2017 Guía de inscripción de beneficios para empleados

Año del plan: 1 de octubre de 2017 - 30 de septiembre de 2018




Rev. 8.29.17

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INFORMACIÓN DEL CONTACTO

Contact	Phone	Email/Website
Médico-Aetna	1.877.352.2583	www.aetna.com
Dental-Aetna	1.800.487.5553	www.aetna.com
Visión-Aetna	1.877.9.SEE.AETNA	www.aetnavision.com
Vida / Incapacidad-Aetna	1.800.351.7500	www.aetna.com
Sandy Harrington-Gerente de Cuenta Alltrust	727.772.4214	sharrington@alltrustinsurance.com

Esta guía destaca sus beneficios. No es una descripción sucinta del plan (SPD). El plan oficial y los documentos de seguro realmente rigen sus derechos y beneficios, incluyendo los gastos cubiertos, exclusiones y limitaciones. Por favor refiérase a los SPD's para mayor aclaración. Si existe alguna discrepancia entre esta guía y los documentos oficiales, prevalecerán los documentos oficiales.

ELIGIBILIDAD

Empleados

- Todos los empleados a tiempo completo son elegibles para los beneficios en el primer día del mes siguiente o siguiente que coincida con 60 días de empleo continuo. Para ser elegible para los beneficios, los empleados deben trabajar por lo menos 30 horas por semana.

Dependientes

- Sus dependientes elegibles también pueden participar en el plan; sin embargo, sus dependientes pueden no inscribirse en el plan a menos que usted también esté inscrito en ese plan.

Se considera que un dependiente elegible es:

- Su cónyuge legal.
- Usted o el hijo de su cónyuge, incluyendo un hijo natural, un hijastro, un hijo legalmente adoptado, un niño colocado para adopción o un niño para el cual usted o su cónyuge son el tutor legal que cumple con las siguientes restricciones de edad:

  Los niños con dependencia médica están cubiertos hasta los 30 años.

  Dental y niños dependientes de la visión están cubiertos hasta el final del año calendario en el cual alcanzan la edad de 26 años.

  Los niños dependientes de AD / D y de Vida Voluntaria están cubiertos hasta los 20 años (26 si son totalmente dependientes de los padres y un estudiante de tiempo completo). Se requerirá una prueba de la condición de estudiante cada año.
- Un niño que es apoyado principalmente por usted e incapaz de auto-sostenerse el empleo por las razones de la desventaja mental o física (la prueba de su condición y dependencia se debe presentar).
- Un dependiente también incluye a un niño para quien se requiere cobertura de atención médica a través de una

EVENTOS DE CALIFICACIÓN

Una vez que haya realizado sus elecciones, NO podrá cambiarlas hasta el siguiente período de inscripción abierta a menos que tenga un cambio calificado en el evento de estatus. Esto se debe a la Sección 125 del código del Servicio de Impuestos Internos (IRS), que le permite pagar ciertas primas de seguro de grupo con dólares libres de impuestos. Usted debe hacer sus elecciones de beneficios cuidadosamente, incluyendo la opción de renunciar a la cobertura. Los cambios de calificación en los eventos de estado incluyen pero no se limitan a:

- Matrimonio o divorcio;
- Muerte del cónyuge u otro dependiente;
- Nacimiento o adopción de un niño;
- Empieza o termina el empleo de un cónyuge;
- Un estado de elegibilidad dependiente cambia debido a la edad, estado de estudiante, estado civil o empleo;
- Usted o su cónyuge experimentan un cambio en las horas de trabajo que afectan la elegibilidad de los beneficios; o
- Reubicación dentro o fuera del área de servicio de su plan

Todos los cambios debidos a un evento calificador deben hacerse dentro de 30 días del cambio de estado familiar. Consulte con su Departamento de Recursos Humanos si tiene

MEDICAL—AETNA

Resumen de Beneficios	HNOnly 3000
En red	
Finanzas	
Deducible (solo / familia)	$3,000 / $6,000
Coaseguro (portador / miembro)	70%/30% *
Máximo de bolsillo (unifamiliar)	$6,500 / $13,000 incluye deducible, coseguro, copagos y Rx
Servicios Médicos	***Visitas preventivas: Sin cargo***
Atención primaria	$30 copago
Especialista	$65 copago
Hospitalización	
Hospitalización para pacientes internados	30% después del deducible se cumple
Cirugía ambulatoria	30% después del deducible se cumple
Servicios Médicos (Hospital y ER)	30% después del deducible se cumple
Atención de urgencias	$100 copago
Sala de emergencias	$300 copago
Diagnóstico Ambulatorio	***Laboratorio contratado: Quest***
Diagnóstico de rutina (Laboratorio y rayos X)	Lab: No copago X-ray: $65 copago
Diagnóstico principal (MRI, CAT, PET Scans, etc.)	$300 después del deducible se cumple
Recetas de Medicamentos	
Nivel 1 (Generics)	$10 copago
Nivel 2 (Marca)	$45 copago
Nivel 3 (no marca)	$70 copago
Nivel 4 (Especialidad)	30% hasta un máximo de $250
Farmacia de pedidos por correo	2 x opago al menudeo (90 suministro diario)
Fuera de la red	
Deducible (solo / familia)	N/A
Co-seguro	N/A
Max de bolsillo (unifamiliar)	N/A

* Deductible must be met before coinsurance is applied.

Our Employee Benefits Advocates Can Help

Did you know you have a benefits advocate to help you navigate the maze of insurance and claims?

You are not alone. Alltrust Insurance provides you with an advocate, offering services to help you deal with insurance problems you may be facing.

alltrust
For the Health of your Business™

What does the Advocate do?

Your Advocates helps with a variety of areas that you may be having trouble with, such as:

- Benefit questions; what is my copay, is this procedure covered?
- Claims resolution.
- Access to Care (help with RX issues or finding a doctor).
- Going on vacation and need early medication refill.
- At the pharmacy and need help
- Going into hospital and not sure what to do.

The Advocates offer education, awareness and claims resolution services to help you with your questions/problems. And your participation with the advocate is strictly confidential.

Advocate assistance available Monday – Friday 8AM-5PM

Claims Advocate: Kim Hubbard

Phone: 727.772.4233 or 1.888.563.7278 x 4233

Email; khubbard@alltrustinsurance.com

Benefits Advocate: Sandy Harrington

Phone: 727.772.4214 or 1.888.563.7278 x 4214

Email; Sharrington@alltrustinsurance.com

made available through aetna®

TELADOC™

Can't leave work for the care you need?

Feeling sick but need to get the job done? This is a common scenario for people in the workplace. Teladoc® can help you combat illnesses that prevent you from performing at your best. **Talk to a doctor anytime without leaving work.**

WHAT IS TELADOC?

Teladoc gives you 24/7/365 access to U.S. board-certified doctors who can treat many of your medical issues by phone or video. It is not insurance but an added medical benefit that gives you an affordable alternative to costly urgent care or ER visits.

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for $40 or less!

Teladoc.com/Aetna

1-855-Teladoc (835-2362)

Facebook.com/Teladoc

Teladoc.com/mobile

Teladoc is being provided as a pilot program to fully-insured Aetna members and members of plans administered by Aetna. It is not available in all States. It is also provided to self-insured Aetna members and members of plans administered by Aetna whose employer has elected to offer the program to their employees. Teladoc and Teladoc physicians are independent contractors and are neither agents nor employees of Aetna or plans administered by Aetna. Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

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SAVE $$$ ON PRESCRIPTIONS

Publix Has FREE Oral Antibiotics!

In order to help consumers like you save on healthcare costs—Publix has great deals on certain generic antibiotics doctors often prescribe. New or current customers: bring in your prescription for one of the generic oral antibiotics listed below to your neighborhood Publix Pharmacy and receive it FREE, up to a 14-day supply. There are no limits on the number of prescriptions you can have filled. And they're FREE to you regardless of your prescription insurance provider.

⇒ Amoxicillin

⇒ Ampicillin

⇒ Sulfamethoxazole/trmethoprim (SMZ-TMP)

⇒ Ciproflaxacin (excluding Ciprofloxacin XR)

⇒ Penicillin VK

Free Lisinopril

Now you can get a 30 day supply of Lisinopril for FREE at Publix. All strengths included. Maximum of 30 day supply (60 tablets). Lisinopril – HCTZ combination products are excluded. Talk to your local Publix pharmacist for details or log onto www.publix.com

Free Metformin

As part of the Publix Pharmacy Diabetes Management System, you can get up to a 30 day supply (90 tablets) of generic immediate-release Metformin (500mg, 850mg, and 1000mg) FREE.

Free Amlodipine

This calcium channel blocker is used to treat high blood pressure and chest pain (angina). Thirty-day supply at a time. (Up to 60 2.5-mg or 5-mg tablets, or 30 10-mg tablets. Amlodipine combination products excluded.)

TIPS FOR SAVING ON MEDICAL EXPENSES

Health care costs continue to increase. This continuing trend can significantly impact your budget. Here are some helpful (suggested) tips on how to save on your medical and pharmacy expenses.

1. **Look into discount generic drug programs that local pharmacies offer.**
2. **Research brand name drug rebates online.** Many manufacturers offer discount/rebates.
3. **Look into freestanding surgical and diagnostic centers.** If you need surgery, you might save money by having it performed at an ambulatory surgical center (a clinic that is not associated with a hospital.) These sites usually charge less than hospitals or their outpatient surgical centers. Freestanding diagnostic centers are also available and tend to charge less for certain tests like MRIs, CAT scans, X-rays and bone density scans. But before you go, make sure the facility is in your plan's network and that your plan's benefits cover the service.
4. **Use in-network providers**: Participating providers (doctors, hospitals, and others in your plan's network) generally charge discounted rates for plan members. When you go to a non-participating provider you will likely pay a higher coinsurance percentage. And, you will likely have to pay the difference in price between the participating provider's discounted fee and the non-participating provider's "regular" fee.
5. **Reference the below chart on where you should go for care.**

Care center	Why would I use this care center	What type of care would they provide for example*	What are the cost** and time considerations?**
Doctor's Office 	You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide preventive and routine care, manage your medications and refer you to a specialist, if necessary.	▸ Routine checkups ▸ Immunizations ▸ Preventive services ▸ Manage your general health	▸ Often requires a copayment and/or coinsurance ▸ Normally requires an appointment ▸ Little wait time with scheduled appointment
Convenience Care Clinic 	You can't get to your doctor's office, but your condition is not urgent or an emergency. Convenience care clinics are often located in malls or retail stores offering services for minor health conditions. Staffed by nurse practitioners and physician assistants.	▸ Common infections (e.g.: strep throat) ▸ Minor skin conditions (e.g.: poison ivy) ▸ Flu shots ▸ Pregnancy tests ▸ Minor cuts ▸ Ear aches	▸ Often requires a copayment and/or coinsurance similar to office visit ▸ Walk in patients welcome with no appointments necessary, but wait times can vary
Urgent Care Center 	You may need care quickly, but it is not an emergency, and your primary physician may not be available. Urgent care centers offer treatment for non-life threatening injuries or illnesses. Staffed by qualified physicians.	▸ Sprains ▸ Strains ▸ Minor broken bones (e.g.: finger) ▸ Minor infections ▸ Minor burns	▸ Often requires a copayment and/or coinsurance usually higher than an office visit ▸ Walk in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first
Emergency Room 	You need immediate treatment of a very serious or critical condition. The ER is for the treatment of life-threatening or very serious conditions that require immediate medical attention. **Do not ignore an emergency. If a situation seems life threatening, take action. Call 911 or your local emergency number right away.**	▸ Heavy bleeding ▸ Large open wounds ▸ Sudden change in vision ▸ Chest pain ▸ Sudden weakness or trouble talking ▸ Major burns ▸ Spinal injuries ▸ Severe head injury ▸ Difficulty breathing ▸ Major broken bones	▸ Often requires a much higher copayment and/or coinsurance than an office visit or urgent care visit ▸ Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first

DENTAL—AETNA

Existe una fuerte conexión entre la salud oral y la salud general de una persona. Un examen dental de rutina puede detectar síntomas de más de 125 enfermedades, incluyendo enfermedades del corazón, anemia, úlceras estomacales, osteoporosis y enfermedad renal. Sus dependientes elegibles también pueden participar en el plan; sin embargo, sus dependientes pueden no inscribirse en el plan a menos que usted también esté inscrito. Para encontrar un dentista participante, vaya a

	PPO Plan
Deducible por año calendario	$50 / $150
Beneficio máximo del año calendario * Vea su paquete de inscripción para más detalles	$1,000 por miembro
Tipo 1: Servicios Preventivos ➤ Exámenes (2 cada 12 meses) ➤ Limpieza de Rutina (2 cada 12 meses) ➤ Radiografías (series de boca y boca llena (limitaciones de frecuencia)	Servicios Diagnósticos y Preventivos Cubiertos 100%
Tipo 2: Servicios Dentales Básicos ➤ Extracciones sencillas ➤ Rellenos ➤ Coronas de acero inoxidable ➤ Extracción quirúrgica del diente erupcionado ➤ Extracción quirúrgica del diente impactado (tejido blando) ➤ Anestesia (limitada a 60 minutos por sesión)	Después de Deducible cubierto al 100%
Tipo 3: Servicios Dentales Mayores ➤ Coronas (no dentro de los 5 años anteriores a la colocación) ➤ Periodoncia Quirúrgico y no quirúrgico (ver el resumen del plan para las limitaciones) ➤ Endodoncia Quirúrgico y no quirúrgico (ver el resumen del plan para las limitaciones) ➤ Dentadura postiza ➤ Puentes	Después de Deducible cubierto al 60%
Ortodoncia	Descubierto
Beneficios fuera de la red	**Los servicios fuera de la red se reembolsan con base en el 90% de la tarifa habitual y habitual**
Deducible por año calendario	$100 / $300
Tipo 1: Servicios Preventivos	Cubierto al 90%
Tipo 2: Servicios Dentales Básicos	Después de Deducible cubierto 70%
Tipo 3: Servicios Dentales Mayores	Después de Deducible cubierto 40%
Provisión para participantes tardíos: Le recomendamos firmemente que se inscriba en la cobertura cuando usted sea elegible inicialmente. Si decide no inscribirse durante su período inicial de inscripción de nuevo empleado, se considerará un participante tardío. Los participantes tardíos serán elegibles para los exámenes, limpiezas y aplicaciones de fluoruro durante los primeros 12 meses cubiertos.	

VISION—AETNA

Su visión es importante para su salud. Si 20/20 o menos que perfecto, cada uno debe recibir cuidado regular de la visión. Puede acudir a cualquier proveedor de visión, pero maximizará sus beneficios y ahorrará costes al ver a un proveedor de la red. **Para encontrar un proveedor, visite www.aetnavision.com. Red de la visión; Aetna Vision Preferred Network.**

AETNA		
Vea el Resumen del Plan para más detalles	**En red**	**Fuera de la red**
Frecuencia de beneficios Exámenes de los ojos Lentes o contactos de prescripción Cuadros	Una vez cada 12 meses Una vez cada 12 meses Una vez cada 24 meses	
Copagos de Beneficios Examen ocular con dilatación	$10 copago	Hasta $ 25 de reembolso
Lentes de Prescripción *Visión única* *Bifocales alineados* *Trifocal forrado* *Vea su Resumen de Beneficios para más copias y beneficios de lentes especiales de especialidad*	$10 copago $10 copago $10 copago	Hasta $ 20 de reembolso Hasta $ 40 de reembolso Hasta $ 65 de reembolso
Cuadros Vea su Resumen de Beneficios para más copias y beneficios de lentes especiales de especialidad	$ 130 de subsidio después de copago de $ 25 + 20% de descuento	Hasta $ 65 de reembolso
Lentes de contacto (electiva) En lugar de gafas Evaluación Estándar, Adaptación y Cuidado de Seguimiento Indemnización por Materiales no Recaudados Materiales de Colección	Examen de Ajuste y Seguimiento: $ 40 Se deben usar hasta $ 115 (electivos) de una sola vez	Hasta $ 80 de reembolso
Lentes de Contacto Médicamente Necesarias ***Se requiere autorización previa***	Cubierto en su totalidad	Hasta $ 200 de reembolso

Lasik descuentos de corrección de la visión por láser para los miembros: 15% de descuento en la venta al por menor o 5% de descuento en el precio promocional. Llame al 1-800-422-6600 para obtener información adicional

Tarjetas de identificación: Las tarjetas de identificación digital están disponibles en www.aetna.com.

SEGURO DE VIDA—AETNA

Vida pagada por el empleador y AD & D

Sutter Roofing provee a todos los empleados elegibles con un empleador pagado vida básica y cobertura de AD & D a través de Aetna. En caso de su muerte, su beneficiario recibirá un beneficio vitalicio de $ 20,000. Si usted pierde un accidente, la póliza también incluye un beneficio por muerte accidental igual al monto del beneficio vitalicio. Bajo esta póliza, el monto del beneficio se reduce a 65 por ciento a los 65 años y 40 por ciento a los 70 años. Por favor, tenga en cuenta que cuando usted designa a menores como beneficiarios, es importante entender que los beneficios del seguro no pueden ser liberados a un menor. Sin embargo, pueden ser pagados a un tutor designado por el tribunal de la herencia del niño. Los reglamentos que rigen a los beneficiarios menores pueden variar según el estado.

Vida voluntaria

Los empleados pueden comprar seguros de vida adicionales, para ayudar a proteger a sus familias. Consulte a continuación o su paquete de inscripción para obtener detalles sobre los beneficios.

Pautas de cobertura	Cantidad del Beneficio	Descripción del Beneficio
Empleado	• Cantidad del Beneficio • Cantidad de la Emisión de la Garantía (al inicio de la nueva elegibilidad de alquiler) • Programa de reducción de la edad	Usted puede elegir cobertura en incrementos de $ 10,000 a un máximo de $ 500,000, no exceder 5 veces su salario anual. Nuevo Elegible / nuevo contrato: $ 50,000 65 años de edad se reduce en un 35% de la cantidad original. A los 70 años se reduce en un 60% de la cantidad original. 75 años de edad se reduce en un 75% de la cantidad original.
Conyugue	• Cantidad del Beneficio • Cantidad de la Emisión de la Garantía (al inicio de la nueva elegibilidad de alquiler)	La cobertura está disponible en unidades de $ 5,000 a un máximo de $ 100,000, no excediendo el 50% del beneficio del empleado. Nuevo elegible / nuevo empleado: $ 25,000 El empleado debe elegir la cobertura para que el cónyuge sea elegible
Niño	• Cantidad del Beneficio • Los dependientes deben ser solteros, por lo menos 14 días de edad pero menores de 19 años; o menores de 26 años, siempre que él / ella sea un estudiante a tiempo completo y solo dependa de usted para apoyo	La cobertura está disponible en incrementos de $ 1,000 a un máximo de $ 10,000, no excediendo el 50% del beneficio del empleado. El empleado debe elegir la cobertura para que el niño sea elegible La vida del niño es un precio si usted tiene 1 niño o niños múltiples que se enrolan.

Tenga en cuenta que las tarifas se basan en la edad y el nivel del beneficio, y que las tasas de cónyuge se basan en su edad. La cobertura para niños dependientes es un costo fijo para todos los niños. Si no elige la cobertura cuando es elegible inicialmente, deberá completar un formulario de Evidencia de Insuficiencia para revisar y aprobar la suscripción antes de que se emita la cobertura.

DEDUCCIONES DE SALARIO

Las deducciones de nómina para todas las coberturas se toman sobre una base semanal.

Plan Médico

Nivel	SIN TABACO	TABACO
Empleado	$34.62	$39.81
Empleado + Cónyuge	$84.23	$96.87
Empleado + Niño (s)	$84.23	$96.87
Empleado + Familia	$138.46	$159.23

Dental y Visión

Nivel	Dental	Visión
Empleado	$5.70	$1.36
Empleado + Cónyuge	$12.61	$2.92
Empleado + Niño (s)	$12.61	$2.92
Empleado + Familia	$19.60	$4.82

Vida Voluntaria

Resumen del costo Por Categoría de edad	Vida Opcional y AD & D Tarifas Por $ 1,000 Empleado	Conyugue	7/5000
Menor de 20	$0.199	$0.199	$0.193 por cada $ 1,000 de cobertura
20 - 24	$0.202	$0.202	
25 - 29	$0.204	$0.204	
30 - 34	$0.220	$0.220	
35 - 39	$0.265	$0.265	
40 - 44	$0.359	$0.359	
45 - 49	$0.551	$0.551	
50 - 54	$0.842	$0.842	
55 - 59	$1.553	$1.553	
60 - 64	$1.685	$1.685	
65 - 69	$2.582	$2.582	
70 - 74	$5.042	$5.042	
75 - 79	$10.753	$10.753	
80 - 84	$10.753	$10.753	
85 - 89	$10.753	$10.753	
90 - 94	$10.753	$10.753	
95 - 99	$10.753	$10.753	
AD & D (todas las edades)	$0.037	Familia: $ 0.043	

SUTTER ROOFING ANNUAL NOTICES –PLAN YEAR 2017

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment 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. If you would like more information on WHCRA benefits, call your plan administrator.

NOTICE OF PATIENT PROTECTIONS

Aetna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers visit Aetna at www.aetna.com.

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

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

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 are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, 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 or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free **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 July 31, 2016. You should contact your state for further information on eligibility.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	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 1-800-403-0964
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075

NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	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
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: 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

To see if any more states have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

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

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

COBRA CONTINUATION OF COVERAGE

Under the federal law, known as COBRA, you and your dependents generally may continue medical, dental, and vision if coverage ends due to either:

- A reduction in the number of hours you work or
- Termination of your employment for any reason other than gross misconduct.

Your dependents may continue their medical, dental and vision coverage under this plan if their coverage ends for any of the following reasons:

- Your death
- You become entitled to Medicare
- Your divorce, annulment, or legal separation, provided the company is notified within 60 days
- Your dependent loses dependent status, provided the company is notified within 60 days.

This is not a complete description of all COBRA-related provisions. You should consult your SPD for more details.

The following chart shows how long you can continue your COBRA coverage:

If you lose coverage because . . .	Then you can continue coverage for . . .
You are no longer eligible	18 months
You are no longer eligible and either you or your dependent is disabled (according to the Social Security Administration) within 60 days of your loss of eligibility	29 months

If your dependent loses coverage because . . .	Then your dependent can continue
Of your death	36 months
You become eligible for Medicare after your COBRA election begins	36 months
You and your spouse divorce	36 months
He or she is no longer a dependent (because of age or divorce)	36 months

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

- 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 limitations on plans' imposing a pre-existing condition exclusion and such exclusions will 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, or
- 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 or beneficiary not receiving continuation coverage (such as fraud).

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. 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. Continuation coverage may be elected for only one, several or all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the 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 listed above. 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.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

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

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure 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 within 30 days of the date coverage ends, you and your eligible dependents may apply for 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.

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

GINA WARNING AGAINST PROVIDING GENETIC INFORMATION

For Wellness Programs Requesting Medical Information

The Genetic Information Nondiscrimination Act (GINA) prohibits collection of genetic information by both employers and health plans, and defines genetic information very broadly. Asking an individual to provide family medical history is considered collection of genetic information, even if there is no reward for responding (or penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses. An employer administering a wellness program might include on the relevant forms a warning such as the following:

> In answering these questions, do not include any genetic information. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which an individual may be at risk.

FAMILY AND MEDICAL LEAVE ACT OF 1993

You are eligible for leave under the Family and Medical Leave Act (FMLA) if you have been employed for a total of 12 months and worked at least 1,250 hours during the 12 months preceding the leave.

Eligible employees will receive up to 12 weeks of leave within any rolling 12-month period for the birth or adoption of a child, for the employee's own serious health condition, or to care for a child, spouse, or parent with a serious health condition.

Eligible employees may also be eligible for FMLA leave to care for a family member who is a member of the Armed Forces under certain circumstances.

NOTICE OF PRIVACY PRACTICES

The group health plan (the Plan) offers health benefits to eligible employees of Sutter Roofing (the Company) and their dependents as described in the summary plan descriptions for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of maintaining these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses personal health information (PHI).

NOTICE OF ADVERSE BENEFIT DETERMINATION

Employer-sponsored group health plans are required to provide notice of an adverse benefit determination when a claim is first denied.

- In the case of a claim filed after medical services are provided, notice of the adverse benefit determination is required within 30 days of filing, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits) the notice of adverse benefit determination with respect to a non-urgent claim is required within 15 days of filing, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- If the pre-service claim is for urgent care, the notice of adverse benefit determination generally is required within 24 hours of filing.

These timing rules are currently in effect for ERISA plans, except that the 24-hour deadline for urgent pre-service claims will become effective for plan years starting on or after September 23, 2010 (currently the requirement generally is to provide the notice within 72 hours). Available at: http://www.dol.gov/ebsa/IABDModelNotice2.doc. Spanish language version available at: http://www.dol.gov/ebsa/IABDModelNotice2sp.doc.

NOTICE OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

For plan years starting on or after September 23, 2010, employer-sponsored group health plans are required to provide notice of a final internal adverse benefit determination when internal appeals procedures have been completed. This notice is similar to the notice of decision on appeal that is currently required of ERISA plans under DOL regulations. If a plan has only one level of appeal, the final internal adverse benefit determination is the only notice of the decision on appeal that is required (provided it also meets applicable ERISA requirements). Plans may have one or two levels of internal appeals and, if a plan has two appeal levels, this model notice is intended for use only after the second internal appeal if it results in an adverse benefit determination.

In the case of a claim filed after medical services are provided, this notice is required within 60 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.

In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits), the notice of final internal adverse benefit determination with respect to a non-urgent claim is required within 30 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.

If the pre-service claim is for urgent care, the notice of final internal adverse benefit determination generally is required within 72 hours after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.

These timing rules are the same as those currently in effect for ERISA plans. Available at: http://www.dol.gov/ebsa/IABDModelNotice1.doc. Spanish language version available at: http://www.dol.gov/ebsa/IABDModelNotice1sp.doc.

NOTICE OF FINAL EXTERNAL REVIEW DECISION

For plan years starting on or after September 23, 2010, employer-sponsored group health plans are required to maintain an external review procedure that meets certain requirements, including a notice of final decision. The agencies have provided a model notice for that purpose. Available at: http://www.dol.gov/ebsa/ IABDModelNotice3.doc. Spanish language version available at: http://www.dol.gov/ebsa/IABDModelNotice3sp.doc.

PREVENTIVE SERVICES

The Patient Protection and Affordable Care Act, or healthcare reform, introduced changes to how many health plans cover preventive services. The legislation's provisions on preventive health coverage affect non -grandfathered health plans (those that began providing coverage after March 23, 2010, or made plan changes triggering the loss of grandfathered status) during plan years beginning on or after Sept. 23, 2010.

Under the new law, health plans must provide 100 percent coverage for certain preventive services and immunizations provided by a network doctor or hospital. Cost-sharing requirements, such as co- payments, deductibles or coinsurance, are prohibited for preventive health provided by a network healthcare provider. However, health plans are not required to provide coverage for preventive services from non-network hospitals and doctors, and they may impose a cost-sharing requirement when the services are provided out of network.

Other Considerations

- A plan is not required to provide coverage for a particular preventive service until the plan year that begins one year after the date the recommendation or guideline was issued.
- A health plan may use reasonable medical management approaches to determine the appropriate frequency, method or setting for a preventive service if it is not specified in guidelines or recommendations.

Office Visits

- If an office visit is billed separately from the preventive service, then the plan may impose a cost-sharing requirement on the office visit.
- If a preventive service is not billed separately from an office visit, and the primary purpose of the office visit is the delivery of the preventive service, then no cost-sharing requirements may be applied to the office visit.
- If the preventive service is not billed separately from the office visit, but the primary purpose of the office visit was for something other than the delivery of the preventive service, then the plan may impose a cost-sharing requirement on the office visit.

Important Notice from Sutter Roofing 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 Sutter Roofing and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Sutter Roofing has determined that the prescription drug coverage offered by Sutter Roofing is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Sutter Roofing and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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 Sutter Roofing 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
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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


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