / $70 / 25% max $500

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

***Combined Deductible:** each member of the family uses and pays for health care services and the amount they pay out-of-pocket for those services is credited toward the family's deductible. After the combined total of those expenses reaches the combined deductible, the health plan begins to pay health care expenses for the entire family. *Ex] One family member satisfies a $2,500 individual deductible, another family member has $500 in expenses, another has $2,000 in expenses, the family COMBINED deductible is then met and after-deductible benefits kick in.*

Medical

United Healthcare

Choice Plus PPO Plan E HSA

Benefits	In-Network
Dr. Office Visit - Primary Care Physician	Plan pays 90% after deductible
Specialist Visit	Plan pays 90% after deductible
Preventive Care	Plan pays 100%
Individual Deductible	$3,500 per INDIVIDUAL in-network
Family Deductible	$7,000 per family *EMBEDDED
Co-Insurance Percentage *(applied after deductible)*	Plan pays 90% in-network Plan pays 70% out-of-network
Individual Out-of-Pocket Max	$4,500 per INDIVIDUAL
Family Out-of-Pocket Max *(after which plan pays 100%)*	$9,000 per family *EMBEDDED
Inpatient Hospital	Plan pays 90% after deductible
Outpatient Hospital	Plan pays 90% after deductible
Emergency Room	Plan pays 90% after deductible
Urgent Care	Plan pays 90% after deductible
Associated Lab Work	Plan pays 90% after deductible
MRI, CT, PET Scans	Plan pays 90% after deductible
Prescription Drug Copays	Deductible then $15 / $40 / $70 / 25% max $500

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

***Embedded Deductible:** a single member of a family does not have to meet the full family deductible for after-deductible benefits to kick in. Instead, the person's after-deductible benefits will go into effect as soon as he or she has met the individual deductible. When a family member has a health care expense, the money paid toward the individual deductible is also credited toward the family deductible. *Ex] An individual satisfies a $3,500 individual deductible, after-deductible benefits kick in and $3,500 is credited toward the $7,000 family EMBEDDED deductible leaving a balance of $3,500 to be satisfies by another family member or members.*

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is an account funded to help you save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment.

Who Can Have an HSA?

Any adult can have an HSA if you:

- Have coverage under an HSA-qualified, high deductible health plan
- Are not enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return

Contributions to your HSA can be made by you, your employer, or both. However, the total contributions are limited annually. If you make a contribution, you can deduct the contribution (even if you do not itemize deductions) when completing your federal income tax return. Alternatively, some employers will allow you to make your HSA contributions as tax-free salary reductions.

Contributions to the account must stop once you are enrolled in Medicare. However, you can still use your HSA funds to pay for medical expenses tax-free.

In general, the deductible must apply to all medical expenses (including prescriptions) covered by the plan. However, the plan can pay for preventive care services on a first-dollar basis. Preventive care can include routine prenatal and well-childcare, child and adult immunizations, annual physicals, mammograms and more.

Annual HSA Contribution Limits

You can make a contribution to your HSA each year that you are eligible.

- Single coverage: $3,650
- Family coverage: $7,300

Individuals ages 55 and older can also make additional "catch-up" contributions for up to $1,000 annually.

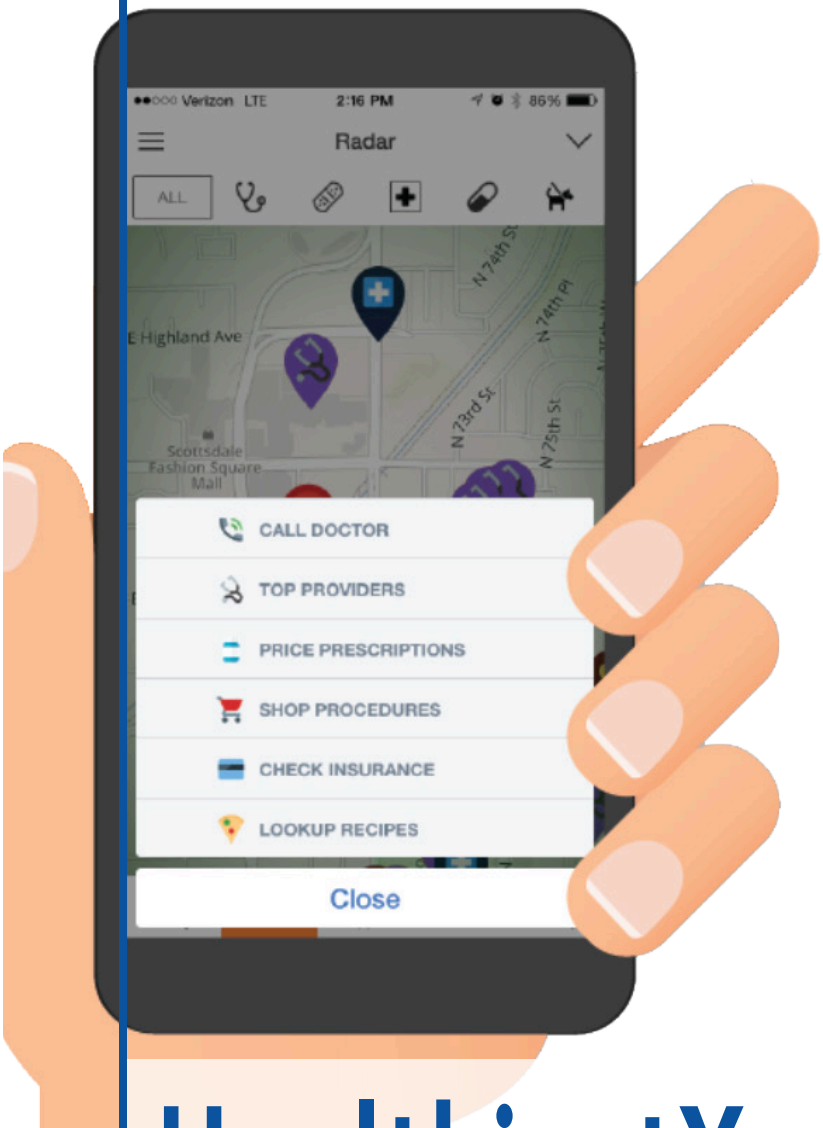
Determining Your Contribution

Your eligibility to contribute to an HSA is determined by the effective date of your HDHP coverage. Individuals who are eligible to contribute to an HSA in the last month of the taxable year are allowed to contribute an amount equal to an annual HSA contribution amount provided they remained covered by the HSA for at least the 12-month period following that year. Contributions can be made as late as April 15th of the following year.

Using Your HSA

You can use money in your HSA to pay for any qualified health-care expense permitted under federal tax law. This includes most medical care services, dental and vision care. Money contributed to an HSA is portable. If you leave employment, the account is yours to keep.

HealthiestYou is a virtual medicine program, where you and your dependents can obtain treatment or advice from a licensed physician, 24 hours a day. There is no cost to call HealthiestYou! Register now at www.healthiestyou.com so you can avoid costly urgent or emergent care facilities at your time of need. You can also download the HealthiestYou app on your iPhone or Android device.



24x7 UNLIMITED DOCTOR ACCESS
Are you sick? Call HealthiestYou first! Our physician network can diagnose, treat, and prescribe with no consult fees, anytime, anywhere. Really!

PRESCRIPTION SAVINGS
Need a prescription? Our geo-based prescription search engine can save you up to 85% on your prescription and will often beat your co-pay.

SHOP & PRICE PROCEDURES
Do you need an MRI or an Ultrasound? Our app puts you in the driver's seat by providing a vehicle to search and price procedures in your direct area. Happy shopping!

LOCATE PROVIDERS
Need to search for a doctor, dentist, or other provider? Our app knows best and will easily lead you through the process. You can even research your doctor first!

HEALTH MANAGEMENT CONTENT
Are you stressed? Let HealthiestYou guide you to improved health and happiness with relevant health content delivered at the time of need.

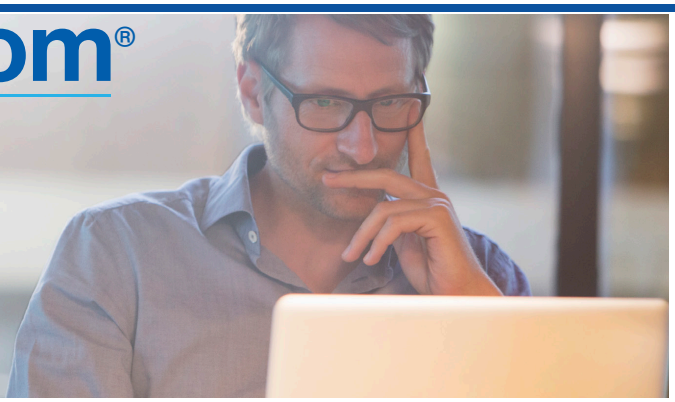
SYNC YOUR MEDICAL BENEFITS
Our app provides you a one stop shop to view your medical plan deductible in real time. Easily shop and book in-network and out-of-network providers for medical, dental, vision, and specialists.

HealthiestYou
24/7 Virtual Medicine

Your healthcare just got a whole lot easier

myuhc.com®

Get all your health plan information. In one place.



Make informed decisions.

As a member, **myuhc.com** gives you personalized plan information, care choices, budgeting tools and wellness tips – all in one spot. Download the UnitedHealthcare Health4Me® mobile app for on-the-go access.

Find and price the care you need.

The find-and-price care tool makes it simple to find a doctor, clinic, hospital, or lab based on location, specialty, reputation, cost of services, availability or hours of operation. You can even see patient ratings and compare quality and costs before you choose services.

Know your health care costs.

Get a clear picture of spending. View a snapshot of account activity, benefits received and outstanding balances.

Track claims. Easily see the status of your claims.

Get and stay healthy.

Discover wellness tools and advice. Tailored to help you live healthier, and get the most from your plan.

Achieve your health goals. Set goals and reach them with individualized recommendations on exercise, diet, therapy and more.

Join a healthy-living community. Connect with other members for support and to share ideas on how to live balanced, healthy and active lives.

Experience the plan that connects with you.

- **myuhc.com** places your plan information at your fingertips.
- The **Health4Me** mobile app provides on-the-go access.
- **Expert support** is here when you have questions.
  - **Ask a Nurse.** 24/7 phone access to a registered nurse.
  - **Chat online.** Rapid replies and guidance through **myuhc.com**.
  - **Talk with us.** Request that a plan representative call you.

United Healthcare

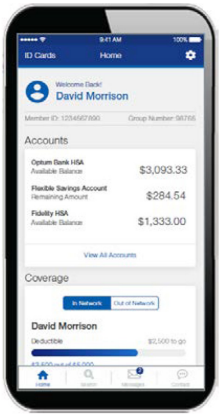
www.myuhc.com

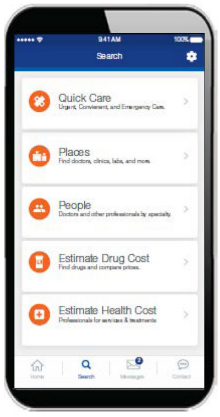
Get all your health plan information.
In one place.

UnitedHealthcare Health4Me®
features overview.

Users have access to:

- A member interface that is consistent with the new myuhc.com®.
- "Contact Us" for quick access to customer service.
- HealthSafe ID™ to protect member information and allow access to all HSID sites using the same log-in.





Home screen

- View or print health plan **ID cards**.
- See **account balances**.
- Get current **coverage information**.
- An intuitive, scrolling design displays **key information**.

Search screen

- Locate **physicians** and **facilities**.
- Learn about **procedures** and **treatments**.
- Research available **providers**.
- Review **hospital quality** and **safety data**.
- Provides price and quality for over **875 medical services** across nearly **600 health events**.
- Compare **costs**.

United Healthcare Health4Me app

Get all your health plan information.
In one place.

PREVENTIVE CARE GUIDELINES

Preventive care guidelines for children and adults.

Under the Affordable Care Act (CA), you can get certain preventive health care services, covered at 100 percent, without any cost to you. Just obtain your preventive care from a health plan network provider. Diagnostic (non-preventive) services are also covered, but you may have to pay a copayment, coinsurance or deductible.

Preventive care guidelines for children:

- Age-appropriate well-child examination
- Anemia screening
- Cholesterol screening for children 24 months and older
- Metabolic screening panel for newborns
- Age-appropriate immunizations
- Vision screening by primary care physician
- Oral health risk assessment by primary care physician
- Fluoride application
- Hearing screening by primary care physician
- Autism and Developmental screening for children under age 3
- Counseling on the harmful effects of smoking and illicit use of drugs
- Counseling for children on promoting improvements in weight
- Screening certain children at high risk for sexually transmitted diseases, lead, depression and tuberculosis

Preventive care guidelines for adults:

- Wellness Examinations
- Well-Women Visits—including routine prenatal visits
- Abdominal Aortic Aneurysm Screening—for age 65-75 years who have ever smoked
- Alcohol Screening and Brief Counseling—screening during wellness examination
- Bacteriuria Screening—during pregnancy
- Blood Pressure Screening—at each wellness examination
- Breastfeeding Primary Care Interventions, Counseling, Support and Supplies—during pregnancy and after birth. Includes personal use of an electric breast pump.
- Cervical Cancer Screening (Pap Smear)—women age 21-65 years old
- Chemoprevention of Breast Cancer, Counseling—for women at high risk of breast cancer
- Chlamydia and Gonorrhea Infection Screening—for sexually active women age 24 and younger
- Cholesterol Screening—for age 40-75 years
- Colorectal Cancer Screening—for age 50-75 years
- Contraceptive Methods—FDA-approved methods of contraception for women
- Depression Screening—for all adults, in a primary care setting
- Diabetes Screening—for age 40-70 who are overweight or obese or for those of any age with a history of gestational diabetes
- Falls Prevention Counseling—during wellness examination, for community-dwelling older adults
- Genetic Counseling and Evaluation for BRCA Testing & BRCA Lab—lab testing requires prior authorization
- Gestational Diabetes Mellitus Screening—during pregnancy
- Healthy Diet Behavioral Counseling—for persons with cardiovascular disease risk factors
- Hepatitis B Virus Infection Screening—for persons at high risk
- Hepatitis C Virus Infection Screening—one-time screening for adults born between 1945-1965 or high risk
- Human Immunodeficiency Virus (HIV) Screening—for all adults
- Human Papillomavirus DNA Testing—for women age 30-65
- Immunizations—FDA approved and have explicit ACIP recommendations for routine use
- Intimate Partner Violence, Interpersonal and Domestic Violence, Counseling and Screening—during wellness examination
- Latent Tuberculosis Infection Screening—for persons at increased risk
- Lung Cancer Screening with Low-Dose CT Scan—for age 55-80 years with at least a 30 pack-year history (prior authorization)
- Mammography Screening
- Obesity Screening and Counseling—at each wellness examination
- Osteoporosis Screening—women age 65 and older, and younger women at increased risk
- Rh Incompatibility Screening—during pregnancy
- Sexually Transmitted Infections, Behavioral Counseling to Prevent—behavioral counseling for adults who are sexually active or otherwise at increased risk, in primary care setting
- Skin Cancer, Behavioral Counseling to Prevent—at each wellness examination, for young adults up to age 24 years
- Syphilis Screening—for adults at increased risk
- Tobacco Cessation, Screening, Behavioral Counseling—screening, and behavioral counseling for adults who smoke

For more information about preventive guidelines for your age and gender, visit uhc.com/preventivecare

United Healthcare

Cost Estimator Tool

Get cost estimates before choosing care

You may pay up to 36% less
Checking cost estimates before you choose where to get care can be an effective way to save on health care costs. In fact, it's been shown that people who look at costs first may pay up to 36% less for their care. So, it can be worthwhile.

How can you look up cost estimates online?
There are a number of ways to find and compare costs using United Healthcare's online tools.

You can:
- Compare average costs for providers in your network, including doctors, hospitals, office visits, mental health services, labs, convenience care and more.
- See the average cost for specific treatments in your area.
- Look up quality ratings and reviews by provider, hospital or facility.

View personalized cost estimates

Sign in on myuhc.com to get the most accurate cost estimates for the plan you have:

- See how much you can expect your specific plan to pay
- Loo up network providers for your plan to see cost and quality ratings

Sign In

Look up general cost estimates

Search for costs by:

- **Service** - like a vaccine or x-ray
- **Condition or symptom** - like sore throat or sports injury
- **Doctor, hospital or facility** - find a preferred or nearby provider

View Estimates

You can view cost estimates anytime, 24/7 to help you make more informed decisions and find ways to save.

Dental

Pueblo City-County Library District offers two options for dental insurance. The first through Beta Health, the second through MetLife. The table below shows the plans in detail. Please refer to your plan descriptions for a full list of covered-services and limitations before making your decision.

Dental		
Dental Plan Options	**Beta Health Alpha Dental (discount dental plan)**	**MetLife Dental (dental insurance plan)**
Calendar Year Deductible	None	$50 Individual / $150 Family
Your Cost for Services		
Preventive Services	Save up to 100%	100%
Basic Services	Save up to 80%	80%
Endo/Perio	Save up to 60%	80%
Major	Save up to 60%	50%
Annual Maximum	Unlimited	$1,500/person

Vision

EyeMed

Vision		
Vision Care Services	**In-Network Member Cost**	**Out-of-Network Reimbursment**
Exam with Dilation as Necessary	$10 Copay	$40
Retinal Imaging Benefit	Up to $39	N/A
Exam Options: -Standard Contact Lens Fit and Follow-Up: -Premium Contact Lens Fit and Follow-Up:	 Up to $55 10% off Retail Price	 N/A N/A
Frames: -Any available frame at provider location	 $0 Copay; $130 Allowance, 20% off balance over $130	 $91
Standard Plastic Lenses: -Single Vision -Bifocal -Trifocal -Lenticular -Standard Progressive Lans -Premium Progressive Lens	 $25 Copay $25 Copay $25 Copay $25 Copay $90 Copay See attached Fixed Premium Progressive price list	 $30 $50 $70 $70 $50 $50
Lens Options: -UV Treatment -Tint (Solid and Gradient) -Standard Plastic Scratch Coating -Standard Polycarbonate - Adults -Standard Polycarbonate - Kids under 19 -Standard Anti-Reflective Coating -Polarized -Photocromatic / Transitions Plastic -Premium Anti-Reflective -Other Add-Ons	 $15 $15 $15 $40 $40 $45 20% off Retail Price $75 See attached Fixed Premium Anti-Reflective Coating price list 20% off Retail Price	 N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A
Contact Lenses: (contact lens allowance includes materials only) -Conventional -Disposable -Medically Necessary	 $0 Copay; $130 allowance, 15% off balance over $130 $0 Copay; $130 allowance, plus balance over $130 $0 Copay, Paid-in-Full	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency: -Examination -Lenses or Contact Lenses -Frame	 Once every 12 months Once every 12 months Once every 24 months	

Basic Life and AD&D for you

This benefit is only available to full-time employees working 40 or more hours per week.

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible, and
- which You elect, if subject to election; and
- which are in effect.

Basic Life Insurance

Basic Life Insurance for You is Portability Eligible Insurance

- For All Active Full-Time Employees..... An amount equal to 1 times your Basic Annual Earnings, rounded to the next higher $1,000.
- Minimum Basic Life Benefit..... $10,000
- Maximum Life Benefits..... $150,000
- Non-Medical Issue Amount..... $150,000
- Accelerated Benefit Option..... Up to 80% of Your Basic Life amount not to exceed $500,000.

If You Are Age 70 Or Older

If You are age 70 or older on Your effective date of insurance, the appropriate percentage from the following table will be applied to the amount of Your Basic Life Insurance on Your effective date of insurance, adjusted for any later changes in Your salary.

If You are under age 70 on Your effective date of insurance, the amounts of Your Basic Life Insurance on and after age 70 will be determined by applying the appropriate percentage from the following table to the amount of Your insurance in effect on the date before Your 70th birthday, adjusted for any later changes in Your salary.

Age of Employee	Percentage
70 or older	50%

Basic Life and AD&D for you

Accidental Death and Dismemberment Insurance (AD&D) for You

Basic Accidental Death and Dismemberment Insurance for You is Portability Eligible Insurance

Full Amount for AD&D

- For All Active Full-Time Employees..... An amount equal to Your Life Insurance

If You Are Age 70 Or Older

If You are age 70 or older on Your effective date of insurance, the appropriate percentage from the following table will be applied to the amount of Your Accidental Death and Dismemberment Insurance on Your effective date of insurance, adjusted for any later changes in Your salary.

If You are under age 70 on Your effective date of insurance, the amounts of Your Accidental Death and Dismemberment Insurance on and after age 70 will be determined by applying the appropriate percentage from the following table to the amount of Your insurance in effect on the day before Your 70th birthday, adjusted for any later changes in Your salary.

Age of Employee	Percentage
70 or older	50%

For All Active Full-Time Employees
Additional Benefits:

- Air Bag Benefit..... Yes
- Seat Belt Benefit..... Yes
- Child Care Benefit..... Yes
- Common Carrier Benefit..... Yes, an amount equal to the Basic AD&D Full Amount

This benefit is only available to full-time employees working 40 or more hours per week.

Basic Life Insurance

Dependent Basic Life Insurance is NOT Portability Eligible Insurance

For All Active Full-Time Employees who elect:

- For Your Spouse..... $5,000
- Non-Medical Issue Amount..... $5,000

For All Active Full-Time Employees who elect:

- For Your Child from age 15 days but less than 6 months..... $100

Schedule of Benefits

- For Your Child 6 months and over..... $2,000
- Non-Medical Issue Amount..... $2,000

Resources

For Questions About...	Contact	Phone	Web/Email
Medical	United Healthcare	1-866-414-1959	www.myuhc.com
Dental	Alpha Dental	800-807-0706	www.betadental.com/alpha19
Dental	MetLife Dental	1-800-metlife	www.metlife.com
Vision	EyeMed (Insight Network)	EyeMed	www.eyemedvisioncare.com
Life and AD&D	Terri Daly	719-562-5632	terri.daly@pueblolibrary.org
FSA	Customer Service	24 Hour Flex	www.24hourflex.com
HealthiestYou	Customer Service	866-703-1259	www.member.healthiestyou.com
Benefits Broker	Lavina Medina	719-545-4840	lmedina@benefitsbroker.com
Benefits Broker	Michelle Ribaudo	719-545-4840	mribaudo@benefitsbroker.com
Human Resources	Terri Daly	719-562-5632	terri.daly@pueblolibrary.org

HR CONNECTION®

THE COMPREHENSIVE WEBSITE FOR ALL OF YOUR BENEFIT NEEDS

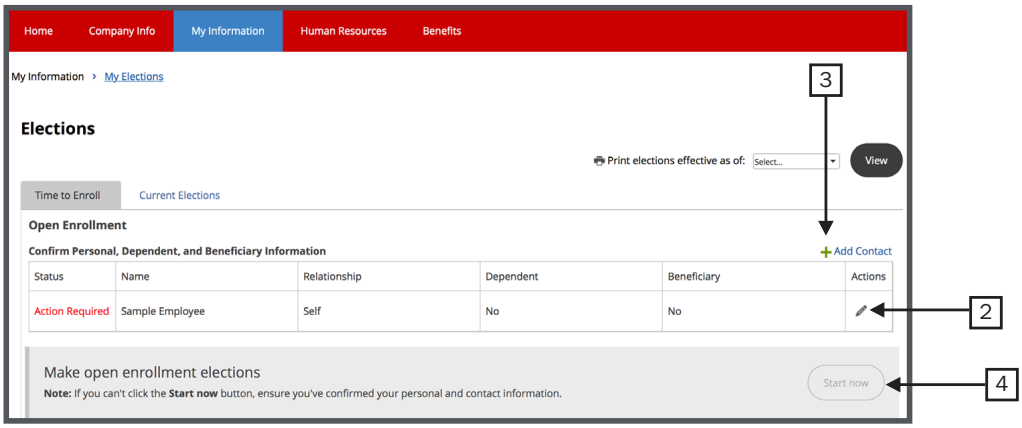
OPEN ENROLLMENT ELECTIONS

Your username and password will be sent to you via email (from "noreply@hrconnection.com")

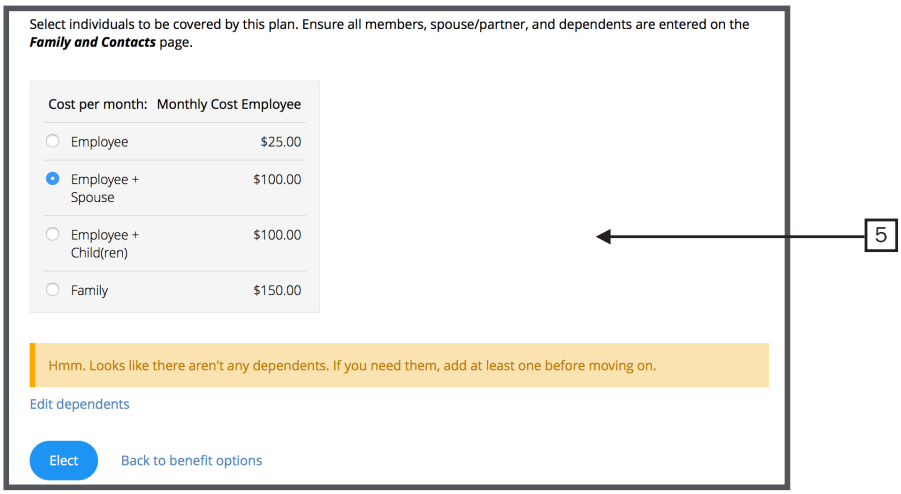
- Login to www.HRConnection.com to enroll in benefits.

- Once logged in:

1. Click the "Time to Enroll" orange button in the upper left corner
2. This takes you to "My Information" tab. Confirm or update your demographic information by clicking the "pencil" button under "Actions"



3. Add or update family members by clicking "+ Add contact" under "My Family and Contacts" tab. Be sure to check the "dependent" box beside each family member that needs to be enrolled. Social security numbers are required.
4. Make Open Enrollment Elections -- click "Start Now." Select the coverage you want to "Elect" or choose "Waived" if you want to decline a coverage. Click the appropriate family election, then "Continue" to move to the next plan that requires an election, if applicable.



5. You can compare and download benefit summaries of each plan option, under "View Plan details," as well as view carrier information and customer service phone numbers.
6. After making your final selections, review the elections you have made and make sure each dependent's name is included in each line of coverage, then click "Confirm" to stamp your elections with an electronic signature.
7. Print out a Summary Report for your records, sign and return to your employer, if requried.
8. The last step in the process requires you to complete any applicable forms. The Forms page appears immediately after the confirmation step. Click a link to open a form, print it, complete it, and return it to your Human Resources adminstrator.
9. Upon completion, click Done. The Time to Enroll tab will be removed and elections will now appear on the "Current Elections" tab.

FOR EMPLOYEES

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

Special Enrollment

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 you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 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.

CHIP

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office at www.insurekidsnow.gov or dial toll free 1-877-KIDSNOW 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, your employer's health plan is required to permit you and your dependents to enroll in the plan -- as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Break Time For Nursing Mothers Under The FLSA

Time and Location of Breaks

Employers are required to provide a reasonable amount of break time to express milk as frequently as needed by the nursing mother. The frequency of breaks needed to express milk as well as the duration of each break will likely vary.

A bathroom, even if private, is not a permissible location under the Act. The location provide must be functional as a space for expressing breast milk. If the space is not dedicated to the nursing mother's use, it must be available when needed in order to meet the statutory requirement. A space temporarily available when needed by the nursing mother is sufficient provided that the space is shielded from view, and free from any intrusion from co-workers and the public.

Coverage and Compensation

Only employees who are not exempt from section 7, which includes the FLSA's overtime pay requirements, are entitled to breaks to express milk. While employers are not required under the FLSA to provide breaks to nursing mothers who are exempt from the requirements of Section 7, they may be obligated to provide such breaks under State Law.

Employers with fewer than 50 employees are not subject to the FLSA break time requirement if compliance with the provision would impose an undue hardship is determined by looking at the difficulty of expense of compliance for a specific employer in comparison to the size, financial resources, nature and structure of the employer's business. All employees who work for the covered employer, regardless of work site, are counted when determining whether this exemption may apply.

Employers are not required under the FLSA to compensate nursing mothers for breaks taken for the purpose of expressing milk. However, where employers already provide compensated breaks, an employee who uses that break time to express milk must be compensated in the same way that other employees are compensated for break time. In addition, the FLSA's general requirement that the employee must be completely relieved from duty or else the time must be compensated as work time applies.

Newborns' & Mothers' Health Protection Act of 1996

The group health coverage provided by Public Sector Health Care Group complies with the Newborns' and Mothers' Health Protection Act of 1996.

Under this law group health plan sand health insurance insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn 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 and 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 ours (or 96 hours).

Women's Health & Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. Therefore, deductibles and coinsurance apply.

Model General Notice of COBRA Continuation Coverage Rights

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 the 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:

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

- Your hours of employment are reduced
- Your employment ends of 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)
- 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 events:

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee become entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Continuation 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. When the qualifying event is the end of employment, reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare Benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. The continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries under the Plan, including special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to the end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. 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 continued 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, 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 last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to qualified beneficiaries.

Can you extend the length of an 18 period of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Human Resources of a disability or second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability: An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has 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. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the plan of that fact within 30 days after SSA's determination.

Second Qualifying Event: An 18-month extension will be available to spouses and depended children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both, or a dependent child's ceasing to be eligible for coverage as a depended under the Plan). These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event has not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Loss of Eligibility for COBRA Continuation Coverage

Continuation coverage will be terminated before the end of the maximum period if any of the following occur:

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitatio on plans' imposing a pre-existing condition exclusion and such exclusion with become prohibited beginning in 2014 under the Affordable Care Act)
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage
- The employer ceases to provide any group health plan for its employees

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant of beneficiary not receiving continuation coverage (such as fraud).

How do you elect COBRA Continuation Coverage?

To elect continuation coverage, you must complete an election form and return it to Human Resources. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. The employee can elect continuation coverage on behalf of a qualified spouse. A parent, the employee or his or her spouse may elect to continue coverage on behalf of any dependent children. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

Important Notice About Your Prescription Drug Coverage & Medicare

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

• 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.

• Public Sector Health Care Group has determined the United medical plans, 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.

HIPAA Basics - Your Right to Privacy

In April 2003, the final regulations that place restrictions on how personally identifiable health information (PHI) may be used and disclosed by certain organizations became effective.

These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protections for all health information. In summary, the HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed
- Require that individuals be told how their health information will be used and disclosed
- Provide individuals with a right to access, amend or copy their medical records
- Give individuals a right to receive an accounting of disclosures, to request special restrictions, and to receive confidential communications
- Impose fines where the requirements contained within the regulations are not met

Patient Protection Model

Health insurance companies generally require the designation of a primary care provider for services and claims to be covered. You have the right to designate any primary care provider who participates in your selected plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

If you do not choose a primary care physician upon enrolling in a health insurance plan, the insurance company may randomly designate one for you. Some insurance plans will not cover any claims or services if you see a primary care physician or specialist that is not assigned to you and the correct referral process followed.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your group administrator.

If you're nearing retirement age, or are over 65 and still working, you may have questions about Medicare.

What is Medicare?

Medicare is health insurance for people are age 65 or older, under 65 with certain disabilities, or any age with End-stage Renal Disease (permanent kidney failure).

Types of Medicare

There are four types of Medicare. Medicare Part A helps cover impatient care in hospitals, skilled nursing facilities, and hospice and home health care. Generally, there is no monthly premium if you qualify and paid Medicare taxes while working.

Medicare Part B helps cover medical services like doctors' services, outpatient care and other medically necessary services that Part A doesn't cover. You need to enroll in Medicare Part B and pay a monthly premium determined by your income, along with a deductible.

Many people also purchase a supplemental insurance policy, such as a Medigap plan, to handle any Part A and B coverage gaps.

Medicare Advantage Plans, also known as Medicare Part C, are combination plans managed by private insurance companies approved by Medicare. They typically are a combination of Part A, Part B and sometimes Part D coverage, but must cover medically necessary services. These plans have discretion to assign their own copays, deductibles and coinsurance.

Medicare Part D is prescription drug coverage and is available to everyone with Medicare. It is a separate plan provided by private Medicare-approved companies, and you must pay a monthly premium.

Getting Started

Medicare sends you a questionnaire about three months before you're entitled to Medicare coverage. Your answers to these questions, including whether you have group health insurance through an employer or family member, help Medicare set up your file and make sure your claims are paid correctly.

Coordination of Coverage

If you have Medicare and another type of insurance, the question of who should pay or who should pay first can be tricky. For example, generally a group health plan would pay before Medicare, but there are several exceptions. Visit www.medicare.gov for additional information.