walking mountains™
science center

2018-2019 Benefits at a Glance

December 1st, 2018 – November 30th, 2019

CONTENT INFORMATION

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

ENROLLMENT SYSTEM - WEB BENEFITS DESIGN

Web Address	www.hrconnection.com

HUMAN RESOURCES Kathleen O'Toole-Gilles

Email	kathleenog@walkingmountains.org
Phone	970-827-9725 ext. 134

BROKER PARTNER – NEIL-GARING / MOUNTAIN WEST INSURANCE

Broker Contact	Andrea Cheney
Phone	970-945-9111 ext 150
Email	acheney@neil-garing.com

MEDICAL page 3

Provider	CIGNA
Phone	1-866-494-2111
Web Address	www.mycigna.com
TeleHealth	1-888-726-3171
Web Address	MDLivefor Cigna.com

DENTAL page 8

Provider	Guardian
Phone	1-800-459-9041
Web Address	www.guardiananytime.com

VISION page 9

Provider	Guardian - VSP
Phone	1-800-459-9041
Web Address	www.vsp.com

FLEXIBLE SPENDING ACCOUNT page 10

Administrator	Rocky Mountain Reserve
Phone	888-722-1223
Web Address	www.rockymountainreserve.com

HEALTH SAVINGS ACCOUNT page 10

Administrator	HSA Bank
Phone	1-800-357-6246
Web Address	www.hsabank.com

LIFE INSURANCE page 11

Provider	Guardian

SHORT TERM DISABILITY page 11

Provider	Guardian

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BENEFIT INFORMATION

YOUR BENEFITS PLAN

Walking Mountains offers a variety of benefits allowing you the opportunity to customize a benefits package that meets your personal needs.

In the following pages, you'll learn more about the benefits offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

Benefit	Who pays the cost?
Medical	Walking Mountains pays approximately 70% of the employee cost for the Gold & Silver Plans and 85% of the cost for the Bronze HSA plan.
Dental	Walking Mountains offers dental coverage on a voluntary basis and pays 75% for the employee.
Vision	Walking Mountains offers vision coverage on a voluntary basis. Employees pay 100% of the cost.
Life	Walking Mountains provides life coverage to all full-time employees.
Short Term Disability	Walking Mountains provides short term disability coverage to all full-time employees.
GAP Plans	Walking Mountains offers GAP insurance on a voluntary basis to assist employees with deductible expenses. There are two GAP plans to choose from; one is HSA compliant and one can be selected with the Gold & Silver medical plans.

PRE-TAX BENEFITS

CHOOSING YOUR BENEFITS

The premium for elected coverages are taken from your paycheck automatically. There are two ways that the money can be taken out, pre-tax or post –tax.

WHY DO I PAY FOR BENEFITS WITH PRE-TAX MONEY?

There is a definite advantage to paying for some benefits with pre-tax money. Taking the money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.

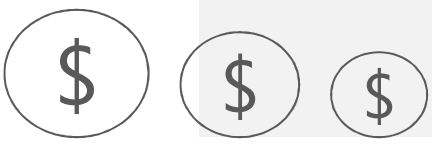
WHICH BENEFIT PREMIUMS ARE TAKEN BEFORE TAX?

PRE tax –

Medical, Dental, Vision, FSA, HSA, 401K

POST tax –

GAP Plans, Roth 401K



ELIGIBILITY

All full-time year round employees and educators are eligible to join the Walking Mountains Benefits Plan once the waiting period has been satisfied. Coverage will begin on the 1st of the month following 60 days from your date of hire. "Full-Time Year Round Employees and Educators" must be regularly scheduled and working at least 30 hours per week. You may also enroll your dependents in the Benefits Plan when you enroll.

WHO'S AN ELIGIBLE DEPENDENT?

- Your legal spouse, civil union partner, common law spouse or domestic partner (with appropriate documentation)
- Your children under age 26, including foster children, legally adopted children and children placed with you for adoption, step children, and children for whom you have legal guardianship
- Your dependent children per above definitions, over age 26, who are physically or mentally unable to care for themselves

WHEN CAN YOU ENROLL?

You can sign up for Benefits at any of the following times:

- As a new hire, at your initial eligibility date.
- During the annual open enrollment period, effective December 1st of each year.
- Within 30 days of a qualified family-status change.

If you do not enroll at one of the above times, you may enroll during the next annual open enrollment period.

MAKING CHANGES

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change your benefit elections during the plan year if you have a change in status including:

- Your marriage or divorce
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects your benefits
- Change in your work status that affects your benefits
- Change in residence that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

You must **submit documentation as proof of life event to within 30 days**. The IRS allows changes to be made within 60 days for those eligible for Medicaid or CHIP under HIPAA Special Enrollment Rights.

If you fail to do so you will be required to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

WHEN DOES COVERAGE END?

Coverage will run through the end of the month following termination / resignation.

Upon termination / resignation of employment, prorated medical / dental / voluntary life premiums will be taken from the final payroll check.

MEDICAL INSURANCE

Walking Mountains offers medical coverage through Cigna. You have three plan options to choose from. To find participating providers go to www.cigna.com and click on "Find a Doctor", then follow the prompts to complete the search within the "Open Access Plus" network. The chart below provides a brief overview of the medical plans offered.

	BRONZE - HDHP / HSA	SILVER Plan	GOLD Plan
IN-NETWORK			
DEDUCTIBLE (your first dollar cost for covered in-network claims)			
Deductible (Individual / Family)	$6,000 / $12,000	$2,500 / $5,000	$1,500 / $3,000
COINSURANCE (your responsibility on claims costs once you've met the deductible)			
	0%	30%	20%
OUT OF POCKET MAXIMUM (once met all in-network covered services are covered by the plan)			
Maximum Out-of-Pocket (Individual / Family)	$6,650 / $13,300	$5,000 / $10,000	$4,000 / $8,000
Maximum Includes	Deductible, Coinsurance, Prescription Costs & Copays		
PREVENTIVE CARE			
Wellness, Immunizations, Mammography, Colonoscopy, etc.	Covered 100%, no cost to you		
OFFICE VISITS			
Referral Required		No	
Virtual Visits (refer to page 5)	***Up to $50***	***$25 Copay***	***$10 Copay***
Office Visits (Illness/Injury)	Covered 100% AFTER deductible	$25 Copay	$10 Copay
Specialist Visits	Covered 100% AFTER deductible	$50 Copay	$35 Copay
Chiropractic & Physical Therapy	Covered 100% AFTER deductible	$50 Copay, 20 visit limit	$35 Copay, 20 visit limit
HOSPITAL SERVICES			
Inpatient Hospital	Covered 100% AFTER deductible	Covered 70% AFTER deductible	Covered 80% AFTER deductible
Outpatient Surgery	Covered 100% AFTER deductible	Covered 70% AFTER deductible	Covered 80% AFTER deductible
Emergency Room	Covered 100% AFTER deductible	$350 Copay	$250 Copay
Urgent Care	Covered 100% AFTER deductible	Covered 70% AFTER deductible	$35 Copay
DIAGNOSTIC TESTING			
Lab & X-Ray / MRI, CAT, PET, etc.	Covered 100% AFTER deductible	Covered 70% AFTER deductible	Covered 80% AFTER deductible
PRESCRIPTIONS	**Medical deductible FIRST then,**		
Retail (30 day supply) Tier 1 / 2 / 3 / Specialty	$20 / $40 / $80 / $375	$20 / $40 / $80 / $375	$20 / $40 / $80 / $375
Medicare (Part D) Creditable	*No*	*Yes*	*Yes*
OUT–OF-NETWORK	Refer to plan summary for details . Copies can be found within forms library on the Benefits Portal.		
Deducible *Out of Pocket*	*$12,000 / $24,000* *$13,000 / $26,000*	*$5,000 / $10,000* *$10,000 / $20,000*	*NA*
	Bi-Weekly Cost for Coverage		
Employee Only	$31.02	$75.24	$81.15
Employee + Spouse	$237.77	$326.04	$351.63
Employee + Child(ren)	$206.76	$288.42	$311.06
Employee + Family	$413.53	$539.21	$581.55

This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. If the below illustration of benefits conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your exact description of services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Employee Assistance Program

Everyday support for everyday life
Some days it can be tough for your employees to take care of their jobs and their lives. Whether they can just use a little extra support or they're going through a crisis, we're here for our members and their families.

What we do for your employees
Members can call us 24/7 for free emotional support and daily life assistance. We're here to help with a wide variety of issues, such as:

- Stress and anxiety
- Self-improvement
- Emotional wellbeing
- Family conflict
- Legal and financial issues
- Alcohol and drug misuse
- Depression
- Grief and loss

800.386-7055

Visit www.ibhworklife.com
User Name : Matters
Password: wlm70101

TERMS TO KNOW

Discounted Rate

When you enroll in coverage you become a Cigna member. A member of Cigna gets access to their network of providers (doctors and facilities) – these are in-network providers. Cigna members receive Discounted Rates with these in-network providers.

Copays

Copays are set dollar amounts you pay for specific services. These cost are typically collected at the time of service. EX: you have a $50 copay for a visit to your primary care physician.

Deductible

Services not subject to a copay are subject to your deductible. You pay first dollar costs for claims subject to your deductible and you receive the Discounted Rate for all covered claims with an in-network provider.

Coinsurance

Coinsurance is a cost share. Once you meet the deductible, Cigna will share in the cost of your claims. The percent of the cost for the claim you are responsible for. The amounts you pay in coinsurance apply to your out of pocket maximum.

Out-of-Pocket

This amount is the maximum amount you will pay towards covered services on the plan for the calendar year. This amount includes the amounts you pay in deductible, coinsurance, copays, and prescription copays.

Preventive Care Services 100% Covered

Preventative Care for Adults

Abdominal aortic aneurysm screening
Aspirin Use
Cholesterol screening
(Colonoscopy)
Depression screening
Diet counseling
Obesity screening and counseling

Syphilis Screening
Preventive Vaccinations

Alcohol misuse screening and counseling
Blood Pressure screening
Colorectal cancer screening

Diabetes screening
HIV screening
Sexually transmitted infection prevention

counseling
Tobacco use screening

Preventative Care for Women

Anemia screening
(BRCA)
Breast cancer mammography screening
Breastfeeding support and counseling
Chlamydia infection screening
Domestic violence screening and
counseling
Gestational diabetes screening
Human Papillomavirus (HPV) DNA test
RH incompatibility screening
Well-woman visits

Breast cancer genetic test counseling

Brest cancer chemoprevention
Cervical cancer screening
Contraception – ACA Approved
Folic acid supplements
Gonorrhea screening
Hepatitis B screening
Osteoporosis screening
Urinary tract or other infection screening

Preventative Care for Children

Autism screening
Blood pressure screening
Depression screening
Fluoride chemoprevention supplements
Hearing screening
Hematocrit or hemoglobin screening
Hypothyroidism screening
Lead screening
Oral health risk assessment
STI prevention, counseling and
screening
Vision Screening

Behavioral assessments – based on age
Cervical dysplasia screening
Developmental screening
Gonorrhea preventive medication
Height, weight and body mass index
HIV screening
Iron Supplements
Obesity screening and counseling
Phenylketonuria (PKU) screening
Tuberculin testing
Vaccinations

*This is a list of services are covered under the ACA. Please note some services are based on gender and race. For the complete listing please go to www.healthcare.gov

PRESCRIPTIONS & WAYS TO SAVE

Ask your doctor or pharmacist if your brand medication has a generic or lower cost alternative.

SAVING ON PRESCRIPTIONS

A wide range of generic medications are offered at low cost at your local pharmacy.
Specific generic drugs are available at Target, Wal-Mart, City Market and many more for **$4 for a 30-day supply and $10 for a 90-day supply**!

90 DAY SUPPLY FOR MAINTENANCE MEDICATIONS

Have the medications you take on a daily basis delivered right to your door at no additional cost. Because you can get up to a 90-day supply at one time, you may even be able to save money. You'll get a reminder when it's time to reorder, and have access to the CoachRx team for help with drug interactions, side effects and ways to lower your medication costs.

USE THE PRESCRIPTION DRUG PRICE QUOTE TOOL

View medication cost based on your pharmacy plan, see if there are lower cost alternatives and compare prices between Cigna Home Delivery Pharmacy and retail pharmacies

GET HELP WITH SPECIALTY MEDICATIONS

Take advantage of TheraCare®. Your personalized team will help you better understand your chronic condition and medication, including common side effects and how to follow your doctor's treatment instructions correctly.

VIRTUAL VISITS

Virtual visits allow you to see and talk to a doctor from a mobile device or computer without an appointment, 24/7. A majority of visits take between 10-15 minutes, and virtual visits are a part of your health benefits.

Through a virtual visit, doctors can diagnose and treat a vast range of non-emergency medical conditions and provide services such as writing a prescription, if needed. This includes:

- Allergies
- Bladder infection
- Bronchitis
- Cold/cough
- Fever
- Migraine/headaches
- Pink eye
- Seasonal flu
- Sinus problems
- Sore throat
- Stomach ache

Access virtual visits :

To get started, go to www.mycigna.com, choose either Amwell or MDLive, or download either mobile app to set up your account and register for a virtual visit. After registering and requesting a visit you will pay your portion of the service cost and then you will enter a virtual waiting room. Payment for service cost can be remitted via credit card. During your visit you will be able to talk to a doctor about your health concerns, symptoms and treatment options.

Virtual visits are subject to the cost of your PCP copay ($10 or $25 Copay) on the Gold & Silver plans. If you are on the Bronze-HDHP/HSA plan the cost for virtual visits is subject to your deductible, but the cost will not exceed $50 per visit.

GAP Plans

Walking Mountains offers GAP insurance on a voluntary basis to assist employees with deductible expenses. There are two GAP plans to choose from; one is HSA compliant and one can be selected with the Gold & Silver medical plans

GAP Plans are designed as a supplement to your Cigna medical coverage and pays a calendar year benefit, up to the maximum benefit selected, for each Covered Person who incurs eligible out-of-pocket expenses. It can reduce the out-of-pocket expenses an employee or dependents may incur as a result of an accidental injury or sickness.

The benefits provided by SIS help pay for out-of-pocket expenses incurred due to a covered Hospital Confinement or covered out-patient medical procedures

	SIS GAP Plans	
	GAP Plan for Gold and Silver Plans	**HSA Compliant GAP Plan**
In-Hospital Benefit Maximum	$3,500 per enrolled member/per calendar year	$5,000 per enrolled member/per calendar year
Out Patient Maximum	$1,750 Max – limit 4 occurrences per family per calendar year	$2,500 Max – limit 4 occurrences per family per calendar year
Cigna Medical Deductible to satisfied prior to GAP benefit	$0	$1,500
	Bi-Weekly Cost for Coverage	
Ages > 40		
Employee Only	$20.03	$15.55
Employee + Spouse	$36.06	$27.99
Employee + Children	$44.28	$34.37
Family	$60.30	$46.81
Ages 40-49		
Employee Only	$27.28	$21.57
Employee + Spouse	$50.00	$38.82
Employee + Children	$51.12	$39.68
Family	$73.34	$56.94
Ages 50+		
Employee Only	$44.85	$34.82
Employee + Spouse	$80.73	$62.67
Employee + Children	$72.66	$56.40
Family	$108.54	$84.26

DENTAL INSURANCE

Walking Mountains offers dental coverage through Guardian. The Dental Plan allows two options. The Enhanced plan is for members who have a dentist in-network with Guardian. The Standard is for those members who have dentists that don't participate in the network.

In-Network Dentist: Patient presents ID card to dentist. The dentist can verify benefits via toll free number on ID card. At the time of visit, patient pays any cost share determined or may be billed after the visit. Dentist then files a claim for a balance. Employees who utilize in-network dentist are protected by the contracted rates for services and cannot be balanced-billed for charges above the contracted prices for services.

Non-Network Dentist: Patient presents ID card to dentist. The dentist can verify benefits via toll free number on ID card. At the time of visit, patient pays any cost share determined or may be billed after the visit. Dentist may or may not file a claim for a balance. Employees are not penalized for utilizing non-network dentists but balance billing can apply. The Plan is set up to pay at the 90th percentile of prevailing charges in the zip code that services are provided.

	Dental Plan	
	Enhanced	**Standard**
Calendar Year Deductible		
	$50 / $150	$50 / $150
Annual Maximum *(per covered member)*		
Per covered member	$1,500	$1,500
Tier 1 – Preventive		
	100%, Deductible Waived	100%, Deductible Waived
Tier 2 – Basic		
	100% After Deductible	80% After Deductible
Tier 3 – Major		
	60% After Deductible	50% After Deductible
Ortho		
Lifetime Benefit	Not Covered	Not Covered
	Bi-Weekly Cost for Coverage	
Employee Only	$4.82	
Employee + Spouse	$23.25	
Employee + Children	$30.45	
Family	$49.47	

Please only select the Enhanced plan if you have verified your dentist is in-network.

VISION INSURANCE

Walking Mountains offers vision coverage through Guardian. The Guardian Vision plan allows you access to VSP network vision providers. To search in-network providers visit www.vsp.com and in search based on your location in the "Locate a Provider" box. You will be asked to select your network, please select "VSP Choice Network".
When you utilize an out-of-network provider you pay expenses at the time of service and file a claim for reimbursement. Below is a list of the reimbursement schedule.

	Vision VSP Choice Network
In-Network	
Routine Eye Exams	Every 12 months
	$10 Copay
Lenses [2]	Every 12 months
Single Vision Bifocal Trifocal Lenticular	$25 Copay Lens upgrades are available at 20%-25% of retail pricing.
Frames	Every 24 months
	$25 Copay provides a $130 allowance PLUS 20% off cost over the allowance
Contact Lenses *(in lieu of glasses)* [1]	Every 12 months
Elective Contact Lenses Contact Lens Fitting[2] Standard Specialty	$130 allowance
Out-of-Network	
Routine Eye Exams	Every 12 months Reimbursed up to $39
Lenses [2] Single Bifocal Trifocal Lenticular	Every 12 months Reimbursed up to $23 Reimbursed up to $37 Reimbursed up to $49 Reimbursed up to $64
Frames	Every 24 months Reimbursed up to $46
Contact Lenses (in lieu of glasses) Elective Medically Necessary	Every 12 months Reimbursed up to $100 Reimbursed up to $210
	Bi-Weekly Cost for Coverage
Employee Only	$3.18
Employee + Spouse	$5.44
Employee + Child(ren)	$6.36
Employee + Family	$8.82

[1] Lenses benefit listed are for a pair of lenses

[2] Standard Contact Lens Fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Specialty Contact Lens Fitting applies to new contact wearers and/or a member who wear toric, gas permeable, or multi-focal lenses.

HEALTH SAVINGS ACCOUNT (HSA)

Employees enrolling in the **Bronze-HDHP Medical Plan** may open and contribute to a Health Savings Account (HSA). With an HSA you have the ability to put money aside, through payroll deductions, to help pay for HSA eligible expenses. The contributions you make are taken pre-tax.

IRS Annual Maximum* HSA Contribution Limits		
	2018	**2019**
Employee Only	$3,450	$3,500
Employee + Spouse, Child(ren) or both	$6,900	$7,000

Additional $1,000 annually catch-up amounts for available for employees 55 years or older

WHAT ARE THE BENEFITS OF AN HSA?

- ✓ The money you put aside is PRE-TAX
- ✓ The HSA is a bank account in your name. If you retire or should you leave Walking Mountains you take this account with you.
- ✓ The account rolls over year to year. You will not have to forfeit any unused funds.
- ✓ You will receive a debit card upon opening an HSA for quick and easy utilization of the fund.
- ✓ The list of eligible expenses is vast! These expenses include things covered under the medical, dental, and vision coverage – as well as some items that aren't!

FLEXIBLE SPENDING ACCOUNT (FSA)

You have the option to contribute to a Flexible Spending Account (FSA). There are 2 types of FSAs. (1) Healthcare FSA and (2) Dependent Care FSA. With an FSA you have the ability to put money aside, through payroll deductions, to help pay for FSA eligible expenses. The contributions you make are taken pre-tax.

If you participate in the HSA, you are NOT permitted to participate in the Healthcare FSA. You are, however, eligible to participate in the dependent Care FSA.

2018 IRS Annual Maximum FSA Contribution Limits		
Healthcare FSA		$2,650
Dependent Care FSA	*Single or married and files a separate tax return*	$2,500
	Married and files a joint tax return as single/head of household	$5,000

Examples of HSA and Healthcare FSA eligible expenses are as follows:

- Dental expenses
- Prescription Drugs and Over the Counter Drugs (when ordered by a doctor)
- Eye surgery (laser eye surgery or radial keratotomy) Fertility enhancements
- Hearing aids and batteries for use
- Long-term care and Nursing home
- Maternity Expenses
- Organ transplants
- Wheelchairs
- Acupuncture and Chiropractic services
- Alcohol and drug dependency treatment
- Ambulance
- Artificial limbs
- Contact lenses and solution
- Physical and speech therapies
- Smoking-cessation programs and products
- Vasectomy

LIFE INSURANCE

Walking Mountains Science Center provides all full-time employees with $20,000 in Life & AD&D coverage. In the event you pass away while employed by Walking Mountains this benefit is paid to the beneficiary you indicated on your enrollment. Employees may port or convert this policy if no longer employed by Walking Mountains.

The cost of this benefit is 100% paid for by Walking Mountains, at no cost to you!

Short-Term Disability

Walking Mountains provides you short term disability (STD) insurance. STD is insurance for your paycheck should you become disabled due to an off the job injury or illness for a period of time.

Walking Mountains pays 100% of the cost for STD coverage.
This benefit is at NO COST TO YOU.

WHEN WOULD THE BENEFIT START?

Benefits would begin on the 8th day from injury or illness.

HOW MUCH WOULD THE BENEFIT PAY?

The benefit would pay 60% of your weekly pre-disability earnings to a maximum of $1,000.00 per week.

HOW LONG WILL THE BENEFIT PAY?

The benefit would pay out to a maximum of 12 weeks or until you no longer meet the definition of disability, whichever occurs first.

401(k)

Walking Mountains Science Center offers a retirement program including 401K and Roth 401K account options to employees in full-time year round positions with the organization. The organization will match up 6% of employee contributions to the plan of their choosing. Eligibility begins the first of the month after 60 days of employment. If you are interested in participating in the WMSC retirement plan, contact Human Resources to enroll.

Perks

The following is an overview of Walking Mountains Science Center benefits and perks for Full-Time Year Round Employees and Educators. Please refer to WMSC Employee Handbook for a full description of the benefits and applicable policies. Contact Human Resources with any questions regarding these benefits.

Vacation Time

Walking Mountains Science Center offers paid vacation time to all full-time year round employees and educators.

Employees

Full-time year round employees begin to accrue vacation time at the start of employment and may begin to use the benefit after the first 90 days of employment. Vacation time accrual rates increase annually based on years of service with the organization and have an annual cap as outlined in the following grid:

Years of Service Completed	Accrual Rate/ Paycheck (26)	Annual Days Available
0-1 year	.58 days (4.62 hours)	15 days (120 hours)
1-2 years*	.69 days (5.54 hours)	18 days (144 hours)
2-3 years	.77 days (6.15 hours)	20 days (160 hours)
3-4 years	.85 days (6.77 hours)	22 days (176 hours)
4+	.96 days (7.69 hours)	25 days (200 hours)

Educators

Full-time year-round educators will receive 20 days of paid vacation annually. These vacation days are scheduled and dictated by the school calendar Winter, Spring, Summer and Fall Breaks. These breaks will be paid in 5 day increments. The actual dates of these breaks will be determined and communicated at the beginning of each calendar year.

Perks

Holidays

Walking Mountains offers the following paid holidays to full-time year round employees and educators.

Thanksgiving Day
Day After Thanksgiving
President's Day
Labor Day
Christmas Eve
Christmas Day
Memorial Day
2 Floating Holidays
New Year's Day
Martin Luther King Day
4th of July

Sick Leave

Full-time year round employees and educators are eligible for paid sick leave. Eligible employees begin accruing sick time at the start of employment. Sick leave accumulation is calculated on a monthly basis and has a maximum days accumulated cap as outlined in the following grid:

Accumulation Rate	Maximum Days Accumulated*
1 day per month (3.69 hours / pay period)	12 (96 hours)

Ski Pass Program

Employees

Full-time year round employees are eligible to receive a discounted ski pass through the Vail Resorts School Pass Program. Passes may be purchased by Walking Mountains and paid by the employee through payroll deduction over a 10 week period if desired. Ski passes will be available to employees each year staring in November.

Educators

Ski passes are included as part of the compensation package for educators. Paperwork for ski pass purchase will be available to employees each year starting in November.

Perks

Volunteer Time Off

Walking Mountains offers a Volunteer Time Off program as a benefit to full-time year round employees. This benefit aims to support volunteer activities that serve our community and enrich the lives of our employees by providing 16 hours of paid volunteer time per calendar year.

Sabbatical Leave

Walking Mountains values long-term employee resilience and supports employees maintaining a high degree of personal wellness. In order to support employee tenure and performance, Walking Mountains offers a sabbatical leave plan to provide time for renewal and rejuvenation to qualified long-term employees. Employees become eligible for 4 paid weeks of sabbatical leave after 7 years of continued service with the organization.

Professional Development

Walking Mountains is committed to providing employees with the opportunity to engage in professional development relevant to the organization or an employee's role within the organization. As a result, employees are eligible to submit applications to the Walking Mountains Professional Development Review Committee each quarter to be considered for funding for professional development opportunities that are of interest to them and of benefit to their role with the organization.

Additional Walking Mountains Perks

- Walking Mountains program and camp discounts
- Home Energy Assessment discounts
- Pro Deals
- Health and recreation club discounts
- ECO bus pass punch card discounts

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery, to less than 48 hours, and (2) following a cesarean section, to less then 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

1. Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
2. Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
3. Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage;
4. Require a mother to give birth in a hospital; or
5. Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

SECTION 111

Effective January 1, 2009 group health plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extensions of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claims assignments. In other words, it will help establish who pays first. The mandate requires group health plans to collect additional information, more specifically Social Security numbers for all enrollees, including dependents 6 months of age or older. Please be prepared to provide this information on your benefits enrollment form when enrolling into benefits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires Kisinger Campo & Associates Hospitality to notify you, as a participant or beneficiary of the Kisinger Campo & Associates Hospitality Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical compilations of the mastectomy, including lymphedema.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

MICHELLE'S LAW

The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. This law applies to medically necessary leaves of absence that begin on or after January 1, 2010

If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if your child was (1) covered under the plan and (2) enrolled as at student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).

Your employer will require a written certification from the child's physician that states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

continued

HIPAA PRIVACY POLICY FOR FULLY-INSURED PLANS WITH NO ACCESS TO PHI

The group health plan is a fully-insured group health plan sponsored by the "Plan Sponsor". The group health plan and the plan sponsor intend to comply with the requirements of 45 C.F.R. §164.530 (k) so that the group health plan is not subject to most of HIPAA's privacy requirements.

I. No access to protected health information (PHI) except for summary health information for limited purpose and enrollment / dis-enrollment information.

Neither the group health plan nor the plan sponsor (or any member of the plan sponsor's workforce) shall create or receive protected health information (PHI) as defined in 45 C.F.R. §160.103 except for (1) summary health information for purpose of (a) obtaining premium bids or (b) modifying, amending, or terminating the group health plan, and (2) enrollment and dis-enrollment information.

II. Insurer for group health plan will provide privacy notice

The insurer for the group health plan will provide the group health plan's notice of privacy practices and will satisfy the other requirements under HIPAA related to the group health plan's PHI. The notice of privacy practices will notify participants of the potential disclosure of summary health information and enrollment / dis-enrollment information to the group health plan and the plan sponsor.

III. No intimidating or retaliatory acts

The group health plan shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights , filing a complaint, participating in an investigation, or opposing any improper practice under HIPAAA.

IV. No Waiver

The group health plan shall not require an individual to waive his or her privacy rights under HIPAA as a condition of treatment, payment, enrollment or eligibility. If such an action should occur by one of the plan sponsor's employees, the action shall not be attributed to the group health plan.

PATIENT PROTECTION:

If the Group Health Plan generally requires the designation of a primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier 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 the network who specializes in obstetrics or gynecology. The health care professionals, 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, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

continued

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) OF 2009

Effective April 1, 2009, a special enrollment period provision is added to comply with the requirements of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. If you or a dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after the date eligibility is lost. If you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after you or your dependent is determined to be eligible for State premium assistance. Please note that premium assistance is not available in all states.

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 July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.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 – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/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**

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

continued

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/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/ma/ 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/index-es.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/hipp 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**
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
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 July 31, 2016, or for more information on special enrollment rights, 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

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.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

continued

MEDICARE PART D

This notice applies to employees and covered dependents who are eligible for Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with United Healthcare and about your options under Medicare's prescription 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.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription 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. CIGNA has determined that the prescription drug coverage offered by the Welfare Plan for Employees of Walking Mountains under the **CIGNA Gold & Silver** options are, on average for all plan participants, expected to pay out as much as the 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.

You should also know that if you drop or lose your coverage with CIGNA and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. _____

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 United Healthcare coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current United Healthcare coverage, be aware that you and your dependents will 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 United Healthcare 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 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 our office for further information (see contact information below). 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 United Healthcare 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 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 notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	09/01/2018
Name of Entity/Sender:	Kisinger Campo & Associates
Contact--Position/Office:	Colleen Carter 201 N Franklin Street, Suite 400 Tampa, FL 33602
Phone Number:	813-871-5331

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

continued

MEDICARE PART D

This notice applies to employees and covered dependents who are eligible for Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with United Healthcare and about your options under Medicare's prescription 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.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription 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. CIGNA has determined that the prescription drug coverage offered by the Welfare Plan for Employees of Walking Mountains under the **CIGNA Bronze option** are not, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is not Creditable Coverage, you can keep this coverage but may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You should also know that if you drop or lose your coverage with CIGNA and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. _____

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 United Healthcare coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current United Healthcare coverage, be aware that you and your dependents will 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 United Healthcare 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 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 our office for further information (see contact information below). 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 United Healthcare 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 your copy of the Medicare & You handbook for their telephone number) for personalized help,
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Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	09/01/2018
Name of Entity/Sender:	Kisinger Campo & Associates
Contact--Position/Office:	Colleen Carter 201 N Franklin Street, Suite 400 Tampa, FL 33602
Phone Number:	813-871-5331

GENERAL NOTICE OF COBRA RIGHTS

*Continuations coverage rights under cobra**

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

GENERAL NOTICE OF COBRA RIGHTS

continued

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

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

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

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

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

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 and employment-based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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% of your household income for the year, 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.[1]

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:

Colleen Carter, VP/Director of HR at Colleen.Carter@kisingercampo.com

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, including an online application for health insurance coverage and ~~contact information for a Health Ins~~urance Marketplace in your area.

1 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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name		4. Employer Identification Number (EIN)
Walking Mountains Science Center		84-1436731
5. Employer Address		6. Employer Phone Number
P.O. Box 9469		970-827-9725
7. City	8. State	9. Zip Code
Avon	CO	81620
10. Who can we contact about employee health coverage at this job?		
Kathleen O'Toole – Gilles		
11. Phone Number (if different from above)	12. E-mail address	
	kathleenog@walkingmountains.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  [ ] All Employees. Eligible employees are:

  [X] Some employees. Eligible employees are:

  Employees who work at least 30 hours per week and have been employed at least 60 days.

- With respect to dependents:

  [X] We do offer coverage. Eligible Dependents are:

  Legal Spouse and Dependents to Age 26

  [ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

1 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 (Section 36(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

[X] **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

[ ] **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

[X] Yes (Go to question 15) [ ] No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$**

b. How often? [ ] Weekly [X] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

[ ] Employer won't offer health coverage

[ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15)

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? [ ] Weekly [X] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

1 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 (Section 36(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

Presented by:

Neil-Garing
MOUNTAIN WEST
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Services