
Leake LTC, LLC

2017-2018

OPEN ENROLLMENT OVERVIEW

This Open Enrollment guide summarizes the Company's Benefits Options for 2017-2018. This guide is a reference to help you decide which benefits are right for you and to answer questions you may have about your benefits.

Every attempt has been made to ensure the accuracy of the information contained in this document; however, this Enrollment Workbook is intended to provide you only an overview of your benefit programs and eligibility. Complete details and limitations are contained in and governed by the Summary Plan Description and/or Plan Document of each plan. If there is any discrepancy between what is written here and what is contained in the Summary Plan Description and/or Plan Document, the Plan Documents is controlling.

Eligibility and Enrollment

You are eligible to participate in the benefits described in this guide if you are a full-time employee working 30 or more hours per week and have satisfied the waiting periods indicated on the next page.

You may enroll your eligible dependents (to age 26) for coverage under the medical and dental insurance plans.

When You May Enroll

Each year during Open Enrollment you have the opportunity to enroll or change your coverage.

The Open Enrollment period begins on April 11th.

Generally, this is the only opportunity during the year to enroll or change coverage.

Unless otherwise elected, premiums for health insurance coverage are deducted on a pre-tax basis.

When Coverage Begins

Elections you make during Open Enrollment will be effective **May 1, 2017 through April 30, 2018**. The elections you make will remain in effect for one full year, unless you experience a qualifying event (such as marriage, divorce, birth or adoption of a child or loss of spouse's coverage or employment).

Important Information

Complete details of the plans are contained in the *Summary Plan Description and other insurance booklets*.

Contact Human Resources if you have questions about benefit coverages that are not answered in this guide.

Medicare Part D Notice:

If you (and/or your dependents) have Medicare or will be eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 16 for more details.

ANNUAL OPEN ENROLLMENT CHECKLIST

Benefits Enrollment is easy! Simply follow the checklist below.

★Review Eligibility Requirements

Medical	Dental	Vision	Life and AD&D	Disability
1 st of the month After 60 Days of Employment	1 st of the month After 60 Days of Employment	1 st of the month After 60 Days of Employment	1 st of the month After 60 Days of Employment	1 st of the month After 60 Days of Employment

★Review the Open Enrollment Guide

IMPORTANT INFORMATION!



Medical Plan:

Your medical plan carrier is Blue Cross Blue Shield of MS.



Dental/Vision Plans:

The dental and vision carrier is Assurant.



Wellness:

The company encourages you and your family to take preventive measures to maintain a healthy lifestyle and prevent illness. Your Healthy You! benefit includes annual physical examinations, screenings and immunizations specific to your age, health and family history. Be sure to log into www.bcbsms.com to see the covered benefits.



Short Term Disability, Long Term Disability and Life Insurance:

The long term disability and life insurance carrier is Assurant.

MEDICAL INSURANCE

The **medical** plan provider is **Blue Cross Blue Shield of MS**. To find individualized information on your benefit coverage, check the status of claims, and search for physicians and hospitals go to www.bcbsms.com and register for **myBlue**. Group #021708

IMPORTANT: You will have two plans to choose from – Please elect one

Services	Base Plan In-Network Benefits	Enhanced Plan In-Network Benefits
Individual Annual Deductible	\$5,000	\$1,000
<i>Individual Out-of-Pocket Maximum (Includes Deductible, Copayments & Coinsurance)</i>	\$6,850	\$4,000
Family Annual Deductible	\$10,000	\$2,000
<i>Family Out-of-Pocket Maximum (Includes Deductible, Copayments & Coinsurance)</i>	\$13,700	\$8,000
Lifetime Maximum	Unlimited	
Healthy You! (includes wellness exams based on age and gender) See: www.bcbsms.com	100%	
Physician Office Visits	\$25 Co-pay for Primary Care Physician \$40 Co-pay for Specialist \$25 Co-pay for Urgent Care	
Outpatient Surgery	80% after Deductible	
Inpatient Services (requires prior authorization)	80% after Deductible	
CAT scans, PET scans, MRI, Advanced lab work	80% after Deductible	
Emergency Room Visit	80% after Deductible	
Inpatient Behavioral Health Benefits	80% after Deductible	
Prescription Deductible – Waived for Tier 1	\$50	
Prescription Drugs Co-pay Tier 1/Tier 2/Tier 3/Tier 4	\$15 / \$35 / \$75 / \$100	

Coverage Type	Base Plan Per Pay Period Premium \$5,000 deductible	Enhanced Plan Per Pay Period Premium \$1,000 deductible
Employee Only	\$ 40.25	\$ 78.92
Employee plus Spouse	\$ 268.27	\$ 353.34
Employee plus Child(ren)	\$ 192.26	\$ 261.87
Family	\$ 420.29	\$ 536.30

Healthy You!

Services Recommended/Number of Times Recommended for Age Range	Female birth-24 months	Male birth-24 months	Female 2-11 Years	Male 2-11 Years	Female 12-17 Years	Male 12-17 Years	Female 18-34 Years	Male 18-49 Years	Female 35-49 Years	Male 50+ Years	Female 50-64 Years	Female 65+ Years
Preventive Medicine Evaluation or Re-Evaluation Once per calendar year As part of preventive medicine evaluation or re-evaluation, preventive counseling as appropriate for age or stage of development and risk factors.	8 Visits	8 Visits	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Hemoglobin, Hematocrit or CBC	1 ◆	1 ◆			1 ◆	1 ◆						
Immunizations See pages 8-9 for details	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Blood Pressure Once per calendar year	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Glucose Once per calendar year			2 ◆	2 ◆	2 ◆	2 ◆	2 ◆	2 ◆	◆	◆	◆	◆
Lipid Profile Once per calendar year			3 ◆	3 ◆	3 ◆	3 ◆	◆	◆	◆	◆	◆	◆
Pap Smear Once every three or five years							4 ◆		4 ◆		4 ◆	◆
Pelvic Exam Once per calendar year					5 ◆		◆		◆		◆	◆
Breast Exam Once per calendar year					◆		◆		◆		◆	◆
Mammogram Once per calendar year									6 ◆		6 ◆	6 ◆
Bone Density Once per lifetime												◆
Flexible Sigmoidoscopy once every five years OR Colonoscopy once every ten years										7 ◆	7 ◆	7 ◆

1. CBC performed at 12 months of age and once between ages 11-18.
2. Annual glucose screenings are available for at risk individuals age 3-39.
 - a. At risk individuals are defined as follows:
 - i. Family history of diabetes (i.e., parents or siblings with diabetes)
 - ii. Obesity
 - iii. Blood pressure of 135/80 or greater
 - iv. Race/ethnicity (i.e., African-Americans, Hispanic-Americans, Native Americans, Asian-Americans or Pacific Islanders)
 - v. Previously identified pre-diabetic or diagnosed diabetic
 - vi. Low HDL cholesterol or high triglycerides
 - vii. History of gestational diabetes
3. Lipid profile screenings are available to high-risk individuals between the ages of 2 and 17. High-risk individuals should have their first lipid profile screening before age 11. A fasting lipid profile is the recommended screening method. High risk is defined as a family history of high lipids or early CVD; unknown history or other CVD risk factors such as overweight, obesity, hypertension or diabetes.

4. Pap smears are available once every 3 years beginning at age 21.
For women ages 30-65 who wish to extend the time between pap smear screenings, a pap smear will be covered every 5 years when it is accompanied by HPV screening.
For females ages 12-20, these services are available and may be covered under the appropriate medical portion of your benefit plan. These should be performed based upon patient and provider discretion.
5. Pelvic exams are available annually for women over the age of 12. These should be performed based upon patient and provider discretion.
6. Mammograms for women ages 35 and older are available.
These should be performed based upon patient and provider discretion. Mammograms recommended every 2 years for ages 50-74.

7. Flexible sigmoidoscopy and colonoscopy information:
Additional screenings (flexible sigmoidoscopy, colonoscopy) for individuals considered to be at high risk for colorectal cancer, as outlined below, may be covered under the appropriate medical portion of your benefit plan. High-risk individuals in this category are defined as follows:
 - a. Strong family history of colorectal cancer or polyps (in first-degree relative younger than 60 or two first-degree relatives of any age). A first-degree relative is defined as a parent, sibling or child.
 - b. Known family history of colorectal cancer syndrome
 - c. Personal history of colorectal cancer polyps
 Gastroenterology consultations prior to colonoscopy are not covered under *Healthy You!*

myBlue



Get *myBlue* today!

To manage your health, it helps to know everything you can.

Get the information you want, when you want it. Register today for *myBlue* at www.bcbsms.com.

myBlue is a secure, online portal provided to you by Blue Cross & Blue Shield of Mississippi.

On *myBlue*, you can:

- Review your Explanation of Benefits
- View detailed claims history as far back as 15 months, with information updated in real time as soon as your claim is processed
- See a summary of your benefits, as well as your complete benefit plan booklet
- Get details about the utilization of your *Healthy You!* wellness benefit
- Make changes to your personal information, such as mailing address or *myBlue* password
- Order a new ID card
- Read current health and wellness articles

myBlue also gives you the ability to review your prescription drug claims and search for the most cost-effective generic drugs that meet your clinical needs.

Register for *myBlue* today! All you need is your computer or a smartphone and your Blue Cross & Blue Shield of Mississippi ID card. If you have questions or need assistance, please call our Customer Service Team at 601-664-4590 or 1-800-942-0278.

be healthy. live healthy.

VOLUNTARY DENTAL INSURANCE

You may elect dental coverage even if you do not elect medical coverage. The dental plan provider is Assurant. To search for a provider go to <https://www.assurantemployeebenefits.com>

For complete benefit details see your Assurant Summary Plan Description

Services	In Network/Out of Network	Plan Details
Preventive Services	In and out of network is covered at 100%	Periodic Oral Evaluation Genetic Testing Bitewing X-rays Intraoral Complete Series/Panoramic XRays Dental Prophylaxis Topical Fluoride Treatment Dental Sealants Space Maintainers Stainless Steel Crowns
Annual Deductible	<u>Applies to basic and major services only – Individual deductible is \$50 and Family deductible is \$150.</u>	
Basic Services	Covered at 80%, you pay 20%	Root Canals Periodontal Scaling and Root Planing Periodontal Maintenance Periodontal Surgery Simple Extractions Biopsy Complex Extractions Incision & Drainage General Anesthesia & IV Sedation Palliative (emergency) Treatment of Pain Fillings
Major Services	Covered at 50%, you pay 50%	Inlays, Onlays and Crowns Dentures Denture Repairs Relining or Rebasing Dentures Fixed Bridges
Maximum Benefit	Dental Services Maximum Annual Benefit is \$1,200	

Employee Cost

Coverage Type	Employee Per Pay Period Premium
Employee Only	\$ 15.13
Employee plus Spouse	\$ 29.56
Employee plus Child(ren)	\$ 31.03
Family	\$ 49.60

VOLUNTARY VISION INSURANCE

You may elect Vision coverage even if you do not elect medical or dental coverage. The vision plan provider is Assurant. To search for a provider or benefits go to <https://www.assurantemployeebenefits.com>

Vision		
	In-Network (Using a Network Provider)	Out-of-Network (Using a Non-Network Provider)
Eye Examination		
Co-Payment	\$10	N/A
Eyewear		
Co-Payment	\$10	N/A
Base Lenses <ul style="list-style-type: none"> • Single Vision • Lined Bifocal • Lined Trifocal • Lenticular 	Covered in full less the Eyewear Co-Payment	Covered up to: <ul style="list-style-type: none"> • \$55 allowance • \$75 allowance • \$95 allowance • \$125 allowance
Frame Allowance	Covered in full up to \$130 allowance less the Eyewear Co-Payment	Covered up to \$57 allowance
Contact Lenses		
Elective	Covered up to \$130 allowance	Covered up to \$105 allowance
Necessary	Covered in full less the Eyewear Co-Payment	Covered up to \$250 allowance

Contact lenses are in place of lenses and frame.

Employee Cost

Coverage Type	Employee Per Pay Period Premium
Employee Only	\$ 4.06
Employee + Spouse	\$ 8.25
Employee + Child(ren)	\$ 8.71
Family	\$ 10.99

LIFE AND AD&D INSURANCE



Employer Paid Life and AD&D Insurance

All employees will receive 1 times your salary in life insurance.

Important:

- Please make sure you update your beneficiary information at this open enrollment period.



Voluntary Life and AD&D Insurance

When you enroll yourself and/or your dependents in this benefit, **you pay** the full cost through weekly payroll deductions. The Voluntary Life insurance provider is **Assurant**.

If you, your spouse, and dependent children **did not** elect voluntary life insurance coverage when you were first eligible, you will be required to complete an **Evidence of Insurability form** if you want to apply for coverage. Also, if you elect more than the guarantee issue amount you will be required to complete an **Evidence of Insurability form**. See Human Resources for more details.

Member	Benefit
Employee	5 times salary up to \$500,000 – Guarantee Issued is \$100,000
Spouse	50% of Employees elected amount - Maximum allowed \$250,000 – Guarantee Issued is \$25,000
Dependent Child(ren)	\$10,000 – Guarantee Issued is \$10,000

Spouse Rates are based on the Employees Age Rates are Illustrated Per Payroll Deduction

Employee	29 & Under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
\$10,000	\$0.35	\$0.44	\$0.54	\$0.63	\$0.95	\$1.46	\$2.38	\$2.98
\$20,000	\$0.70	\$0.89	\$1.07	\$1.26	\$1.90	\$2.92	\$4.76	\$5.96
\$30,000	\$1.05	\$1.33	\$1.61	\$1.88	\$2.85	\$4.38	\$7.14	\$8.94
\$40,000	\$1.40	\$1.77	\$2.14	\$2.51	\$3.80	\$5.83	\$9.53	\$11.93
\$50,000	\$1.75	\$2.22	\$2.68	\$3.14	\$4.75	\$7.29	\$11.91	\$14.91
\$60,000	\$2.10	\$2.66	\$3.21	\$3.77	\$5.70	\$8.75	\$14.29	\$17.89
\$70,000	\$2.46	\$3.10	\$3.75	\$4.39	\$6.66	\$10.21	\$16.67	\$20.87
\$80,000	\$2.81	\$3.54	\$4.28	\$5.02	\$7.61	\$11.67	\$19.05	\$23.85
\$90,000	\$3.16	\$3.99	\$4.82	\$5.65	\$8.56	\$13.13	\$21.43	\$26.83
\$100,000	\$3.51	\$4.43	\$5.35	\$6.28	\$9.51	\$14.58	\$23.82	\$29.82
\$110,000	\$3.86	\$4.87	\$5.89	\$6.90	\$10.46	\$16.04	\$26.20	\$32.80
\$120,000	\$4.21	\$5.32	\$6.42	\$7.53	\$11.41	\$17.50	\$28.58	\$35.78
\$130,000	\$4.56	\$5.76	\$6.96	\$8.16	\$12.36	\$18.96	\$30.96	\$38.76
\$140,000	\$4.91	\$6.20	\$7.50	\$8.79	\$13.31	\$20.42	\$33.34	\$41.74
\$150,000	\$5.26	\$6.65	\$8.03	\$9.42	\$14.26	\$21.88	\$35.72	\$44.72
\$160,000	\$5.61	\$7.09	\$8.57	\$10.04	\$15.21	\$23.34	\$38.10	\$47.70
\$170,000	\$5.96	\$7.53	\$9.10	\$10.67	\$16.16	\$24.79	\$40.49	\$50.69
\$180,000	\$6.31	\$7.98	\$9.64	\$11.30	\$17.11	\$26.25	\$42.87	\$53.67
\$190,000	\$6.66	\$8.42	\$10.17	\$11.93	\$18.06	\$27.71	\$45.25	\$56.65
\$200,000	\$7.02	\$8.86	\$10.71	\$12.55	\$19.02	\$29.17	\$47.63	\$59.63
\$250,000	\$8.77	\$11.08	\$13.38	\$15.69	\$23.77	\$36.46	\$59.54	\$74.54
\$300,000	\$10.52	\$13.29	\$16.06	\$18.83	\$28.52	\$43.75	\$71.45	\$89.45

Child Life - \$10,000 benefit - \$0.58 per payroll deduction

DISABILITY INSURANCE



Short-term Disability Insurance

The company offers full-time Hourly employees Short-Term disability benefits. In the event you become disabled from a non work-related injury or sickness, disability income benefits are provided as a source of income. A claim will need to be submitted to the carrier for approval. The Short-Term disability provider is **Assurant**.

If you **did not** elect short term disability insurance coverage when you were first eligible, you will be required to complete an **Evidence of Insurability form** if you want to apply for coverage.

Benefits	Short-term Disability
Benefits Begin After:	15 Days
Percentage of Income Replaced	11 Weeks
Maximum Benefit	60% of covered earnings up to \$1,000
Pre-Existing Condition	6 / 12

Employee Age Rates	Employee Age Rates
<25	0.808
25-29	1.116
30-34	0.958
35-39	0.782
40-44	0.683
45-49	0.693
50-54	0.773
55-59	0.848
60-64	0.968
65-69	1.092
70+	1.182

To calculate your deduction:
Annual Salary: _____
Divided by 52 _____ X 0.6 divided by 10 X your rate X 12
divided by 26 = _____



Long-term Disability Insurance

The company offers full-time employees Long-Term disability benefits. In the event you become disabled from a non work-related injury or sickness, disability income benefits are provided as a source of income. A claim will need to be submitted to the carrier for approval. The Long-Term disability provider is **Assurant**. The company pays the benefit for you.

Benefits	Long-term Disability
Benefits Begin After:	90 Days
Percentage of Income Replaced	60% up to a Monthly maximum of \$5,000
Maximum Benefit	Social Security Normal Retirement Age
Pre-Existing Condition	3 / 12

Accident Insurance

Group Accident Insurance Schedule	
Initial Accident Hospitalization	\$1,000; limited to once each benefit year
ICU Initial Accident Hospitalization	\$1,500; limited to once each benefit year. ICU Initial Accident Hospitalization payable instead of Initial Accident Hospitalization, if confined immediately to ICU.
Accident Hospital Confinement	\$250 per day, not to exceed 365 days
Intensive Care Unit Confinement	\$500 per day, limited to 15 days for each accident. This benefit is paid in addition to any Accident Hospital Confinement benefit.
Accidental Death	Employee – \$25,000; Spouse - \$25,000; Child - \$5,000 Common Carrier Accident – Employee – \$100,000; Spouse - \$100,000; Child - \$20,000 Either the accidental death or the common carrier accidental death benefit will be paid, but not both.
Accidental Dismemberment	Employee – up to \$15,000; Spouse - up to \$7,500; Child - up to \$7,500
Accident Emergency Treatment *	\$150 – Emergency Room \$75 – Non-Emergency Room Limited to once each accident and once in any 24-hour period
Accident Follow-Up Treatment *	\$25 per day, not to exceed 6 payments
Ambulance *	\$200 – Ground ambulance; \$1,500 – Air ambulance
Appliances	\$125 – Wheelchairs, leg or back braces, crutches or walkers. Payable for one appliance for any accident.

Group Accident Insurance Schedule	
Blood/Plasma/Platelets	\$200; payable once for any accident
Burns *	Third Degree Burns – \$1,000 to \$20,000** Second Degree Burns – \$400 to \$2,000** Skin Grafts – If the covered employee or dependent receives one or more skin grafts for a second degree or third degree burn, we will pay 50% of the total burn benefit amount paid. **Fixed benefit amount is determined by the surface area burned.
Coma	\$20,000
Concussion *	\$100
Dislocation *	Up to \$4,000 for open reduction (surgery); Up to \$1,000 for closed reduction (repair by manipulation). Limited to 2 dislocations per accident; reduction under general anesthesia. (If reduction is administered without general anesthesia, we will pay 25% of the amount shown for the closed reduction dislocation.)
Emergency Dental Work *	\$200 – Broken teeth repaired with crowns; \$65 - Broken teeth resulting in extractions. Limited to 1 benefit per accident.
Eye Injury	\$300 – Surgical repair; \$65 – Removal of foreign body by a doctor
Fractures	Up to \$5,000 for open reductions; Up to \$2,500 for closed reductions. Limited to 2 fractures per accident. (We will pay 25% of the amount shown for the closed reduction for chip fractures and other fractures not reduced by open or closed reduction.)
Lacerations *	\$35 to \$500
Lodging	\$100 per day; limited to one benefit per day and 30 days per accident per benefit year
Major Diagnostic Exams	\$200 per benefit year. Initial treatment must be provided within 6 days of the accident.
Paralysis	\$50,000 for Quadriplegia; \$25,000 for Paraplegia. Payable only once per lifetime.
Physical Therapy *	\$25 per day, for up to 10 days of treatment
Prosthesis	\$500; limited to one prosthesis per accident
Rehabilitation Unit	\$150 per day; limited to 30 days per period of confinement and limited to 60 days per benefit year.
Surgical Procedures (must be performed within 90 days of the accident)	\$1,250 – Open abdominal (including exploratory laparotomy), cranial, hernia, or thoracic surgery \$625 – Repair of tendons and/or ligaments, torn rotator cuffs, ruptured discs, or torn knee cartilages \$300 – Arthroscopy without surgical repair, or miscellaneous surgery requiring general anesthesia that is not covered by any other specific-sum injury benefit. Miscellaneous surgery limited to one surgery per 24-hour period.

Accident Insurance Continued

Wellness Screening Benefit	Applies to employee and dependent coverage. Pays \$50 per benefit year for one covered wellness screening test performed while covered under the policy. (See General Information for list of covered tests)
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Accident Monthly Premiums	
Plan	
Accident with Wellness Option	
Employee	\$20.88
Employee plus Spouse	28.14
Employee plus Child	31.03
Employee plus Family	38.29

Critical Illness

Group Critical Illness Insurance Schedule

Employee	Units of \$5,000, up to a maximum of \$50,000
Spouse	Units of \$2,500, up to a maximum of \$25,000. Amount cannot exceed 50% of the employee amount.
Child	Units of \$2,500, up to a maximum of \$5,000. Amount cannot exceed 50% of the employee amount.
Age Reductions	50% at age 70, rounded to the next highest \$1000

Guarantee Issue Limits

Employee Guarantee Issue	\$10,000
Spouse Guarantee Issue	\$5,000
Child(ren) Guarantee Issue	\$5,000

Core Covered Conditions	Initial Diagnosis Benefit	Recurrence Benefit *
Heart Attack	100% of face amount	100% of face amount
Stroke	100%	100%
End Stage Kidney Disease	100%	100%
Major Organ Failure	100%	100%
Coronary Bypass Surgery	25%	25%
Angioplasty	5%	5%
Occupational HIV / Hepatitis B,C or D	100%	NA
Core Recurrence Waiting Period	12 months wait after initial diagnosis or procedure	
Cancer Option		
Invasive Cancer	100%	0%
Cancer in Situ	25%	0%
Skin Cancer	5%	0%
Supplemental Conditions - Option 1	Included	
Blindness	100%	NA
Loss of Speech	100%	NA
Loss of Hearing	100%	NA
Supplemental Conditions - Option 2	Included	
Benign Brain Tumor	100%	NA
Paralysis	100%	NA
Coma	100%	NA
Supplemental Conditions - Option 3	Included	
Advanced ALS	100%	NA
Advanced Alzheimer's	25%	NA
Advanced Parkinson's	25%	NA

Critical Illness Insurance

Monthly Critical Illness Rates Per \$1,000 of Benefit				
Employee Issue Age	Employee Non-Tobacco	Employee Tobacco	Spouse Non-Tobacco	Spouse Tobacco
0-29	\$0.75	\$0.95	\$0.75	\$0.95
30-39	1.13	1.63	1.13	1.63
40-49	2.03	3.46	2.03	3.46
50-59	3.47	6.52	3.47	6.52
60-69	5.40	11.94	5.40	11.94
70+	11.80	20.77	11.80	20.77
Monthly Critical Illness Rates Per \$1,000 of Benefit				
All Eligible Dependent Children	\$0.28			

Monthly Wellness Premiums			
	Employee	Spouse	Child
\$50 Wellness Benefit Per Person	\$1.48	\$1.48	No Charge

WHO TO CALL



It's good to be Blue.

BLUE CROSS BLUE SHIELD OF MISSISSIPPI

Claims * ID cards * benefit questions * Prescription Formulary

www.bcbsms.com

1-800-942-0278



ASSURANT Employee
Benefits

Dental * Vision * Life * Disability* Accident * Critical Illness

www.assurantemployeebenefits.com



REGIONS
INSURANCE, INC.

Anna Metz

Account Manager

Anna.Metz@regions.com

601-790-8527

IMPORTANT NOTICES

There are several important notices in this guide that the Blue Cross Blue Shield of MS (referred to as the “Plan”), as sponsored by Leake LTC, LLC (referred to as the “Company”) is required to provide to employees. Please be sure to review these notices and contact Human Resources with any questions.

The notices included are:

1. Medicare Part D Disclosure Notice
2. The Woman’s Health and Cancer Rights Act of 1998 (WHCRA) Notice
3. Special Enrollment Notice
4. COBRA Coverage Notice
5. Notice of Privacy Practices

1. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Leake LTC, LLC 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.

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

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. The Company has determined that the prescription drug coverage offered by the Plan, 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 coverage through the Company will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits, and this Plan will coordinate with Medicare Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage through the Company, be aware that you will also drop coverage for other health expenses and that you and your dependents may not be able to get this coverage back until an Open Enrollment period or you experience a qualifying event.

You can retain your existing coverage and elect not to enroll in a Medicare Part D prescription drug plan. 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 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 through the Company and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll 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 the Company changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov;
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help; or
- Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available.

For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

Date:	05/01/2017
Name of Entity/Sender:	Leake LTC, LLC
Contact-Position/Office:	Linda Wilcher
Address:	1100 MS-16, Carthage, MS 39051

2. *Woman's Health and Cancer Rights Act of 1998 (WHCRA) Notice*

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 plan administrator.

3. *Special Enrollment Notice*

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

Loss of Other Coverage

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

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer of your request of enrollment in writing within 30 days of the date coverage ends, you and your eligible dependents may be eligible to enroll in coverage under our health plan.

Marriage, Birth or Adoption

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

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

Medicaid or CHIP

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

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

4. COBRA Coverage Notice

In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end as a result of certain events defined under federal law (known as qualifying events).

Qualified beneficiaries are entitled to elect COBRA when a qualifying event occurs, and, as a result of the qualifying event, coverage for that qualified beneficiary ends. Qualified beneficiaries who elect COBRA continuation coverage must pay for coverage at their own expense.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce or legal separation, or a child ceasing to be an eligible dependent. The maximum period of COBRA continuation coverage is generally either 18 or 36 months, depending on the qualifying event.

For questions regarding any of the above notices, including Medicare Part D, WHCRA or COBRA, or to request special enrollment or obtain additional information, please contact: HR

5. Notice of Privacy

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ See page 2 for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ See page 3 for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ See pages 3 and 4 for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the [information](#) on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you

Effective Date: 05/01/2017

Privacy Officer: Linda Wilcher

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

In addition to the important notices included in your open enrollment packet, the Leake LTC, LLC, Group Employee Benefit Plan (referred to as the "Plan"), as sponsored by Leake LTC (referred to as the "Company") is also required to provide employees the following notice regarding **Premium Assistance Under Medicaid and the Children's Health Insurance Program**. Please be sure to review this notice and contact Human Resources with any questions.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, 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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/indexes.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473

TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT – Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Services Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2017 open enrollment period for health insurance coverage through the Marketplace ran from Nov. 1, 2016, through Jan. 31, 2017. Individuals must have enrolled or changed plans prior to Dec. 15, 2016, for coverage starting as early as Jan. 1, 2017. After Jan. 31, 2017, you can get coverage through the Marketplace for 2017 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year (9.56 percent for 2015), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Linda Wilcher; Leake LTC, LLC; 1100 MS-16, Carthage, MS 39051; 601-267-1352**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.