



BENEFITS GUIDE

An overview of the wide array of benefits provided by Hightech Signs, to help you enjoy increased well-being and financial security.

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How to Get Health Insurance Through Your Employer

Who is Eligible?

Employees working 30+ hours per week (on average over a calendar year).

Opportunities to Join Group Coverage

- Initial Enrollment Period (new hire employees)
- Annual Open Enrollment Period
- Qualifying Events

How to Enroll

Complete the carrier applications and election form(s) provided by your HR manager. Whether you are enrolling for coverage, or declining coverage, you will need to sign and return the necessary documents to your employer **within 30 days** of your effective date of coverage.

If you do not complete and return your paperwork within the 30-day window, you will not be able to join the coverage again until the next annual open enrollment period, or unless a qualifying event occurs.

What are the perks of taking the health insurance benefits offered through your employer?

Your employer splits the monthly premium cost for medical, non-voluntary ~~dental & vision~~, and basic life coverage. Also, premium contributions from your employer are not subject to federal taxes, and your contributions can be made, pre-tax, which lowers your taxable income. Plus, the benefit structure of the plan(s) offered through employer sponsored coverage are often much richer than those of individual plans.

If I choose to decline coverage during my initial enrollment period (new hire employees), can I join coverage at a later point in time?

Yes, but only during the annual open enrollment period OR if you experience a qualifying event (see page 4).

Can I add my spouse and/or child(ren) to my coverage anytime I want?

No. After your initial enrollment period, dependents can only be added to your medical, dental, and vision coverage during the annual open enrollment period OR if you experience a qualifying event (see page 4).

Qualifying Events and Important Dates to Remember

**You have 30 days after a qualifying event occurs to notify your HR of any benefit changes that need to be made.*



Marriage

Notify your employer within 30 days of marriage in order to add your new spouse to coverage. The coverage effective date will be the date listed on marriage the certificate.



Child's Birth/Adoption

Notify your employer within 30 days to begin new dependent child coverage. The coverage effective date will be the child's official date of birth, or adoption date listed on legal documentation.



Dependent Status Change

Child dependents may stay on parental coverage until the age of 26. At age 26, the dependent must assume their own coverage. Children with certain disabilities may qualify to remain on parental coverage beyond age 26.



Starting a New Job

New employees are eligible to join group coverage when first hired. A completed application must be submitted to your employer within 30 days of your coverage effective date.



Divorce

Notify your employer of your change in marital status and update your beneficiary information within 30 days. The effective date of coverage will be the date listed on the divorce decree.



Loss of Coverage

Notify your employer within 30 days of loss of other coverage. You may have an opportunity to enroll in your group plan. See your employer for details.



Medicare Eligible

Medicare doesn't change eligibility for your group health plan if you're an active employee, but may provide additional medical options. See your employer for details.



Last Day at Work

(Not a qualifying event)
Ask your employer if you are eligible to continue group coverage under COBRA /State Continuation.



Moving Day

(Not a qualifying event)
Notify your employer ASAP of your change in address.

IMPORTANT: If you do not enroll within your eligibility window, you CANNOT make changes to your coverage until your company's next open enrollment period.

Hightech Signs

Employee Benefit Election Form

Effective from January 01, 2021 to December 31, 2021

Hightech Signs offers competitive benefits to full-time employees who work at least 30 hours per week. Your costs are paid over the course of 24 pay periods throughout the year with pre-tax dollars. If you are already covered by the group policies and you would like to keep your elections the same, then you do not need to complete an application. If you wish to add, change, end, or waive coverage, please complete this election form and the provided applications.

MEDICAL: ANTHEM

Hightech Signs pays roughly 2/3rds of the employee only cost of coverage for Medical insurance through Anthem. You are responsible for paying the remaining cost of coverage for yourself and your covered spouse and dependent children. Coverage for new hires begins 90 days after your date of hire for the benefits you elect. The Summary of Benefits & Coverage (SBC) and the medical rate sheet for the medical policy have been provided in this packet. Use the chart below to elect and calculate your coverage.

Anthem	Total Monthly Cost (enter rates by age)	Your Estimated Monthly Cost (multiply the Employee Only Total Monthly Cost by 0.6667 and enter below)	Your Estimated Cost Per Paycheck (multiply your monthly cost by 12, then divide by 24)
Employee Only			
Spouse		Same as Total Monthly Cost	
Dependent Child 1		Same as Total Monthly Cost	
Dependent Child 2		Same as Total Monthly Cost	
Dependent Child 3		Same as Total Monthly Cost	
NO COVERAGE (Waiver)	--	--	--
Total Your Monthly Amount			

HEALTH SAVINGS ACCOUNT (HSA)

If you are covered by Hightech Sign's medical policy, you may be eligible to contribute funds **TAX FREE** to a Health Savings Account (HSA). The table below shows the IRS HSA contributions limits for 2021.

Coverage Tier	Annual Employer HSA Contribution	Maximum HSA Contribution	Additional Amount You Can Contribute
Single	\$400	\$3,600	\$3,200
Employee + Spouse or Family	\$400	\$7,200	\$6,800
Age 55+ Catch-Up Contribution is \$1,000			
Enter the amount you would like to contribute annually			

*Contribution maximums adjust according to length of time you are covered by a qualified HSA-compatible plan and length of time during the year you have either Single or Family coverage. See IRS Publication 969 for more information on Health Savings Account rules and regulations. [Link: <https://www.irs.gov/pub/irs-pdf/p969.pdf>]

Hightech Signs

Employee Benefit Election Form

Effective from January 01, 2021 to December 31, 2021

VISION: ANTHEM

Hightech Signs pays roughly 2/3rds of the employee only cost of coverage for Vision insurance coverage through Anthem. You are responsible for the remaining cost of coverage for yourself and the full cost of coverage for your covered spouse and dependent children. Coverage for newly hired employees begins 90 days after your date of hire for the benefits you elect. A Benefit Summary has been included in this packet. Use the chart below and the provided Anthem application to elect your coverage.

Anthem	Your Coverage Election (Please select one by placing a mark in this column)	Total Cost Per Month	Your Estimated Cost Per Month	Your Estimated Cost Per Paycheck
Employee Only		\$1.87	\$0.62	\$0.31
Employee + Spouse		\$3.27	\$2.02	\$1.01
Employee + Child(ren)		\$3.20	\$1.95	\$0.98
Family		\$5.15	\$3.90	\$1.95
NO COVERAGE (Waiver)		--	--	--

AUTHORIZATION:

By signing below, I hereby authorize my employer to deduct the amounts listed above for the purposes of purchasing health insurance coverage. Changes to health benefit elections may only take place in qualified instances such as marriage, divorce, death or birth of a dependent, loss or gain of coverage or employment by a dependent and certain other IRS-qualified situations. I realize I have 30 days from the date of the event to make a change to my health benefit elections.

DATE: _____ SSN: _____

NAME OF EMPLOYEE: _____

SIGNATURE : _____

Complete and return this page to Ellen Bender by the requested deadline.

Which Preventive Care Services are Covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of some of the common services that are included in the plans offered:

- Routine Annual Physical Exam
- Well Baby and Well Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy (Age and frequency restrictions may apply)
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms (Age restrictions may apply)
- Routine Pap Smear (Age and frequency restrictions may apply)
- Smoking Cessation Programs
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

Refer to additional carrier documentation for more information on covered Preventive Care Services.



KEY TERMS TO REMEMBER

Premium

Your premium is the fee you pay each month to maintain your coverage. In addition to your monthly premium, you may have to pay additional health care costs, including deductible, copayments, and coinsurance.

Coinsurance

Coinsurance is the percentage of costs of a covered health care service you pay after you've met your plan deductible(s).

Copayment (copay)

A copayment is the fixed cost that you will pay for certain health care services and prescriptions that are covered by your plan.

Deductible

The amount you must meet before the carrier will begin to apply coinsurance towards prescriptions and other covered services.

In-Network versus Out-of-Network

A doctor, hospital, or other provider is considered "in network" when they are contracted with your health insurance company to provide services to plan members at specific pre-negotiated rates. Out-of-network providers are not contracted with your health insurance plan. Costs for visiting in-network providers are typically lower than for those out-of-network.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most that you will have to pay for covered services within a calendar year. Once amount is spent on deductibles, copayments, and coinsurance, your health plan will cover 100% of the cost of covered benefits, provided they are in network.

These terms can feel overwhelming. Don't worry, we're here to help walk you through your plan. We do the heavy lifting so you don't have to. Contact us today with any questions you might have.

Health Savings Account (HSA)

FOR 2021 HIGHTECH SIGNS IS OFFERING A HEALTH SAVINGS ACCOUNT (HSA). THIS IS HOW AN HSA WORKS:

The main purpose of a Health Savings Account (HSA) is to off-set the cost of a qualifying high deductible health plan (HDHP) and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement.

This is a “portable” account. You own your HSA! It’s included in your current employee benefits package, but even if you leave your job with your current employer, you may use the remaining monies in the account towards future, qualified, medical expenses.

Once your HSA is established, money is contributed to your account by you and your company. You can then use your HSA dollars tax-free to pay for eligible health care expenses. You can save money to put towards qualifying medical expenses like doctors’ office visits, prescription drugs, and much more.

WHY IS IT A GOOD IDEA TO HAVE AN HSA?

HSAs help you save money on taxes in three ways:

Tax-free deposits

The money you contribute to your HSA isn’t taxed (up to the IRS annual limit)

Tax-free earnings

Your interest and any investment earnings grow tax-free

Tax-free withdrawals

Money used toward eligible health care expenses isn’t taxed—now or in the future

By setting aside pre-tax dollars into your HSA you pay fewer taxes and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket. For example, if you are in the 30 percent tax bracket, you can save \$30 on every \$100 spent on eligible health care expenses

HSA funds roll over from year to year and accumulate in your account. There is no “use-it-or-lose-it” rule with HSA’s, and you decide how and when to use your HSA funds, which can be used for eligible expenses you have now, in the future, or during retirement.

Refer to additional H.S.A documentation for more information.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/fi>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,000 /single or \$6,000 /family for Network Providers . \$6,000 /single or \$12,000 /family for Non- Network Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care for Network Providers .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$4,000 /single or \$8,000 /family for Network Providers . \$10,000 /single or \$20,000 /family for Non- Network Providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Non- Network Transplant Services, Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes, Blue Access. See www.anthem.com or call (855) 333-5735 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of- network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of- network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral	No.	You can see the specialist you choose without a referral .

to see a [specialist](#)?



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	-----none-----
	Specialist visit	0% coinsurance	30% coinsurance	-----none-----
	Preventive care / screening / immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	\$10/prescription (retail) and \$10/prescription (home delivery)	\$60/prescription or 50% coinsurance , whichever is greater (retail)	*See Prescription Drug section
	Tier 2 - Typically Preferred / Brand	\$30/prescription (retail) and \$75/prescription (home delivery)	\$60/prescription or 50% coinsurance , whichever is greater (retail)	
	Tier 3 - Typically Non- Preferred / Specialty Drugs	\$60/prescription (retail) and \$180/prescription (home delivery)	\$60/prescription or 50% coinsurance , whichever is greater (retail)	
	Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$200 maximum /prescription (retail) and 25% coinsurance up to \$200 maximum /prescription (home delivery)	\$60/prescription or 50% coinsurance , whichever is greater (retail)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	0% coinsurance	30% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In- Network	
	Emergency medical transportation	0% coinsurance	Covered as In- Network	-----none-----
	Urgent care	0% coinsurance	30% coinsurance	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Physical medicine and rehabilitation services (including day rehabilitation programs) are limited to 60 days of care regardless of the provider's network status.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance	Office Visit 30% coinsurance	Office Visit -----none-----
		Other Outpatient 0% coinsurance	Other Outpatient 30% coinsurance	Other Outpatient -----none-----
	Inpatient services	0% coinsurance	30% coinsurance	-----none-----
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	100 visits/benefit period.
	Rehabilitation services	0% coinsurance	30% coinsurance	*See Therapy Services section
	Habilitation services	0% coinsurance	30% coinsurance	
	Skilled nursing care	0% coinsurance	30% coinsurance	90 day limit/benefit period.
	Durable medical equipment	0% coinsurance	30% coinsurance	*See Durable Medical Equipment Section
	Hospice services	0% coinsurance	0% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Eye exams for a child
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes.
- Acupuncture
- Dental care (adult)
- Glasses for a child
- Long-term care
- Weight loss programs
- Bariatric surgery
- Dental Check-up
- Hearing aids
- Routine eye care (adult)

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care 12 visits/benefit period.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing \$50,000 maximum/benefit period. \$100,000 maximum/lifetime.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State of Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (800) 622-4461, (317) 232-2395, www.in.gov/idoi/3008.htm. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

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

State of Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (800) 622-4461, (317) 232-2395, www.in.gov/idoi/3008.htm

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
--------------------	----------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,070

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,520

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 333-5735

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5735 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5735.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 333-5735:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nìà ke dyí ní, ɔ̀ m̀ò nì dyí-bédɛ̀in-dɛ̀ bɛ̀ m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ bídì-wùdùùn b́ó pídyi. B́é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d́á (855) 333-5735.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 333-5735 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 333-5735 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 333-5735。

Dinka (Dinka): Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (855) 333-5735.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 333-5735.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 333-5735 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5735.

Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 333-5735.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 333-5735.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 333-5735.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5735.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 333-5735 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 333-5735.

Igbo (Igbo): O bụr u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (855) 333-5735.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 333-5735.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 333-5735.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5735

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 333-5735 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 333-5735 ។

Language Access Services:

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuze, akura (855) 333-5735.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ນລັບວ່າມແບພາສາ, ໃຫ້ໂທຫາ (855) 333-5735.

Navajo (Diné): Dít naaltsoos biká'ígíí lahgo bína'idíłkídgó ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj̄' hodiłnih (855) 333-5735.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 333-5735

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 333-5735 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (855) 333-5735 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 333-5735.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (855) 333-5735.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 333-5735 ਤੇ ਕਾਲ ਕਰੋ।

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (855) 333-5735.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5735.

Language Access Services:

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 333-5735.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 333-5735.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 333-5735.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 333-5735.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 333-5735 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (855) 333-5735.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (855) 333-5735 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 333-5735.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (855) 333-5735.

Yoruba (Yorùbá): Tí o bá ní èyíkẹyí ibèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (855) 333-5735.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice eye care doctors. Our network also has many convenient optical stores, including popular national retail stores LensCrafters®, Target Optical®, Sears Optical®, JCPenney® Optical and most Pearle Vision® locations. When you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. To locate a participating network eye care doctor or location, log in at anthem.com, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	\$5 copay	Up to \$42 allowance	Once every 12 months

USING YOUR BLUE VIEW VISION PLAN

When you are ready to schedule your eye exam, just make an appointment with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. See page 2 for further details.

OUT-OF-NETWORK

If you choose to, you may receive covered services outside of the Blue View Vision network. If you choose an out-of-network doctor, you must pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. To download a claim form, log in at anthem.com, or from the home page menu locate Support and select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at **1-866-723-0515** to request a claim form. To request reimbursement for out-of-network services, complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
 Attn: OON Claims
 P.O. Box 8504
 Mason, OH 45040-7111

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit anthem.com or call us at 1-866-723-0515.

This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		Member Pays
Retinal Imaging	<ul style="list-style-type: none"> At member's option can be performed at time of eye exam 	Not more than \$39
Eyeglass Frame	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses* 	35% off retail price
Eyeglass Lenses Standard plastic material	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses*: <ul style="list-style-type: none"> Single Vision \$50 Bifocal \$70 Trifocal \$105 	
Eyeglass Lens Options and Upgrades When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	<ul style="list-style-type: none"> UV Coating \$15 Tint (Solid and Gradient) \$15 Standard Scratch-Resistant Coating \$15 Standard Polycarbonate \$40 Standard Anti-Reflective Coating \$45 Standard Progressive Lenses (add-on to Bifocal) \$65 Other Add-Ons 20% off retail price 	
Conventional Contact Lenses (non-disposable type)	<ul style="list-style-type: none"> Discount applies to materials only 	15% off retail price

* If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations.

Some of the Blue View Vision participating in-network providers include:



ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM

Other savings offers are available on eyewear, hearing aids and even LASIK laser vision correction surgery through a variety of vendors. Just **log in at anthem.com**, select discounts, then Vision, Hearing & Dental.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Company (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association. CR EO LG (2017)

**2021
Required Notices
For Castleton Village Center dba Hightech Signs
Employees**

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NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

To request special enrollment or obtain more information, contact the HR department of the employer sponsoring the plan(s).

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA) NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see your current plan year's Summary of Benefits and Coverage for more information. If you would like more information on WHCRA benefits, call the insurance company listed on your member ID card.

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call the insurance carrier listed on your insurance member ID card for more information.

NOTICE OF PATIENT PROTECTIONS

Your MEDICAL PLAN may generally request your designation of a primary care provider. You have the right to designate any primary care provider who participates in the provider network and who is available to accept you or your family members. In some cases, until you make this designation, the MEDICAL PLAN or health insurance issuer may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Medical Plan Administrator or insurance company listed on the member ID card.

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

For obstetric or gynecological care, you do not need prior authorization from the group health plan or issuer 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 medical plan 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, contact the Medical Plan Administrator or insurance company listed on the member ID card.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 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 Insurance Marketplace in your area.

NOTE: 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 also referred to as "BRONZE" level coverage in (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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.

Employer Name	Castleton Village Center dba Hightech Signs
Employer TIN#	35-1746592
Employer Address, City, State, Zip	6321 Huguenard Road, Suite A Fort Wayne, IN 46818
Employer Phone Number	(260) 484-2600
Who can we contact about employee health coverage at this job?	Ellen Bender
Contact Phone & Email (if different than above)	(260) 484-2600 ellen@hightech-signs.com

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

As your employer, we offer a health plan to:	
<input checked="" type="checkbox"/>	All eligible employees defined in our Summary Plan Description.
<input checked="" type="checkbox"/>	All eligible dependents as defined in our Summary Plan Description.
<input checked="" type="checkbox"/>	This coverage meets the minimum value standard and the cost of this coverage may or may not be considered 'affordable' as defined by the government based on your household income and other factors.

*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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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. **Contact employer if needed.**

Is the employee currently eligible for coverage offered by this employer or will they be eligible in the next 3 months?		
<input type="checkbox"/>	YES	When is the employee eligible for coverage? <i>Enter mm/dd/yyyy</i>
<input type="checkbox"/>	NO	STOP and return form to employee
Does the employer offer a health plan that meets the minimum value standard* (Bronze level coverage)?		
<input checked="" type="checkbox"/>	YES	Go to next question
<input type="checkbox"/>	NO	STOP and return form to employee
For the lowest cost plan that meets the minimum value standard* offered only to the employee (don't include family coverage). Provide costs for non-tobacco use but no other wellness discounts:		
\$		<i>How much does the lowest cost Single coverage plan for non-tobacco users cost the employee per month?</i>
If the plan year will end soon and you know that health plans offered will change, go to the next question. If unsure, STOP here and return form to employee. What change will the employer make for the new plan year?		
<input type="checkbox"/>		Employer not offering health coverage
<input type="checkbox"/>		Employer will begin offering health coverage to employees or change the premium for the lowest cost Bronze plan's Single coverage for non-tobacco users (with no other wellness discounts applied).
\$		If premiums are changing, what will lowest cost Single coverage for non-tobacco users be per month?

*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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.

This notice goes to all employees even if the state the employee resides in does not have a CHIP program as they may have dependents living in other states.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

<p align="center">ALABAMA – Medicaid</p>	<p align="center">COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)</p>
<p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442</p>
<p align="center">ALASKA – Medicaid</p>	<p align="center">FLORIDA – Medicaid</p>
<p>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</p>	<p>Website: https://www.flmedicaidtprerecovery.com/flmedicaidtprerecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
<p align="center">ARKANSAS – Medicaid</p>	<p align="center">GEORGIA – Medicaid</p>
<p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131</p>
<p align="center">CALIFORNIA – Medicaid</p>	<p align="center">INDIANA – Medicaid</p>
<p>Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676</p>	<p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx X Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100 7

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

**Important Notice from Castleton Village Center dba Hightech
Signs 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 Castleton Village Center dba Hightech Signs 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. Castleton Village Center dba Hightech Signs has determined that the prescription drug coverage offered by the company 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.

If you decide to join a Medicare drug plan, your current *Employer Group coverage *will not be affected. The plan covers prescription drugs as described in your Summary of Benefits & Coverage provided each year. Depending on the size of your employer at the time of claim, the Part D coverage or the Plan may pay primary.

If you do decide to join a Medicare drug plan and drop your current *Employer Group coverage, be aware that you and your dependents would be able to get this coverage back during the next open enrollment period offered by Castleton Village Center dba Hightech Signs as long as you are an active, full-time employee and/or meet the eligibility criteria to be covered by the plan.

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

You should also know that if you drop or lose your current coverage with Castleton Village Center dba Hightech Signs 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 your HR or Benefits Contact at Castleton Village Center dba Hightech Signs for clarification or 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 Castleton Village Center dba Hightech Signs 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).

Your Employee Benefits Team
www.arcbenefitsolutions.com
888-530-9497



ARC Benefit Solutions is focused on simplifying the lives of our clients. With more than 35 years of experience in the ever-changing insurance industry, we have made it our mission to get to know our clients' needs so we can match them with the best insurance solution.



JEREMIAH KNOX

Client Relations Advisor

Day-to-day contact for group benefits, assisting both employer and employees.

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ext. 5078



LATONYA WILLIAMS

Client Relations Advisor

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llwilliams@arcbenefitsolutions.com

ext. 2719



KIM KINNAIRD

Director, Employee Benefits

Kim leads your employee benefits team and provides expert guidance on health insurance, legislative changes, trends, and updates.

kkinnaird@arcbenefitsolutions.com

ext. 2718

**WE STRIVE TO BE AN
EXTENSION OF YOUR
BUSINESS**

Creative Analysis

Analyze the health benefit market, negotiate renewals, evaluate plans, and provide creative solutions.

Effective Engagement

Engage and communicate with employees about benefits, assist with enrollments, handle questions, and resolve service issues.

Minimizing Risk

Find ways to prevent or reduce costs for the employer, employees, and their families.

Simplifying Compliance

Access streamlined and meaningful guidance when you need it.

Useful Tools and Resources

Get the most out of your benefits with a trusted advisor who brings you more.

Proactive Wellness

Implement programs to improve health and prevent future costs.